

Report on the Outcome of the Integrated Inspection of Safeguarding and Looked After Children's Services in Cumbria

Date of Inspection	10 th April 2012 – 20 th April 2012
Date of Joint Report	29 th May 2012
Commissioning PCT	NHS Cumbria
CQC Inspector name	Sue Talbot
Provider Services Included:	University Hospitals of Morecambe Bay NHS Foundation Trust North Cumbria University Hospitals NHS Trust Cumbria Partnership NHS Foundation Trust
CQC Region	North
CQC Deputy Director	Amanda Sherlock

This report relates to the recent integrated inspection of safeguarding and services for looked after children which took place in the above Authority recently

It provides more detailed evidence and feedback on the findings from the Care Quality Commission's (CQC) component of the inspection, and links these to the outcomes requirements as set out in the Essential Standards for Quality and Safety.

Thank you for your contribution to the inspection and for accommodating the requests for interviews and focus groups with your staff and those of partner agencies at relatively short notice.

The team provided feedback to your local Director of Children's Services at the end of fieldwork and the joint inspection report to the authority is now published on the Ofsted website and can be accessed via this link: [The joint inspection report](#) .

Cumbria County Council	
Safeguarding Inspection Outcome	Aggregated inspection finding
Overall effectiveness of the safeguarding services	Inadequate
Capacity for improvement	Adequate
The contribution of health agencies to keeping children and young people safe	Inadequate
Looked After children Inspection Outcome	Aggregated inspection finding
Overall effectiveness of services for looked after children and young people	Adequate
Capacity for improvement of the council and its partners	Adequate
Being Healthy	Inadequate

This report includes findings from the overall inspection report, and provides greater detail about what we found, mapped where relevant to the Essential Standards, in order that your organisation can consider and act upon the specific issues raised.

A copy of this report is being sent to your commissioning PCT, and CQC Regional Director. This report is also being copied to the Strategic Health Authority/Monitor as appropriate and CQC's Regional Director, who has overall responsibility for this inspection programme.

The Inspection Process

This inspection was conducted alongside the Ofsted-led programme of children's services inspections. These focus on safeguarding and the care of looked after children within a specific local authority. The inspection process comprises a range of methods for gathering information – document reviews, interviews, focus groups (including where possible with children and young people) and visits – in order to develop a corroborated set of evidence which contributes to the overall framework for the integrated inspection.

CQC contributes to the inspection team and assesses the contribution of health services to safeguarding and the care of Looked after children relating to that authority. Our findings from the inspection contribute to the joint report published by Ofsted and also enrich the information we use to assess providers against the Essential Standards of Quality and Safety. This report sets out specifically the evidence we obtained in relation to these standards and extracts from the published report are included and identified.

CQC used a range of documentary evidence in advance of and during this inspection, and interviewed individuals and focus groups of selected staff and, where possible, children and young people, their parents and carers in order to provide a robust basis for the findings and recommendations.

This document sets out the findings in relation to the NHS organisations listed above, but includes some areas which may apply to one or more NHS bodies where pertinent.

Context

Cumbria is the second largest county in England. There are significant differences between districts in the level of affluence and deprivation experienced by local people. Approximately 110,000 children and young people aged between 0-19 years live in the area out of a total population of just under 495,000 people. Almost 97% of the school population are White British. There are 1,139 children who have English as an additional language, 2,387 children who are from minority ethnic communities and 151 children who are Gypsy Roma Travellers. The popularity of the area as a holiday destination contributes to peaks in seasonal demand for local NHS services. At the time of the inspection 355 children were subject to a child protection plan, 603 were looked after children and 146 young people were entitled to leaving care services. In addition it is estimated that in excess of 400 looked after children are placed by other local authorities in Cumbria which results in additional pressures on NHS services operating in the area.

Planning and commissioning of children and young people's health services and primary care is carried out by NHS Cumbria (the PCT) in conjunction with the shadow Cumbrian Clinical Commissioning Group (CCG). The main providers of acute hospital services are the North Cumbria University Hospitals NHS Trust (NCUHT) and the University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBFT). NCUHT provides acute services including paediatric in-patient and maternity care on two sites in North and West Cumbria. UHMBFT provides in-patient paediatric services on one site and midwifery services on two sites. Community health services including health visitors, school nurses, child and adolescent mental health (CAMHS) teams and specialist teams supporting young people with complex health or long term conditions are provided by the Cumbria Partnership NHS Foundation Trust (CPFT). Children and families access primary care services through one of 82 GP practices. Urgent Treatment/Minor Injury Centres are available at 6 locations across the county. Cumbria has a relatively low spend on children and families health services compared to other areas in the region.

At the time of the inspection, CQC was conducting an investigation into the delivery of emergency care services provided by UHMBFT. In addition, Monitor¹ and NHS Cumbria were engaged in reviewing the progress of the Trust in improving the quality and safety of maternity care at UHMBFT. NCUHT was in the process of working toward integration of its operations with Northumbria Healthcare NHS Foundation Trust. CPFT was working to consolidate operational standards and working practices between the community health staff transferred from the PCT and its mental health services. The Children's Services Directorate within the County Council had also been restructured during 2011. NHS Cumbria and Cumbria County Council was working to promote integration of health and social care services aligned to the new Clinical Commissioning Group arrangements.

