

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

Date of Inspection	10th April 2012 – 13th April 2012 14th May 2012 – 18th May 2012
Date of final report	27th June 2012
Commissioning PCT	NHS North East Lincolnshire Care Trust Plus
CQC Inspector name	Tina Welford
Provider Services Included:	Northern Lincolnshire and Goole Hospital NHS Foundation Trust (NLAG) Rotherham, Doncaster and South Humber NHS Foundation Trust (RDASH) Lincolnshire Partnership NHS Trust NAViGO

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](#) .

NHS North East Lincolnshire Care Trust Plus	
Safeguarding Inspection Outcome	Aggregated inspection finding
Overall effectiveness of the safeguarding services	Adequate
Capacity for improvement	Adequate
Contribution of health agencies to keeping children and young people safe	Good
Looked After Children Inspection Outcome	Aggregated inspection finding
Overall effectiveness of services for looked after children and young people	Good
Capacity for improvement of the council and its partners	Good
Being healthy	Good

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 Head of Operational Improvement who has overall responsibility for this inspection programme.

*In respect of the recommendations in the report, please complete an action plan detailing how they will be addressed and submit this to CQC and your SHA Chief Executive within **20 working days** of receipt of the final report.*

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 two-week 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 organisations listed above, but includes some areas which apply to one or more other NHS bodies where pertinent.

Context:

North East Lincolnshire Care Trust Plus is the accountable commissioner for health services in North East Lincolnshire. In response to the new planned changes in the NHS, North East Lincolnshire Care Trust Plus is now one of four “Primary Care Trusts” who along with NHS Hull, NHS East Riding of Yorkshire and NHS North Lincolnshire have formed NHS Humber Cluster to ensure stability in NHS commissioning arrangements in preparation for the transition to commissioning responsibilities to GPs. Alongside this a Clinical Commissioning Group has been formed in shadow form to begin the development of transition arrangements into the future arrangements.

As a result of unique arrangements in place in North East Lincolnshire since 2012, the commissioning of Health Visiting, School Nursing, Child and Adolescent Mental Health Services, (CAMHS) and Family Action Support Team (FAST) have been transferred via a section 75 partnership agreement to North East Lincolnshire Council through their Children’s Trust arrangements. Other services continue to be directly commissioned by North East Lincolnshire Care Trust Plus.

Paediatric therapies are delivered primarily by Northern Lincolnshire and Goole Hospitals’ NHS Foundation Trust. The acute hospital providing accident and emergency services for children is Diana, Princess of Wales Hospital in Grimsby, part of Northern Lincolnshire and Goole Hospitals’ NHS Foundation Trust. Maternity and newborn services are provided by Northern Lincolnshire and Goole Hospitals’ NHS Foundation Trust at Diana, Princess of Wales Hospital. Children and families access primary care services through one of 31 GP Practices which include two walk-in centres. There is a single minor injuries unit (in working hours only) in Immingham, overseen by the local General Medical Practice.

Child and adolescent mental health services (CAMHS) are provided by Lincolnshire Partnership NHS Foundation Trust. Services for children with learning disabilities and difficulties and who have complex health needs services are provided collaboratively between North East Lincolnshire Children’s Health Provision and Northern Lincolnshire and Goole Hospitals’ NHS Foundation Trust. Adult, acute and community, mental health services are provided by NAViGO, a social enterprise formed in April 2011.

Young people’s substance user services are provided by North East Lincolnshire Council via North East Substance Team (NEST) and adult substance services are provided by Rotherham, Doncaster and South Humber NHS Foundation Trust.

Safeguarding Children professionals’ leadership is provided via Designated and Named Professionals. North East Lincolnshire Care Trust Plus shares a full-time Designated Nurse with neighbouring NHS North Lincolnshire. They also have, via a service level agreement, a Designated Doctor employed for 1.5 sessions (6 hours per week). The Designated Doctor is otherwise employed as Consultant Paediatrician with Northern Lincolnshire and Goole Hospitals’ NHS Foundation Trust.

