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.
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| **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 | ADEQUATE |

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 national Inspections, 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 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:**

Thurrock lies to the east of London on the north bank of the River Thames and within the Thames Gateway, the UK's largest economic development programme. Thurrock has a strong manufacturing and retail focused economy and benefits from excellent transport links including nationally significant port capacity. There is a very significant regeneration programme centred on five growth hubs: Purfleet; Lakeside; Grays; Tilbury; and London Gateway. The London Gateway deepwater port will open in 2013 and provide over 10,000 jobs in the coming decade.

Thurrock has a resident population of approximately 40,200 children and young people aged 0 to 18, representing 25% of the total population of the area. In 2012, 25.7% of the school population was classified as belonging to an ethnic group other than White British compared with 22.5% in England overall. Some 12% of pupils speak English as an additional language. English and Yoruba are the most commonly spoken community languages in the area.

Deprivation levels in Thurrock are consistent with the national average. Thurrock has significant pockets of deprivation and inequality, with several areas falling within the 20% most deprived areas in England.

Thurrock's children's partnership (formerly the children's trust) provides a forum to support integrated strategy development and service delivery. The partnership board has a small executive and a wide stakeholder network which includes representatives from health services, schools, police, community and voluntary sector organisations and elected members. The children's partnership is a sub-group of the Thurrock shadow health and well-being board. The local safeguarding children board (LSCB) is independently chaired, bringing together the main organisations working with children, young people and families in the area that provide safeguarding services.

A specialist team for disabled children provides the full range of social care services for disabled children and their families. An in house service provides emergency out of hours cover for the borough.

At the time of the inspection 148 children were the subject of a child protection plan. This is a decrease over the previous two years. The number comprises 66 (45%) girls and 80 (54%) boys (two were unborn children). Of these children, 45% are aged under five, 39% are 5-11 and 16% are 12 years or older. The primary category of abuse, specified in child protection plans was neglect (61%), emotional abuse (28%), physical abuse (2%) and sexual abuse (1%). There were 244 looked after children. The number comprises 41 (17%) children less than five years of age, 170 (71%) children of school age (5–16) and 29 (12%) young people post-16. There were 159 care leavers.
Commissioning and planning of primary and secondary health care for children is led by NHS South Essex (a cluster of NHS SE and SW Essex) in partnership with the local authority. The main provider of acute hospital services is Basildon & Thurrock University Hospital NHS Foundation Trust. Community-based child and adolescent mental health services (CAMHS) and specialist services for children with learning disabilities are provided by South Essex Partnership University Foundation NHS Trust (SEPT). In-patient CAMHS are jointly commissioned with the North Essex PCT cluster and are provided by SEPT. This PCT cluster is the lead commissioner for the Essex sexual assault referral centre (SARC) in Brentwood.

Universal services such as health visiting, school nursing, and paediatric therapies are provided by North East London NHS Foundation Trust (NELFT) which also provides health services for looked after children. Services for young people who misuse substances are provided by Open Door, a voluntary sector organisation.
General – leadership and management

1. The local authority, health and other partners, including those in the voluntary and community sector, share aspirations for children and young people. These are clearly expressed in the children and young people’s plan (CYPP). There is an agreed vision and shared ambition across the partnership. Priorities for the children’s partnership, Thurrock’s local safeguarding children’s board and children’s services are aligned, with robust service delivery plans to achieve these aims. The shadow health and well-being board has understood the need to integrate existing priorities in its wider ambitions for Thurrock. The early offer of help strategy to integrate service delivery at all levels of need provides an example of the existing commitment to ensuring that the needs of the most vulnerable are recognised. NHS South Essex commissioning unit has regular dialogue with the Director for People’s Services over safeguarding issues and the development of commissioning approaches to a range of preventative services.

2. The overall effectiveness of safeguarding services is good with health’s contribution being adequate with some areas of good practice. The shared vision and priorities of the local authority, organisations represented on the shadow health and well-being board and the children’s partnership, have been developed from a thorough joint strategic needs analysis. The LSCB is working effectively to monitor, develop and improve multi-agency safeguarding arrangements. For example, the partnership has responded positively to embed recent learning from a case review undertaken using the Social Care Institute for Excellence (SCIE) model and an action plan including training activity is in hand.