¹ The independent regulator of NHS Foundation Trusts

Whilst the health of many local people is good, there are pockets of considerable health need and inequalities between people living in different areas of Cumbria. Analysis of public health data indicates a mixed picture in terms of the health outcomes for children living in the area. Whilst childhood immunisation rates are better than the average for England, breast feeding initiation and rates of tooth decay fall below national comparators. Data also indicates a higher rate of admission to paediatric wards and very high rates of admissions of young people and adults due to alcohol and substance misuse compared to England averages. The rate of all admissions for deliberate self-harm in Cumbria (including adults) is significantly higher than the national average. Emergency admissions of children with long term conditions, particularly diabetes and epilepsy are higher than national comparators. All of these patients current have open access to the paediatric wards for medical management. Although the rate of teenage conceptions overall has fallen and is below the national average; in some localities, levels are considerably higher than the national average. The mortality rate from road traffic accidents in Cumbria is much higher than the national average.

1. General – leadership and management

1.1 The contribution of health to keeping children and young people safe is inadequate. Health and social care agencies have been slow in addressing some historical gaps in local provision and fully implementing some key national policies and guidance. Although a range of service development and improvement activity is evident, progress in building a strong shared safeguarding culture and delivery of improved outcomes for vulnerable children is not sufficiently embedded. Workforce capacity and gaps in locality working remain a challenge in effectively meeting children’s needs in some areas. Gaps and weaknesses in delivering the requirements of *Working Together* have led to inconsistencies in practice. Inspectors found a lack of a shared focus on the management of risk, gaps in the contribution of health staff to the Common Assessment Framework (CAF), deficiencies in record keeping and sharing of information, and under developed quality assurance arrangements.

1.2 Senior health managers, designated and named safeguarding staff have taken appropriate action in response to learning from serious case reviews and have strengthened their leadership and safeguarding systems. The quality and impact of safeguarding activity within individual Trusts is now being increasingly challenged and monitored. Senior health managers are now more aware of incidents of concern through strengthened escalation arrangements. A positive feature of the new safeguarding arrangements is the engagement, leadership and development programme for GPs. However, partnership working and peer review is still relatively immature and requires strengthening to increase the pace of change and provide greater assurance of joint agency accountabilities and learning. Audits of child health records and safeguarding practice are not yet sufficiently robust, embedded or focused on outcomes for children and their families. The engagement of most NHS leaders with the work of Cumbria's Local Safeguarding Children Board (CLSCB) has been good. However, UHMBFT has only relatively recently been represented on Cumbria's LSCB. It is not clear however all partners understand the contribution of individual health agencies and the Health Safeguarding Network Group. All health partners have reviewed and updated their safeguarding policies and procedures to provide better guidance and support to staff.

1.3 The contribution of health agencies to improving outcomes for looked after children is inadequate. The recently established multi-agency looked after partnership board (MALAP) demonstrates a clear commitment by senior leaders across the partnership to improve the life chances of looked after children. However, it is too early to judge the impact of this work. Capacity issues at senior management level within the local authority and health agencies have meant that not all identified gaps in service provision have been successfully addressed including services Timely and quality assessments of children's health needs are not consistently undertaken. Work is required to reduce the number of young people misusing substances. Care leavers require additional help to support their transition to adulthood. Performance in undertaking annual health assessments has dropped, and there is significant variability in performance between districts. The LAC health team's practices do not fully comply with CQC essential standards and statutory regulations.

2. Outcome 1 Involving Users

2.1 Children we met who are looked after thought the review of their health care was satisfactory. They said they knew who their nurse was and appreciated their assessments being undertaken at home. However, shortfalls in current staffing levels impact on organisational capacity to consistently offer children and young people a choice of location. This particularly relates to support provided by school nurses, health visitors, community paediatricians and CAMHS. Young people told us community health and therapy staff encouraged them to ask questions and worked sensitively with them to improve their understanding of their health and medical needs. Foster carers also reported good access to advice and training in addressing children's health and development needs.

2.2 Children reported having received information, but said it could be better tailored to their individual needs and age and stage of development. They also told us that letters needed to be clearer and easier for young people to understand. Advocacy support was not available to all children who are looked after. While this is positively promoted to children and young people placed in local authority children's homes, access to advocacy services is limited for children who live in foster care. Many of the children spoken to by inspectors or who responded to the survey were not aware of the advocacy support they could access if they needed it.

2.3 Limited work has been undertaken to date to systematically evaluate children and young peoples' views and experience of LAC health care arrangements. Health staff identified the need to strengthen shared approaches with the Children in Care Council to expand young peoples' participation in shaping the design and delivery of local services. Positive practice included one young woman talking about her experience of the Family Nurse Partnership at a midwifery conference and the involvement of a care leaver in the selection of a service provider. The added value of their contribution is recognised. However, there are not sufficient opportunities to hear and learn from the experience of children and young people using local health services. Work to promote child and young person friendly health services is not yet strategically driven or embedded in service delivery. Most providers have only made limited progress in evaluating their performance against '*You're Welcome*' quality criteria. In some cases where work had been initiated, it had not been sustained.

2.4 The council and CPFT are working to strengthen their arrangements to support the engagement of parents with disabilities through the '*Learning to Change*' Network. Senior managers acknowledge stronger strategic leadership and parental engagement is required to transform local services. Parents we met told us that they have not been effectively supported and can see little impact so far from their feedback in addressing long standing gaps and inequities in the provision of services. Although some parents have been involved in the short breaks monitoring work, they felt their contribution to shaping future commissioning arrangements was too limited. They said they would like the opportunity to become more involved in the transition development work taking place in localities.

2.5 Individual Health Trusts expressed commitment to strengthening their arrangements for seeking feedback from people using local health services. The West Cumberland Infirmary (NCUHT provision) undertakes monthly monitoring of care provided on its children's ward and tracks trends in satisfaction levels. This Trust is beginning to routinely use patient stories, including fathers' views of maternity services to inform work required to continuously improve the delivery of patient centred care. Heads of service have clear accountabilities for addressing any shortfalls in achieving the required standards of care identified through patient feedback. UHMBFT is in the process of undertaking a comprehensive review of the users of its maternity services to promote improved understanding of their care, treatment and support.