Northern Lincolnshire and Goole Hospitals' NHS Foundation Trust have a Named Nurse for Safeguarding (in North East Lincolnshire) supported by specialist nurse capacity. As an organisation providing maternity services, Northern Lincolnshire and Goole Hospitals' NHS Foundation Trust also have a full time Named Midwife in post covering the maternity services for North Lincolnshire and Goole, as well as North East Lincolnshire. In addition to employing the Designated Doctor, Northern Lincolnshire and Goole Hospitals' NHS Foundation Trust have a separate Consultant Paediatrician as Named Doctor for Safeguarding Children.

North East Lincolnshire Council Children's Health Provision, have a named nurse supported by a specialist nurse. These two posts provide a specialist safeguarding children support service to North East Lincolnshire Council health staff, but also to NAViGO and Care Plus Group (provider of Adult community based health and social care). The named nurse is on maternity leave. However, robust cover arrangements via uplift in Specialist Nursing capacity, supported by the Designated Nurse and Head of Children's Health Provision are in place. Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust have a Named Nurse for North and North East Lincolnshire as part of a wider team of Named Nurses to cover their 5 locality areas. A lead GP fulfilling the role of Named Doctor is in place within primary services is in post.

Looked After Children health services are commissioned by North East Lincolnshire Council via their Children's Trust arrangements, and are provided by Northern Lincolnshire and Goole Hospitals' NHS Foundation Trust including Designated Nurse and Doctor and Lincolnshire Partnership NHS Foundation Trust provides the CAMHS support.

General – leadership and management

1. Whilst the NHS is undergoing significant restructuring, North East Lincolnshire Care Trust and NHS Humber cluster have maintained clear lines of accountability for safeguarding children arrangements, with the executive leadership remaining with the Director of Quality and Nursing. Governance structures are still subject to development and review with the emerging Health and Well Being Board. However, reporting lines to the Children Trust Board are embedded. There is a clearly articulated vision for children's health services. The CAMH service, at the time of the inspection, was being recommissioned, with a view to move from the traditional models of delivery.

2. Since 2012 North East Lincolnshire Council is both the commissioner and the provider of childrens' health provision which includes: health visiting, school nursing, nursery nurses, community family nurses, youth offending service nurses and the FAST service. The named nurse and specialist nurse for safeguarding as well as the specific infant feeding and breastfeeding support posts are also employed by the council. These arrangements are well embedded.

3. The looked after children health task group is reviewing the strategic service direction and the operational delivery monitoring arrangements. Governance and accountability structures are robust, through this task group. Looked after children health performance, annual and quarterly reports are effectively scrutinised at both the Corporate Parenting Board and the Children Trust Board. A new service specification has very recently been agreed which aims to address some of the challenges with the capacity of the designated nurse post.

4. There is good representation and attendance by senior health staff and designated professionals at the local safeguarding children board (LSCB). The Director of Children Services and Head of Safeguarding (who is currently the interim LSCB Chair) from NLAG ensure there is an adequate level of challenge. The sub groups such as child death overview panel (CDOP), the serious case review (SCR) and training sub groups are held to account. The designated nurse for safeguarding confirmed that there is robust challenge from LSCB membership. Adult substance misuse service commissioners are proactive members of the LSCB, which has raised the hidden harm agenda, and ensured training is provided.

5. All safeguarding and looked after children annual reports, including the quarterly updates, are submitted to the respective trust board through the robust governance arrangements. All trusts have up to date safeguarding policies in place.

Outcome 1 Involving Users

6. The looked after children health service provision has gained the You're Welcome Quality Criteria for Young People Friendly Health Services accreditation. All looked after children/young people (including care leavers) are given a choice as to by whom and where their review health assessment (RHA) will take place. Age appropriate leaflets, designed by looked after children and young people, explaining the range of choices and the role of foster carers in the decision making process are well used. 'Health days' have been held for some years targeting the 'hard to reach' groups. As a result of the success of these events and through good engagement with this group and other looked after children/young people the 'health day' focus has now changed and reflects the young people's needs and wishes.

7. There is access to translation and interpretation services, although due to the current demography this is infrequently used.