3. The safeguarding children’s clinical network (SCCN), which includes the Thurrock designated and named professionals, provides a supportive forum for all designated and named professionals across the wider health economy in Essex County. This is facilitating the development of increasingly consistent safeguarding practice. The clinical commissioning group (CCG) has two GPs as lead members with one being from the walk in centre and is beginning to recognise its safeguarding responsibilities. There is routine reporting of safeguarding activity and performance to the LSCB, and greater cohesion between the child death overview panel (CDOP) and the SCCN is developing.

4. Local Operational Group (LOG) Meetings are held quarterly, which includes all providers from the South West Essex health economy. The LOG provides a forum for the PCT and partner health providers to exchange information and identify safeguarding issues for children within the health services across SW Essex. It also acts as an effective conduit between Thurrock & Essex safeguarding children boards, the safeguarding children clinical network and health commissioners and providers at a local operational level.
The strategic partnership shares clear aspirations and strong ambition aspirations for children and young people in care and care leavers. The partnership’s priorities show strong ambition with corporate parenting, children’s rights, placement stability, health and well-being, education, accommodation and support all being areas being given close attention. Whereas progress by the partnership on most of these areas is good, Being Healthy outcomes for looked after children are adequate with a number of key areas for development.

Statutory guidance set out in 'Promoting the Health of Looked After Children' 2009 and 'Working Together to Safeguard Children’ 2010 requires the appointment of a designated doctor and designated nurse to provide leadership and oversight of the delivery of health care for looked after children. Although well supported by the designated looked after children nurse, leadership within the looked after children health service is underdeveloped and effective performance management is at an early stage. Since the retirement of the previous post holder in March 2011, there has been no substantive designated doctor appointed. The interim designated doctor has been on long-term sick leave since taking on the interim role. This has resulted in a reduction in quality assurance of health care delivery, particularly for children placed outside of the area, and a lack of strategic clinical perspective within the health and social care partnership. Foster carers report that the service has become less responsive since the designated doctor retired, who they found to be accessible and supportive.

The interim cover arrangements have recently been strengthened through additional session time allocated from the SCCN. The service provider’s clinical director is also now providing additional support to the service by addressing issues of health care provision quality raised by the nurses in relation to individual children. Assignment of the designated doctor role for looked after children should be resolved as a priority however, to ensure ongoing compliance with Working Together 2010 and the effective securing of strategic clinical leadership and oversight within the borough.

Outcome 1 Involving Users

Thurrock is a pilot site for young people’s Healthwatch which will facilitate young people’s engagement in health and social care development and delivery.

For children and young people with disabilities, there is a clear pathway from early diagnosis and co-operative working between hospital services and the child development centre multi-disciplinary team to put a team around the child in a close partnership with parents.

Staff at the BTUHT are very positive about new A&E environment and how the interactive environment is having positive benefits for young people with autistic spectrum disorder (ASD) or attention deficit and hyperactivity disorder (ADHD) in calming them and thereby facilitating treatment. Examples were given of schools and young people and parents having an input into the design and decor of the new build department.
Seventeen years old attending BTUHT for emergency treatment have a choice about accessing adult or paediatric A&E but are still subject to same routine daily notes and treatment check by the hospital trust’s named nurse.

Health promotion leaflets are available in the minor injuries unit and in the emergency department of BTUHT and tear off numbers for domestic violence are being sited on the back of toilet doors to facilitate men and women obtaining numbers discreetly.

Access to interpreting services is reported by health staff across provider services to be good.

The provision of two male health improvement practitioners in the school health team as well as a male receptionist and several male doctors is facilitating gender choices of worker for young people.

Risk assessments in maternity services are being informed by an increasing awareness of cultural issues within, such as female genital mutilation and attitudes within some communities towards disabled children.

The looked after children health service is flexible in approach and gender balanced, facilitating choice for young people about where assessments take place and the gender of the practitioner they meet. Some older young people are asked to give their own consent to having a health review but this is not consistent practice. Unaccompanied asylum seekers have their health care needs overseen by the designated nurse.