2.6 There is adequate access to interpreting and translation services for people who require additional support. Community health staff host a local health group for women living in the south of the county whose first language is not English. A range of posters and leaflets have been developed in community languages to improve their awareness and promote better take up of services.

3. Outcome 2 Consent

3.1 Consent and confidentiality issues are appropriately managed and recorded. The age, vulnerability and mental capacity of young people are carefully considered when making decisions about their care and treatment. Midwives are aware of their responsibilities toward young women who become pregnant under the age of consent, and appropriately alert social care staff about risks to their safety and wellbeing. School nurse records seen denote sensitive recording of puberty and sexual health issues. The website of the NCUHT provides good information about common paediatric surgical procedures to enable people to be better informed when giving consent.

4. Outcome 4 Care and welfare of people who use services

4.1 The common assessment framework (CAF) is not sufficiently embedded in the work of all frontline health care teams. Audits of practice for the past two years indicate ongoing gaps in coverage and implementation. Early intervention and prevention work with children and families is acknowledged by senior managers as an area for further development. Action is being taken to secure appropriate levels of community health staff to enable the full delivery of the Healthy Child Programme. School nurses are working to enhance access to advice and support through the expansion of their drop in services.

4.2 Child health records for children who are looked after provide a basic overview of their health and development needs. Health promotion work, including smoking cessation, sexual health and substance misuse issues are adequately promoted. However, the trends and outcomes of this work are not yet effectively tracked. Use of and the findings from strengths and difficulties questionnaires are not embedded in health assessments and reviews, and do not provide a comprehensive picture of children's needs or risks to their well-being. The focus on safeguarding looked after children was not sufficiently clear on records seen and some case notes did not adequately focus on or explore children's wishes and feelings. Care leavers are not provided with a comprehensive health history on leaving care.

4.3 Some children have clearly benefited from additional health screening and support, with risks to their physical health and development being appropriately identified and addressed. However, their looked after status has not been consistently flagged as a priority resulting in delays for some children in accessing relevant care and treatment, and difficulties in monitoring specific outcomes from the care and treatment provided. Late notifications by social care of the child's looked after status and placement details as well as difficulties in gaining parental consent have added to delays in some cases. This means that Cumbria is not fully compliant with Statutory Guidance on Promoting the Health and Wellbeing of Looked After Children.

4.4 Initial assessments undertaken by GPs are of variable quality and do not consistently ensure a clear and comprehensive overview of children and young people's needs on admission to care. Work has recently commenced to strengthen the involvement of GPs in looked after children arrangements and to address their training needs. Review health assessments undertaken by health visitors and school nurses are also of variable quality. The shortfall in school nursing capacity is a significant issue with respect to monitoring and supporting children and young people with complex needs. Medical advice to adoption and fostering panels has been stretched, contributing to delays in assessments being completed and permanency planning for children. CPFT have addressed this by identifying medical leads within the Community Paediatrician establishment to focus on supporting adoption medicals. This has led to an improving trend in meeting the required performance.

4.5 Health care plans for children with complex emotional, mental health or behavioural needs are not sufficiently clear, measurable or secured through effective communication and joint working arrangements. Performance in undertaking annual health assessments has dropped, and there is significant variability in performance between districts. Most children have been immunised and there is rapid access to dental health checks, although recent performance in this area indicates a need for further improvement.

4.6 Efforts are made to ensure an appropriate level of support to the relatively low number of young people with complex needs placed out of area. However, robust monitoring of the quality of their health care can be difficult given the distance of their placement from Cumbria. A new charging tariff introduced across the NHS North West area aims to establish a financial incentive for early clarification of health responsibilities for children moving between councils in the region. This should support better scrutiny of the health and wellbeing of some looked after children placed in the region. Work recently undertaken to map the needs and placements of children who are looked after in independent residential schools and care homes provides a clearer picture of pressures on local NHS services. Levels of support required by young people placed by other councils in these schools and homes requires careful monitoring given the overall capacity and demands on the local LAC service. Capacity to strengthen management oversight of current demands and activity levels is being addressed through the recent appointment of a service manager. Additional dedicated Children Looked After nurses have been recruited to address the fall in performance. Further review of the roles and accountabilities of specialist nurses is required to assure effective delivery of the required changes in a timely manner. Although there is a stated ambition to integrate looked after nurses into multi-agency teams, plans are still at a relatively early stage of development.

4.7 There are gaps in access to services and professional support for children with disabilities and complex health needs that place significant pressures on the coping capacity and sustainability of some families. Parents we met raised a number of concerns about the lack of service development and inadequate partnership working that left them without sufficient support. Gaps in specialist provision for children with autism were identified as an urgent area for improvement. Waiting times for wheelchairs were a concern in some areas. Increasing numbers of children are on the waiting lists of community paediatricians for diagnosis or further review due to gaps in their capacity to meet current levels of demand. Parents reported shortfalls in the availability of sensory impairment workers and Occupational Therapists including support for specialist equipment or adaptations. They reported positively on the work of physiotherapists in promoting the mobility and independence of their children. Slow progress has been made in addressing planned work including transforming the delivery of speech and language services and addressing historical gaps and inequities in provision between localities. There remain ongoing gaps in the provision of early years, behavioural management and short breaks support. A Disabled Children's Charter has been developed but few parents or staff we met knew of its existence or impact.