8. Care leavers are given an excellent individualised child health information portfolio product which is developed and used throughout their time in care. There remain challenges for those who are adopted and are issued with a new NHS number as previous health history information is no longer available. This has been partially addressed through the use of information transfer agreements and the health portfolio product.

9. Sexual health services have the You're Welcome Quality Criteria for Young People Friendly Health Services accreditation. Young mothers have been involved with the recruitment of practitioners for the recently commenced Family Nurse Partnership. There has been good engagement by the designated nurse for looked after children and the named midwife, with looked after young parents and pregnant women improving their engagement with children centre services. This has resulted in a young person driven programme, and the further development of peer mentoring. There is good use made of the young women peer mentors service for breast feeding.

Outcome 2 Consent

10. All looked after children health files contained information relating to consent, with consent being obtained before each health assessment.

11. There is good adherence to consent practice within CAMH services. Only if the young person consents will information on their treatment /interventions be shared with other health professionals.

Outcome 4 Care and welfare of people who use services

12. Looked after children and young people services 'Being healthy' is judged to be outstanding.

13. Looked after children and young people's review health assessments are undertaken by either GPs, school nurses (although only 4 out of the 145 health assessment/reviews in last year, were done by school nurses) or more frequently the looked after designated nurse or designated doctor depending on the choice made. Consequently, this has helped maintain good quality control of the health assessment process. The designated nurse completes health assessments on all out of area children placed in the authority area, of which on average there are 75-85 at any one time. The postholder also ensures that all NELC looked after children placed out of area have had their health assessment. The designated nurse completes all the health action and care plans. Those children and young people who are seen in the child development centre (CDC) have a joint assessment, which includes their annual health review. This reduces appointments and duplication.

14. The latest health outcome data shows that 98% health assessments completed, 96% of looked after children had received a dental assessment, with immunisation and vaccine rates between 97.2% -99%. These rates consistently remain above both England and statically neighbours.

15. Good notifications systems are in place for new into care looked after children and status updates for all looked after children and young people, are reviewed weekly to ensure health staff are aware of any changes. GPs interviewed reported good communication and information sharing processes for all new looked after children within their practice population.

16. Initial health assessments (IHA) are currently undertaken by GPs, although there was a general lack of timeliness (from 7 days to 78 days) the average times are now between 28 -30 days. The previous lack of timeliness was due to the processes used by social care staff to arrange the IHAs. The social worker, the child, foster carer and GP are all contacted prior to a date being booked and once agreed then consents obtained. This increases the delay in the initial health assessments being undertaken within 28 days of coming into care. Plans are well developed to fully transfer the IHA function to the LAC health team although capacity and resource issues for the LAC health team are yet to be resolved.

17. Good use is made of the strength and difficulty questionnaire (SDQ) analysis which is effectively used in health assessments and reviews. Excellent use is made of the emotional assessment screening and the subsequent multi agency meetings to review outcomes for children identified with complex needs such as sexualised behavioural needs. The out of area looked after children placed by other authorities, all care leavers and adopted children highly valued dedicated two looked after children Clinical Psychologists but capacity is becoming stretched. At the time of the inspection waiting lists were twelve weeks. These staff provide a good service for those out of area placed young people from other authorities. They also provide highly valued and flexibly delivered training for foster carers, adoptive parents and for the five residential children home staff. This helps to build resilience and supports placement permanence.

18. There are challenges to delivering and maintaining the healthy child programme due to the current high number of child protection cases. Care pathways have been developed for the under five year olds, which health visitor teams deliver. A developing pathway for older children delivered by the school nurses will include immunisations and improve the number of contacts with children in line with national directives.

19. The rates of teenage conception remain high, above England averages at 59.7/1000, although the termination of pregnancy rate is reducing, now 46%. There is good and flexible access to contraceptive services, including emergency contraception, through the dedicated provision from CHOICES, COAST, SHOUT outreach services. It is recognised that the provision of emergency contraception is not being well promoted, although this is yet to be addressed. The condom distribution (C-Card) scheme is well promoted through local events, although there has been little monitoring of the effectiveness of the scheme. There is very good take-up of long acting reversible contraception (LARC), although a high number are removed within a short timeframe following initial insertion. Practitioners equate this to a general apathy to the use of contraception within the local community, despite good levels of awareness of this form of contraception. However, the use of some long acting contraceptives such as Depo injections has resulted in a decline of second conceptions.