4.8 Access to CAMHS is variable and gaps in the availability of out of hours provision is a significant deficit. There is a lack of social care provision that could be supported by the NHS. This is resulting in some children and young people being admitted to paediatric wards and remaining for longer stays in hospital. CPFT has been working to reduce the waiting time from referral to first consultation. This is currently estimated at 28 days against a target of 25 days. However, lengthy waiting times are evident before care and treatment commences in some cases. Improvements are required to strengthen support to young people between the ages of 16 and 18 years. There are no tier 4 mental health facilities in the area resulting in some children and young people having to receive specialist in patient care and treatment some distance from home. The National Support team in February 2011 highlighted gaps and fragmentation of services for children with emotional and mental health needs leading to inequity of access, including for children and young people with learning disabilities. They also found inequities in responsiveness and consistency of access to specialist CAMHS. Our inspection found limited progress has yet been made in addressing these issues. Current team capacity, coupled with high and increasing demand has resulted in a primary focus on children and young people in crisis with limited capacity to undertake longer term or preventative work. Two additional psychiatrists have been appointed recently to enhance local leadership and expertise; and a joint review of the CAMHS service has recently commenced.

4.9 Conception and pregnancy rates have increased over the past year, with a significant rise in the number of children born to young people who are looked after or care leavers. The vulnerability of this group of young people is recognised. However, there is a limited number of mother and baby units or specialist fostering arrangements available locally resulting in some young mothers having to be placed out of area by social care services. Local health services need to be actively engaged in such planning to ensure young people receive the level of follow up care and support they need. The family nurses and teenage pregnancy midwives provide good support to young women and their partners. There is some positive work to engage young people, including young parent groups. Additional capacity is being secured as currently not all young people who meet the family nurse partnership criteria can be helped. Access to sexual health services out of hours has been recently expanded. Improved take up of Chlamydia screening and use of contraception by young men is evident, however staffing capacity is stretched. Planned integration of contraception and sexual health screening services has not yet been achieved in the north of the county. Local sexual health staff report good links with Sexual Assault Referral Centre (SARC) in Preston, but have identified some inconsistencies in local access to community based health support.

4.10 Relatively high numbers of young people who are looked after and care leavers misuse alcohol and this has remained the case for the past three years. Similar authorities have seen a fall in the number of young people misusing substances. Data provided to inspectors indicates relatively high drop out rates of young people with alcohol related needs prior to commencing treatment. The young person's substance misuse team delivers training and support to foster carers and children's home staff to enhance their knowledge and support provided to young people who misuse alcohol or drugs. The substance misuse team offers a weekly drop in for care leavers living in the west of the county.

5. Outcome 6 Co-operating with others

5.1 The Council and NHS Cumbria have a good shared understanding of the health needs and inequalities experienced by local people. The new Clinical Commissioning Locality Groups have membership that includes primary care, community and acute providers as well as local authority partners. Plans are evolving that identify the range of services required to meet current and future need. A significant programme of transformation work is in progress including new service specifications, workforce plans and clinical pathways to secure improvements in service quality and outcomes for local people. Work streams have a strong focus on the improved management of urgent and unscheduled care, promoting better access to preventative services and the delivery of health care closer to home. It is too early to assess the impact of much of this activity. NCUHT has recently created a new consultant midwife post for health inequalities in recognition of the significant need in the north and west of the county.

5.2 The leadership and impact of the Cumbria Local Children’s Safeguarding Board (CLSCB) on delivering improvements in front line practice across the partnership has historically been weak in some key areas. A recent peer review of safeguarding arrangements in Cumbria identified the need for a stronger contribution by all health partners to the work of the Board. This is now being addressed. The action plan from the peer review included the need for commissioners together with CPFT to address significant gaps in CAMHS provision and provide up to date position statements on waiting lists and service availability. A new independent chair is working to increase the engagement of all partners including health, to build a shared strategic direction, and to more effectively hold partner agencies to account. Recent work to address lessons from serious case reviews indicates a stronger challenge of individual and joint organisational practices. It is acknowledged that the locality based multi agency Safeguarding Expert Reference Groups have not been effective and require re- invigoration to improve the focus on outcomes for children.

5.3 At an operational level, there remains a considerable programme of work to secure robust shared responses to the management of risk. Frontline community health staff reported delays in response to referrals they made to children’s social care services and having to escalate concerns given differing perceptions of tolerance of risk, particularly in cases of neglect and the care of adolescents. They also reported very late notification of case conferences that impacted on their ability to attend or prepare reports. The pilot work to implement ‘Munro²’ new ways of working in the north of the county has begun to identify and address some inter agency barriers and promote better alignment of agency responses. Action is being taken within health trusts and between partner agencies to secure stronger management oversight and assurance that children and young people are appropriately safeguarded. A new clinical partnership project is working to bring together the safeguarding leadership and expertise of named GPs and doctors across the wider health economy. There is recognition of the need to strengthen joint governance arrangements between health and social care at an operational and practitioner level including the management of information, assessment activity and record keeping.

5.4 Multi agency working to support children who have been subject to domestic abuse is effective. However, some children who require counselling support now have to travel further to access the help they need given reductions in local provision. Community health staff are appropriately involved in and informed about decisions taken at the multi agency risk assessment conferences (MARAC). Around 100 clinicians have agreed to act as domestic violence champions to support a stronger shared focus in this area of risk to children.

² Work being spearheaded by Professor Munro to transform child protection arrangements

5.5 In a number of cases seen, workload pressures and gaps in team capacity and the availability of local services have adversely impacted on the quality of joint working and outcomes for children. There remain some significant gaps in responsiveness and access to support for young people with complex emotional, mental health and behavioural needs. Young people who self harm or are intoxicated are sometimes admitted to children's wards out of hours due to lack of alternative provision. This results in significant added pressure on ward management arrangements, including patient safety. The local police force recently took a decision not to accommodate young people overnight in police stations. There is an urgent need for partners to work together to develop more appropriate alternatives. Whilst hospital staff generally reported a good response from the CAMHS services during the working day, the absence of out of hours support is a significant gap for young people under the age of 16. Although NHS Cumbria has commissioned a crisis out of hours service for young people aged 16-18, its capacity can be over-stretched on occasion resulting in a slow response to requests for help out of hours. The timeliness of response has also been affected by the reduction in out of hours social work.