20. There is good support provided to victims of sexual assault and sexual abuse. Youth workers deliver support and individual programmes of work with young people to improve their aspirations and re-engage them with education or employment. However, there is a perceived culture by health staff of an increasing aspiration by teenagers to have babies at a young age. There are good partnerships with the youth offending services especially working with perpetual fathers. Through this work there have been some positive behaviour changes by some males.

21. There is good access and take up of sexual health disease screening. Although it is recognised that health education is still required especially related to HIV and AIDS.

22. There is good support for those young people who choose to terminate their pregnancy, with youth workers accompanying them to appointments. There is good support provided for bisexual, gay and lesbian young people, although it is recognised that more support could be provided to the male members of the local Polish and other communities.

23. The Family Nurse Partnership has only recently commenced and as yet has not fully recruited to the programme. There is an ambition to work with young fathers, along with the dedicated fathers' worker.

24. There is an effective multiagency young parents' group. This ensures that there is support provided for young people, with various work streams targeting the local priority areas, such as reducing second conceptions, and the provision of sexual health outreach services.

Outcome 6 Co-operating with others

25. The designated nurse for looked after children is well engaged with the Independent Reviewing Officers (IROs) with good quality reports submitted and feedback on the review outcomes received.

26. The Young People Vulnerable Project has been effective, with positive feedback from foster carers. There is good support provided when sibling separation occurs (especially at adoption) with dedicated clinical psychology intervention. At the time of the inspection there were no concerns relating to unaccompanied asylum seeking children.

27. Edge of care thresholds applied by social care, are not robust, with delays reported in children coming into care, especially those referred because of neglect. Review of the last 47 new looked after children cases showed that despite these children being classified as 'child in need' or having a child protection plan, health needs such emotional needs, attending dental or immunisation appointments were not addressed.

28. There has been a reported increase within the last month of child protection and child in need meetings including strategy meetings. In the case of some community health practitioners, they have been attending five strategy meetings a week.

29. Child and adolescent mental health service (CAMHS) referrals are all through a 'single point of access'(SPA). Referrals are reviewed weekly therefore routine appointments can wait up to seven days before screening. There are good referral routes for urgent and A&E referrals into CAMHs and primary mental healthcare services. The effective CAMHS primary care advice line has good acceptance rates of telephone referrals. Waiting times during the inspection were 12 weeks for all services. The choice and partnership approach (CAPA) is well used, with highest referrals received for sexual abuse, anorexia and self harm. Currently self harm rates are increasing, which is attributed to examination stress (100/month received) and in response a dedicated team has been established. Education and training programmes are in place, such as a proactive approach being taken for primary and secondary schools addressing emotional well-being at time of examinations. There is good use of the school nurse 'drop-in' sessions and teenagers have produced leaflets to de-stigmatise and reduce exam stress. The impact of these interventions has yet to be seen in practice.

30. The effective CAMHs transition staff, working in partnership with adult services for 18 months prior to transition date, has improved the transition experience for service users. These dedicated transition posts, through highly valued joint working with early intervention teams, provide a service for young people from 16 year olds with low level transition needs. There are very good transition pathways for children with learning disabilities and difficulties.

31. Dedicated Section 136, place of safety facilities, are provided by NAViGO at Harrison House. Police cells are used for violent and intoxicated individuals and although not required recently, good protocols are in place should they be used. Accident and emergency staff reported that frequently NHS Direct send young people with a mental health crisis to A&E to see the 'mental health team', which is inappropriate, as there is no team within A&E. This increases the stress and anxiety of the young person and delays them receiving treatment.

32. The '16-17 year olds in crisis' joint meetings with NAViGO provide good integrated approaches and proactive intelligence sharing of adult/carer mental health issues that can affect young people. This information is robustly shared with the out of hour service teams. The out of hours CAMH service is led by a child psychiatrist. There is good identification by NAViGO staff of adults who have mental health concerns and the impact on their parenting ability. NAViGO staff are trained in parenting skills assessments and also have well developed skills in identifying and working with adults who have suicidal tendencies involving children and psychosis associated with 'child belief' cases.

33. NAViGO staff, along with maternity staff, jointly work cases where there are parental mental health concerns and substance misuse, ensuring that children's needs are met. These staff provide highly valued training for midwives.

34. The Family Action Support Team (FAST) has good established attention and behavioural pathways to address needs identified through the common assessment framework (CAF). Capacity is now full with 133 children currently using the service, although at the time of the inspection there was no waiting list. The FAST team's strength is their flexible working such as: direct, parallel and extended work with families with open access post interventions supported by the health visitor or school nurse, depending on the age of the child. Good support from a dedicated team is provided for young carers and siblings (from the age of eight years).

35. The recent 'think family' agenda has strengthened the use of the CAF and alerted adult services to the hidden harm effects for children and young people within and across a range of adult services. The recent revision of the CAF documentation has increased the referral rate due to the ease of use, and greater staff training. However, CAFs are too frequently being used just as referral tools. Due to the social care process there are up to 3 months delays in referrals being processed, which for some families is too long, resulting in families becoming disengaged.

36. The revised attention deficit hyperactivity pathway is well embedded providing for timely structured interventions supporting transitions, which previously were reported as being 'scatter gun'. A good range of out of school and short break services are provided, including for young people on the Autistic Spectrum who are high functioning. The links with the educational statement process are less well developed. This is a missed opportunity.

37. There is effective use of the 'team around the child' meetings to support and minimise vulnerability risks of children with disabilities/ life limiting conditions and their families. Good use is made of the advance life care plans, with very good partnership working with the ambulance, police and hospice services.

38. The two special schools have a valued dedicated school nurse who is working with the multi professional team to ensure that care plans are developed and that plans are reviewed as a result of health reviews and after clinical consultations with consultants.

39. There are very good partnership working arrangements, through a 'whole systems' approach, in place across the safer community groups. These include the children and young person drug and alcohol services as well as adult services. Youth offending services are well engaged. Good use is made of the intelligence to target 'hot spot' areas, ensuring a responsive service. Through effective partnership working and the work of the young offending service, there has been a reduction in the rate of crime relating to substance misuse. There is good engagement of school nurses with substance misuse services, promoting the reduction of risk taking behaviours, although this is not the case with GPs where there is too variable.

40. There has been outstanding learning from a young person's death related to the misuse use of substances. The use of a whole systems approach with the significant independent learning process (SLIP) has enabled services to standardise documentation to be used across all substance misuse services whilst streamlining and enhancing the referral process. Services are aware that more work is required to engage community and faith leaders to ensure a comprehensive service for minority groups.

41. The community health staff, youth service and police force use mobile units to access groups across the authority area, enabling an increasing level of engagement with young people. This, along with the youth patrols, has enabled good targeting of vulnerable young people, who may become at risk of sexual exploitation due to their substance misusing habits. The lack of personal health education in schools has limited the health education and information that substance misuse services are able to provided. Schemes of work are being developed to identify alternative ways of providing timely information for young people. Early pilots with social media have proved successful.

42. There are effective arrangements in place for the sharing of domestic violence notifications, including those that do not reach the multi agency referral and assessment conference (MARAC) threshold. Community health staff ensure that domestic violence alert notices are placed on the patient information management systems. There is good attention is paid to lone working with these families. Midwives are core members of both MARAC and multi agency public protection arrangements (MAPPA), with effective sharing of information. Information is also shared with GPs, although there is a lack of consistency to addressing concerns. Midwives ensure during pregnancy that women are asked when alone about whether they are victims of, or involved in, domestic violence. Responses are recorded and audited on the health files.

Outcome 7 Safeguarding

43. Contribution of health agencies to keeping children and young people safe is judged to be good.

44. The designated nurse for looked after children role complies fully with the Statutory Guidance on Promoting the Health and Well-being of Looked after Children. The role only has indirect reporting access to the executive lead, which restricts the autonomy and fails to recognise the position's seniority. The designated doctor role is in place and a dedicated nurse for care leavers. This team have dedicated administrative support which enables better monitoring and tracking of looked after children and young people.