5.6 Multi agency meetings are regularly held in both hospital Trusts to monitor mothers and unborn/new born babies about whom there are concerns. Action is being taken to review pathways and promote improved information sharing and communication between midwives and health visitors in the north of the county. Good joint working is evident between midwives and health visitors working in the west of the county. This midwifery team received an award from the Department of Health in 2010 for their work in supporting vulnerable teenagers in a remote rural area. Care plans are put in place at an early stage in the pregnancy. Plans are now regularly monitored and further reviewed on a joint agency basis prior to hospital discharge. The mental health crisis team provides a prompt response to mothers with mental health needs on maternity wards. However, some community health staff reported the need for better engagement of adult mental health teams in preventative work, including timely sharing of information. There are gaps in the availability of counselling support for parents who have their babies removed or placed for adoption.

5.7 Transition pathways for care leavers require stronger partnership working and recognition of their vulnerability and risks to their wellbeing as young adults. This includes review of the care pathways and fit of local safeguarding children and adult arrangements. Transition arrangements for young people with complex needs or disabilities are adequate, and pilot transition work in progress at the time of the inspection is helping to promote more person centred practice.

5.8 NHS providers in partnership with Cumbria County Council have undertaken some pilot projects that are leading to better outcomes for some children. This includes the assertive young person's alcohol project, working closely with the local police force and the West Cumberland Infirmary in following up young people who have attended the hospital in an intoxicated state. Positive findings of this work include a reduction in the number of repeat attendances. Multi agency work focusing on the lifestyle and dietary needs of families is contributing to better outcomes for obese children aged 4-8 years in one locality. Joint working between a range of community health and school staff has been effective in promoting healthier lifestyles and reducing childhood constipation.

6. Outcome 7 Safeguarding

6.1 Child health records were of variable quality in evidencing effective analysis of risk, including parental protective factors and detailing follow up actions taken to safeguard children. The child's voice, their experience and needs were not adequately recorded or consistently used to inform health support or wider analysis of children's care and welfare. We found examples of some good engagement and supportive relationships that were valued by children and their families. Awareness of professional accountabilities and confidence in using safeguarding children procedures is growing, and opportunities for reflective learning are increasing. However, we found that understanding of thresholds and shared approaches to the management of risk across teams and partner agencies are not yet sufficiently shared or embedded resulting in delays in investigation or action being taken in some cases.

6.2 NHS Trusts have clear action plans to support learning from serious case reviews. However some actions are still at an early stage of development or have yet to have the desired impact. Work is ongoing to raise standards of practice and complete outstanding actions. Frontline health staff are becoming more vigilant in their approach to identifying and assessing risk. Training has been provided to improve understanding of non accidental injury to immobile children. Care is being taken to clearly identify all household members and the social history of families including previous incidents of domestic abuse. A and E staff we met from both Hospital Trusts recognise the importance of listening to children and seeing them on their own. More recent records of medical examinations provide a clear picture of children's views and feelings.

6.3 There are adequate levels of engagement of community health and adult mental health staff in a range of safeguarding activity. Late notification of key meetings and insufficient flexibility about their location is a barrier to the attendance of many health professionals including GPs and paediatricians. Specialist substance misuse and domestic abuse midwives have recently been given protected time to support improved partnership working, discharge planning and report writing. However, current caseloads of school nurses and the CAMHS teams detract from their capacity to undertake targeted or intensive work with some children in need.

6.4 The growing focus of GPs on safeguarding children is recognised in their new clinical commissioning responsibilities. Good progress is being made in ensuring lead GPs are appointed to each locality with strong leadership and support from a designated GP. The training of GPs, including out of hours GPs and practice staff has been given a high priority. Lead and deputy safeguarding roles have been identified in most GP practices. Safeguarding systems, including flagging of children on child protection plans and routine recording of concerns are being implemented to enable primary care to act as a single hub for overseeing safeguarding health arrangements. There is improving analysis of the contacts with children out of hours including checks of the outcomes of previous contacts. Some GP practices have established regular safeguarding meetings involving a range of professionals to strengthen awareness of risk and the specific needs of children and their families. This was seen to be effective in monitoring children where there are growing concerns about their wellbeing and safety.

6.5 The work of the Child Death Overview Panel (CDOP) has not been effectively embedded in the work of the CLSCB. Strategy meetings have not been consistently held in a timely manner and in accordance with CLSCB's procedures. Work is required to ensure requirements in completing child death forms are fully understood. Improved co-ordination of investigations and strengthening support to parents and siblings are highlighted in the annual report as key areas for improvement. Further work is required to strengthen public awareness campaigns to improve the focus on child safety. The recent appointment of a new designated doctor provides enhanced capacity to develop practices in this area.

6.6 Children who require examination for alleged sexual abuse have to travel out of area to Preston. The service provided there is compliant with clinical requirements, and is staffed by suitably trained and experienced staff. Senior health staff have recognised the need to review the care pathway to ensure local arrangements deliver appropriate levels of follow up support to achieve full compliance with the NHS Operating Framework.

6.7 Accident and emergency departments do not currently have appropriate levels of paediatric nurse cover. Although access to expert paediatric advice is available through the acute paediatric ward and the consultant rota; this has been identified as a risk by both acute trusts. A robust and sustainable solution has yet to be found. The alert systems in use within A and E, minor injuries/primary care and assessment units and out of hours GPs (Cumbria Health on Call) are not sufficiently developed to ensure prompt recognition of safeguarding children concerns. Action is being taken to improve alignment of ICT systems and strengthen identification and management oversight. Analysis of A and E records in both Trusts indicates improvements are being made in their awareness and recording of adults who attend with children. Learning from a recent serious case review has promoted tighter analysis of previous attendances. A programme of training has been delivered to ensure staff working in A and E, minor injuries/primary care and assessment units are competent in paediatric observations and are up to date with advanced life and resuscitation training. The role and contribution of paediatric liaison nurses where they exist is valued in strengthening links between hospital and the wider community health and social care services.

7. Outcome 11 Safety, availability and suitability of equipment

7.1 Both acute hospital trusts have separate waiting areas in their A and E departments for children. Work is progressing to upgrade the West Cumberland hospital to improve assessment and treatment facilities for children and young people attending the hospital. Medical and nursing staff are child focused and appropriately consider the needs of babies and children, including assessment of their weight and height prior to administering medication. The '*Brave Child Teddy*' initiative provides positive recognition of children's experience. The Primary Care Assessment Service in Kendal has appropriate separate facilities for examining children and a room can be accessed for confidential discussions as required.

7.2 Security arrangements in A and E in both hospital trusts are considered to be adequate by staff, with good back up from the local police force in dealing with incidents of patient safety or risks to frontline staff. Use of restraint of young people who are intoxicated and training for staff in the control and handling of incidents requires review on a joint agency basis. NCUHT has strengthened its security arrangements for the care of babies in its Maternity and Special Care Baby Units across the Trust.

8. Outcome 12 Staffing recruitment

8.1 Local NHS providers, including GPs, comply with safe recruitment requirements. They ensure vetting and barring regulations are met when appointing staff. NCUHT has reviewed its Criminal Records Bureau (CRB) checks on all employees who started to work for the Trust prior to 2002. Job descriptions include professional accountabilities for safeguarding children. Systems for dealing with allegations of abuse or poor care by professional staff are in place in all local NHS Trusts. Contracts with NHS providers clearly specify employer responsibilities for safeguarding children in their recruitment arrangements.

9. Outcome 13 Staffing numbers

9.1 NHS Cumbria has suitably experienced senior staff supporting its designated nurse and Associate Director for Safeguarding. The designated nurse covers both children and adult safeguarding activity. The designated doctor post has been vacant for the past year, but has been recently filled. Organisational capacity has been stretched given the level of safeguarding and improvement work required whilst at the same time supporting new developments in clinical commissioning group arrangements. The recent appointment of a designated GP and locality GP leads is directing a stronger focus on safeguarding children work. However, there remain shortfalls in the staffing establishment of GPs in some parts of the county.

9.2 Gaps in the capacity of the LAC health team have been recognised and nursing provision has been increased to a whole time equivalent nurse covering each of the three localities. CPFT has plans to appoint a further nurse to provide extra capacity to address the health care needs of children placed by other councils in Cumbria. Gaps in the management and co-ordination of their work have been identified and a new management post has been developed to take forward the improvement agenda. There had been difficulties in recruiting to CAMHS posts resulting in use of locums. This is now being addressed. There remain vacancies in community paediatric posts resulting in some paediatricians having very high caseloads.

9.3 NHS North West, the Strategic Health Authority, has been working with local health partners to develop an agreed workforce development plan to meet future health visitor workforce requirements. There are currently gaps in the capacity of the health visitor workforce in some localities. School nursing capacity is stretched and requires review to provide additional support to vulnerable children including adolescents. A nurse consultant public health post has been recently appointed to lead workforce developments including the transformation of school nursing provision. There are plans to increase health visitor staffing numbers by a third over the next 3 years. Priorities include re-designing professional practices and working relationships to fully meet the requirements of the Healthy Child Programme. Two additional family nurse posts have been established in recognition of the need to expand service provision across the wider council area. Community nursing capacity is limited in the south of the county.

9.4 NCUHT has an adequate level of named and lead safeguarding posts supporting its safeguarding children work. It has named nurses for safeguarding children and adults and a dedicated training role for safeguarding. Capacity has been enhanced in recognition of the need to embed lessons from serious case reviews and expand the provision of clinical supervision and reflective practice. NCUHT is currently undertaking a review of its midwifery services to ensure its arrangements provide safe care and value for money. Action is being taken to ensure the correct level and skill mix in its frontline teams. The Trust is working to build its capacity to address future workforce challenges relating to the ageing profile of its midwives, widening choice and flexibility of local services, and ensuring protected time for teenage parents.

9.5 UHMBFT has recognised the need to strengthen its named nurse arrangements and has agreed to the appointment of an additional post to ensure appropriate levels of cover at both its Lancashire and Cumbria hospital sites. A and E at Furness hospital now has a full complement of medical staff and is no longer reliant on locums. Divisional leaders have implemented a comprehensive induction programme and support to build the competencies of junior doctors.

9.6 CPFT has expanded its safeguarding team since the transfer from the PCT. There are clear lines of accountability and strong management and leadership of improvement activity. CPFT is working with Cumbria County Council to implement new locality based models of safeguarding support. A professional head of children's nursing has been appointed to lead on workforce development. Additional health visitor capacity is planned including the appointment of eight trainee health visitors due to qualify in September 2012.

10. Outcome 14 Staffing support

10.1 A Safeguarding Health Network Group and Safeguarding Practitioner Forum led by NHS Cumbria are working to build a shared vision, standards and outcomes across the wider health economy. NHS providers are engaged in and value the work of these groups in strengthening partnerships, managing change and helping to deliver the shared improvement agenda. A group of health trainers and GPs are working to promote wider access to safeguarding children training and secure full compliance with inter collegiate requirements and CQC training targets. Gaps in management support, oversight and training coverage are now beginning to be systematically identified and addressed.