45. The designated nurse, doctor and named staff for safeguarding roles all comply with national guidance. There are dedicated safeguarding and child dedicated anaesthetists in post.

46. Safeguarding threshold understanding has improved with now rare use of the resolution (escalation) policy. Good use of the common assessment framework (CAF) has contributed to low use of the escalation policy. The telephone advice line is effective in address concerns. Feedback from children's social care on referrals has improved, including for GPs. There still remains a concern for school nursing services that those cases of low level 'concern', are frequently the most 'needy' families and there is a lack of coordinated services for them as they are just below the CAF thresholds. This results in some of these families becoming involved with safeguarding services when a lower level early intervention would have been more appropriate.

47. Unborn baby referrals are not accepted until 24 weeks gestation, which prevents proactive early intervention joint working for example with substance misusing mothers. This is a missed opportunity. Birth plans are not always shared with health staff in a timely manner, inhibiting effective communication. Although this is known as an area for improvement this is still to be resolved. Maternity staff are well versed in promoting plans, and the newly appointed named midwife will be the lead practitioner for ensure that these are in place. The development of the 'family folder' aims to improve the record keeping and storage of pre-birth plans, birth plans and discharge plans.

48. There are improving case handovers between maternity staff and health visitors. The effectiveness of joint case work has been reduced due to the capacity within the health visitors' services resulting in very few antenatal joint visits. Good use is made of alert systems between professionals and the national and regional alert networks for those cases of high risk of absconding or where there have been concerns such as domestic violence.

49. There are effective specialist practitioner posts such as the health visitor for asylum seekers, the consultant midwife. Since the termination of the domestic violence midwife post, practitioners are now sharing this caseload. Despite training and good liaison with MARAC, however, midwifery staff still perceive that there is a significant gap in services for vulnerable women.

50. A&E and unscheduled care notification processes are good and appropriately acted upon by the designated nurse for looked after and adopted children. All looked after children are flagged on SytSmOne (GPs and community staff) and Symphony, the A&E patient information management system. There is good supportive follow up action taken by community practitioners once they receive the unscheduled care notification.

51. There is good access to the high specialist intervention beds (teir4) which are hosted by Lincolnshire Partnership Foundation Trust. There is good use made of the care programme approach (CPA) and, along with good service user engagement, repatriation and transition is effective.

52. The child death overview panel (CDOP) processes are good, with all consultant paediatricians trained in rapid response. There are effective communication and dissemination of national campaigns with a current high profile being given to 'co-sleeping' following a number of child deaths. There is no care of the next infant scheme (CONI) to support families.

53. All consultant paediatricians have received training in child sex abuse examinations, ensuring robust covering arrangement within the sexual assault referral centre (SARC).

54. The multi agency public protection arrangements (MAPPA) are good, with effective use of flags on patient information systems to identify cases of concern. There is good child and adult services mental health representation, at MAPPA and with the multi agency risk assessment conference (MARAC), at which there is also good health representation. Through engagement with the national children's information system group, a national flag is now to be introduced so MARAC cases can be flagged on patient records.

Outcome 11 Safety, availability and suitability of equipment

55. There are dedicated waiting and treatment areas within Diana Princess of Wales Hospital A&E department for both children and young people.

56. Professionals who work with families who have children with disabilities or life limiting conditions report that there are good processes for securing funding for equipment. However, there are prolonged delays in obtained the specifically designed wheelchairs, which negatively impacts on engagement and inclusion of the young people with activities and services.

Outcome 12 Staffing recruitment

57. All staff interviewed confirmed that they have enhanced criminal records bureau check. Those employed by a health provider are reviewed every 3 years; health staff employed by council are reviewed yearly.

Outcome 13 Staffing numbers

58. Recruitment campaigns have been very effective for the school nursing services. There are no vacancies within the school nursing service, although high numbers of child in need and child protection cases are affecting capacity. Some staff report having 120 'child in need' cases on their caseloads, all of which were deemed to be appropriate cases. This, together with an increasing number of child protection cases for which there has been a significant increase in the last month, has reduced the universal health provision. There is good use made of skill mix, especially with the delivery of the healthy child programme and the national screening programmes.