10.2 NHS Cumbria has strongly championed the role and contribution of GPs to local safeguarding activity. GP Practices report that all staff members have now completed the basic safeguarding awareness training. Performance in this area is verified in practice review meetings. A specialist development programme has been commissioned over a 12 month period to prepare GPs for safeguarding roles at locality and county level. The named GP has been working to complete a gap analysis of GP knowledge and skills. A central thrust of this work is to strengthen partnership working between primary care, local health teams and wider partner agencies.

10.3 UHMBFT has provided safeguarding supervision on an *ad hoc* basis to date. Building the confidence, knowledge, and capabilities of frontline staff are key priorities for the new named midwife and named nurse. There is a need to ensure regular safeguarding and clinical supervision arrangements for all staff, including named and lead safeguarding staff. A programme of obstetric study days is being delivered to improve the quality of recording. Data supplied by the Trust evidenced gaps in the number of staff who have completed level 1 basic awareness safeguarding training, with medical staff reported as the lowest percentage of staff to have completed the training. Trust training records do not clearly demonstrate whether organisational requirements are adequately met. Information from annual staff appraisals is not yet systematically used to drive individual training and education requirements.

10.4 The appointment of a dedicated child protection and safeguarding adult training post within North Cumbria Hospitals will complement and support improvement in the Trust performance in meeting professional standards. At the time of our visit 88% of the Trust staff were appropriately trained. However, there remain gaps in safeguarding training coverage of medical and surgical staff on both hospital sites. This was highlighted as an area for development in the Trust's Annual Safeguarding Report in February 2011 and raised again in the recent annual report in January 2012. In addition, safeguarding supervision needed to be available and embedded in for all staff working with children to ensure sufficient reflection on the issues of concern and outcomes of work undertaken.

10.5 Community health staff employed by CPFT reported good access to safeguarding training and support for their professional development. They told us named professionals are helpful when dealing with complex cases. At the time of our inspection, over 60% of the workforce had undertaken safeguarding children training. The Trust was on target to achieve 80% compliance by the end of May. There is work in progress to expand the expertise of school nurses and community nurses to provide a more holistic model of support. Adult mental health staff identified the need to widen their awareness of safeguarding children training to enable stronger promotion of 'Think Family' work. Some health staff reported difficulties and delays in being able to access multi agency training. Work undertaken to deliver joint training to frontline staff involved in the Munro pilot work was valued. However, further training is required to embed shared approaches to the application of risk thresholds, and promote improvements in the quality of information sharing and joint working. NHS providers recognise they need to strengthen their systems to fully evaluate the impact of training on driving improvements to practice.

10.6 NHS Trusts have been working to build their peer support arrangements. CAMHS teams hold weekly meetings to discuss young people with complex needs. The consultation work provided by CAMHS teams to a number of other frontline community health teams was seen to be helpful. Midwives in both Trusts would welcome further guidance on report writing for child protection conferences and court. They have recently received training to support wider implementation of CAF. Information sharing, child sexual exploitation and fabricated and induced illnesses were identified as areas for further training by a number of health staff. A and E and paediatric ward staff require additional training in supporting young people with emotional, mental health and behavioural needs. Some community health staff have very high and complex caseloads which has contributed to a reduction in their capacity to undertake preventative and health promotion work. Caseload weighting requires further development to ensure sufficient capacity to address local need and increase in demand for services.

11. Outcome 16 Audit and monitoring

11.1 Leadership and commitment to raising standards of practice is evident, but a number of developments have yet to be fully embedded across the local health economy to support a robust safeguarding culture. Serious case reviews have highlighted a number of areas where health organisations and their partners had not adequately protected children. Progress against action plans is regularly monitored through individual Trust Safeguarding Forums and Trust Boards. Senior managers recognise further improvements are required to partnership working and early intervention and prevention services to ensure robust co-ordination of safeguarding activity around children and their families. Audits of practice are developing but further work is required to ensure effective challenge and evaluation of outcomes. The recent peer review identified the need for performance management arrangements to be more specific and measurable, with a more robust approach to the management of risk.

11.2 NHS Cumbria has developed new contract specifications with providers to enable effective benchmarking of provider performance in this area, but these have not yet been published or implemented. Contract monitoring and review processes require further development to provide robust assurance of the effectiveness of local safeguarding children arrangements. A new training evaluation sheet has been drafted to support a stronger focus on the outcomes of training and assurance of staff competencies. The Health Safeguarding Network Group has introduced a self assessment tool and audit process to assess compliance with LSCB arrangements for safeguarding and promoting the welfare of children. NHS Cumbria is working closely with UHMBFT to ensure shared areas for improvement identified in the recent joint inspection in Lancashire are addressed.

11.3 Audits of practice provide feedback on the progress being made by individual Trusts in embedding the required standards of practice. Audits of the work of frontline health teams found significant variation in the quality and use of CAF. Areas identified for improvement include sharing of information, thresholds for access to support, and the need for a stronger focus on children's wishes and feelings.

11.4 Inspectors found NCUHT is working to strengthen its capacity to continuously improve the quality of its services. It recently reviewed its maternity records to ensure confidential safeguarding information is appropriately managed and transferred to baby's case notes. Action has been taken to address areas for improvement. The Trust is working to ensure all areas of its operations have an identified paediatric link nurse for safeguarding. It is working to strengthen its management information to ensure a stronger focus on safeguarding activity including staff attendance at multi agency safeguarding meetings, and the provision of reports and medical examinations. This forms part of a shared performance dashboard to support better monitoring of service effectiveness.