59. Health visiting services are also experiencing increased numbers of child in need, CAF and child protection cases. Along with the high number of vulnerable families vacancies (although rates are low) affects their capacity which is very stretched.

Outcome 14 Staffing support

60. Yorkshire and Humber regional safeguarding and looked after children meetings act as a form of supervision for the designated looked after children nurse, although supervision for this role is not robust, partially due to the reporting structures. However, the designated nurse is well supported by their peer group the wider multiagency team.

61. All staff interviewed confirmed that they were up to date with safeguarding training. Training was valued and reflects learning from serious case reviews. Training data is recognised as improving and is now more accurate, however, all the health organisation's training rates are variable, between adequate and good, (84%-100%). Although GP training data was not available, rates reported by safeguarding staff were that only 30% GPs are trained to level 3. GPs spoken to believed that the rates were much higher. There has been robust challenge from the LSCB, recently resulting in all GP practices having a safeguarding lead and practice based training. Safeguarding training has been changed to reflect learning from significant incidents and outcomes from child death reviews and course evaluation. Community health practitioners report that since they have been employed by North East Lincolnshire Council access to safeguarding training has improved, and that mandatory training systems are very robust. These staff are now receiving safeguarding supervision, which previously was not the case. The wide range of supervision available to staff, has successfully supported practitioners to address safeguarding concerns.

62. Health staff are aware that more training is required in terms of faith, equality and diversity issues that impact on safeguarding and vulnerabilities, such as forced marriages, concealed pregnancies, sexual exploitation and trafficking.

63. At Diana Princess of Wales hospital A&E there are children qualified staff on duty, although not in sufficient numbers for every shift. To mitigate risks there is good support provided by the dedicated paediatric teams. All A&E staff have received children safeguarding and paediatric life support training.

Outcome 16 Audit and monitoring

64. There is good quality assurance of health assessments including the out of area looked after children and young people's health assessments by the designated nurse. Due to the fact that the designated nurse undertakes most of the health assessments, very good use is made of benchmarking and networking across Yorkshire and Humber region.

65. Good reporting and governance structures are in place for safeguarding activities within health providers, with information used to inform performance monitoring and the strategic direction such as in the joint strategic needs assessment (JSNA).

66. Due to poor GP compliance with safeguarding arrangements, the LSCB has now instigated the use of a section 11 safeguarding 'styled' audit, although the response rates remain low. Individual management review information has only recently started to be shared with GPs to improve safeguarding practice. As a result there has been some increase in the contact of GPs with the named GP.

67. The safeguarding health staff receive duplicate copies of all safeguarding referrals for both quality assurance and tracking, with copies now scanned into the patient information systems.

68. The limited and, within some academy schools, lack of sexual and relationship education and personal health and relationship education is having a negative impact on the delivery of health promotion and sexual health contraception advice.

69. The multi agency sexual health team 'MASH' provides a valued six week programme with sexual health 'drop-in' sessions for some schools. However, due to the lack of comprehensive countywide coverage the impact is limited. Individual impact from case studies shows that for some young people, this programme and the MASH+ programme have prevented unwanted teenage conceptions and reduced vulnerabilities and changed behaviours such as those at risk of misusing substances.

Outcome 20 Notification of other incidents

70. Staff are aware of whistle blowing processes for their respective organisations.

Outcome 21 Records

71. All looked after children health files seen were of a very good quality and well maintained. Chronologies and supporting information was easy to identify. Copies of IRO review reports and other documentation relating to the legal status of the child and young person were available. All records complied with professional regulatory record keeping standards.

Recommendations

(Those from the joint report in italics)

Within 3 months

NHS North East Lincolnshire Care Trust Plus and the Local safeguarding children board must ensure that all health providers and organisations' safeguarding compliance rates are maintained at a minimum of 80% for each staff group and each level of training.

NHS North East Lincolnshire Care Trust Plus and the Local Safeguarding Children Board must ensure that all safeguarding training needs, identified as a result of the changing local demographic are addressed.

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.