11.5 Clinical governance arrangements within UHMBFT have been reviewed and strengthened to provide strategic management and oversight of the management of risk. Audits of the case records of midwives are currently being undertaken on a monthly basis. Paediatricians and A and E staff at Furness hospital have formed a special interest group to support learning and promote a higher standard of practice. Members are working to implement safeguarding audits in A and E and their records are fully integrated into children's health records. New Quality and Safety Midwifery posts have been created to review all clinical incidents. An additional 13 midwives have been appointed to enhance local capacity. A substantial programme of staff guidance, training and mentoring is being implemented to drive improvements in clinical practice. This includes the delivery of culture change workshops to ensure adherence to best practice and professional standards. Monitor and CQC continue to closely monitor the Trust's progress against action plans.

11.6 CPFT, since Transforming Community Services, has reorganised its internal governance arrangements and regular reports are received by the safeguarding committee which provides regular reports to the Board.

11.7 Current performance reporting of CAMHS and young person's substance misuse activity does not support effective tracking of trends, levels of demand and outcomes for looked after young people or care leavers. A stronger focus is required on the quality of services for children with disabilities or complex health needs. Cumbria health partners and the local authority do not have sufficient assurance of the impact of service provision in tackling the health inequalities experienced by this vulnerable cohort of children. Improving systems for capturing feedback from young people and their families is a key priority in strengthening the quality and levels of satisfaction with services provided.

12. Outcome 20 Notification of other incidents

12.1 NHS Cumbria has appropriate systems to monitor serious incidents and breaches of safeguarding practices. Its Safeguarding Hub provides a central communication and coordination point for managing information about serious incidents reported by NHS providers. It brings together an overview of organisational risk, litigation, critical incidents and patient experience to inform analysis of the performance of local health care providers. Performance reporting and monitoring systems have been strengthened and now include monthly position statements on new significant incidents and progress on action plans. UHMBFT has strengthened its reporting of incidents given improved awareness of professional accountabilities for patient safety.

13. Outcome 21 Records

13.1 Child health records were of variable quality. Whilst adequate attention was paid to children's physical health needs, the focus on their emotional and mental health was limited or insufficiently assessed to provide a comprehensive picture of children's needs. Children's faith, cultural and identity needs were inadequately explored on most records seen. Care plans were not specific or measurable in some key areas and did not adequately focus on outcomes. There was low use of chronologies to inform analysis of risk. The child's voice, their experience and individual needs were not sufficiently recorded or consistently used to inform health support or wider analysis of children's care and welfare.

13.2 The current reliance on paper records in some organisations and the lack of alignment of electronic child health records is a significant barrier to the efficient retrieval, risk management and oversight of the quality of work and outcomes for children. This has been recognised by senior managers and a new child health record and an electronic case management system are being introduced to support improved information sharing between community health teams.

Recommendations

Immediately

NHS Cumbria together with Cumbria County Council and NHS Providers take action to:

- *Ensure that consistently comprehensive assessments of all children at risk of harm are undertaken to inform outcome focused plans that are effectively progressed and monitored across the partnership (Ofsted, May 2012).*
- *Ensure that health and social care partners work together more effectively to ensure there is timely and quality assessment of the health needs of looked after children and care leavers and that identified needs are met, clearly monitored and reported (Ofsted, May 2012).*
- *Ensure that all looked after children know how to complain and how to access advocacy services (Ofsted, May 2012).*
- *Ensure that children's identity needs are fully assessed and inform planning for them (Ofsted, May 2012).*

Within 3 months

NHS Cumbria together with Cumbria County Council and NHS Providers take action to:

- *Ensure that the current review of CAF arrangements develops robust plans for the coordinated and effective use of CAF across the partnership (Ofsted, May 2012).*
- *Develop and implement robust quality assurance systems to improve the quality of assessments, recording supervision and safeguarding practice across the partnership (Ofsted, May 2012).*
- *Develop robust partnership arrangements to review the thresholds for access to services so that children and families receive coordinated support appropriate to their level of need (Ofsted, May 2012).*
- *Expand local arrangements for managing child deaths and ensure a comprehensive range of support to young people who have been sexually abused (Ofsted, May 2012)*
- *Ensure that effective supervision arrangements are in place for all staff (Ofsted, May 2012).*
- *Ensure that a robust looked after children's strategy is in place that reflects a full and accurate picture of the profile of looked after children, current resources and ensuring that the sufficiency duty is met going forward (Ofsted, May 2012).*
- *Improve participation of all looked after children and young people in service planning across the partnership (Ofsted, May 2012).*
- *Ensure children's health records provide a comprehensive picture of children's development and well-being, and that care leavers are provided with a full health history on leaving care (Ofsted, May 2012).*
- *Promote effective communication and joint working arrangements between front line health and social care teams to ensure that looked after children's health services comply with statutory and good practice guidance (Ofsted, May 2012).*

Within 6 months

NHS Cumbria together with Cumbria County Council and NHS Providers take action to:

- *Ensure that learning from serious case reviews is embedded in policies and practice and that the impact of related training is fully evaluated (Ofsted, May 2012).*
- *Ensure the child's voice, their experience and needs are clearly recorded and used to inform their individual plans and the work of the CLSCB (Ofsted, May 2012).*
- *Address gaps in access, joint working, and service responsiveness in supporting young people with complex emotional, mental and behavioural needs (Ofsted, May 2012).*
- *Address gaps in the availability of support for children with disabilities or complex health needs and ensure fair access to services (Ofsted, May 2012).*
- *Secure an appropriate range of local services to meet children's emotional, mental health and behavioural needs (Ofsted, May 2012).*

NHS Cumbria together with CPFT

- *Ensure community health teams have sufficient capacity to meet local demand and are able to undertake early intervention and prevention work (Ofsted, May 2012).*

Next steps

An action plan is required from the commissioning PCT within 20 working days of receipt of this report. Please submit the action plan to your SHA copied to CQC through childrens-services-inspection@cqc.org.uk and it will be followed up through the regional team.