Health support to care leavers is underdeveloped. Care leavers are not given health histories and no health chronologies are developed within the health records to facilitate the development of these. Health promotion material given to them is generic rather than locally developed with the involvement of young people to facilitate their access to local health and wellbeing support services. Care leavers’ final health reviews are not routinely well coordinated with the final statutory reviews or at the point of leaving care. As the care leaver age has recently been lowered from 19 to 18 years, the cohort falling within the effected period may not have received a clearly identifiable final health review before leaving care.

There has been no formal engagement with the CICC on the development and delivery of the Being Healthy agenda until recently and it is not clear how young people are being enabled to hold the health and social care partnership to account for the health elements of the Pledge.

The sexual assault referral centre, Oakwood Place, offers a pleasant and quiet décor, giving some choices to young people attending about which room they are seen in as each has a different colour scheme.

Peer mentors have not been developed in the sexual health service to date although there are plans to introduce young inspectors to accredit services against the You’re Welcome criteria on which the service model has been based.
Outcome 2 Consent

21 Consent to undertake a health assessment is obtained by the looked after children health team in accordance with Department of Health’s Guidance. In some cases from the case sample, older looked after children give their own consent but this is not a consistent approach.

22 Staff demonstrate good awareness of the need to obtain appropriate parental consent for treatment in both BTUHT and Orsett minor injuries unit (MIU).

Outcome 4 Care and welfare of people who use service

23 Capacity in the CAMHS is under significant pressure with high thresholds and limited availability, with waiting times of up to 18 weeks. This is recognised and a commissioning strategy is in place aiming to start procurement of a new service in September. The tier 2 service provided for looked after children and commissioned by the local authority is to be redefined as part of the strategy. The Single Gateway provides a single point of access to the service, signposts to wider support services and provides a helpline with clinician of the day for advice and support as an interim while waiting for service intervention. CAMHS provision within the youth offending team is working well and delivering positive outcomes. The crisis CAMHS team has good engagement with BTUHT A&E department and effective use is made of a crisis bed at the specialist unit in Rochford. For young people requiring longer-term in-patient mental health treatment there are sufficient tier 4 beds available to meet local need. Connectivity between specialist CAMHS service for looked after children and the looked after children health team is not well secured. CAMHS attend a monthly multi-agency looked after children meeting but this is not sufficiently connected to the health steering group or health core group for looked after children.

24 Sexual health services have successfully contributed to a reduction in the teenage pregnancy rate in Thurrock to 39% which is close to the England average. Chlamydia diagnosis rate (15-24 years; per 1000) is 6.9 compared to England average of 13.4. Two sexual health advisors work closely with schools and there is a good range of drop-in clinics as well as the GUM service. The GUM clinic has sustained a 48 hour waiting target for the past four years. The implantation of long acting reversible contraceptives (LARCs) is being undertaken by nurses rather than consultants with scope to further expand this expertise. Information on teenage pregnancies, currently one, among the looked after children and care leaver population is not well known or utilised. To date, the looked after service provider and the PCT has not collected data on the number of looked after children young mothers and fathers and therefore commissioners cannot be sure that the needs of this cohort are being fully identified and met. Of 99 care leavers currently, 17% are young parents or pregnant.
25 A small substance misuse service for young people has recently been recommissioned through Thurrock young people’s drug and alcohol service (TYPDAS), part of Open Door but numbers are currently small with 80 young people having engaged with the service since January with eight currently receiving intervention and it is too early to evaluate impact. Looked after children with an identified substance misuse issue can be fast tracked to this service, although TYPDAS report none are currently in receipt of the service.

26 The absence of a designated doctor role since the retirement of the previous substantive postholder has had a significant negative impact on ensuring the delivery of quality assured healthcare. A backlog of health assessments developed last year as a result. Since interim cover for the initial health assessment aspect of the designated doctor function was put in place in May 2011, performance on the completion of initial health assessments (IHAs) and reviews of health assessments (RHAs) within expected timescales has improved significantly to 100% compliance currently.

27 The quality of IHAs and RHAs undertaken by local health professionals; health visitors, school nurses and the specialist looked after children nurses, employed by North East London NHS Foundation Trust (NELFT) is good with a consistent approach. The personality and voice of the child is evident in the case records examined. Training delivered by the looked after children nurses for community health practitioners, who undertake most health reviews, has recently been initiated and early participants can describe areas where their practice has developed as a result. However, recommendations from health assessments are not formulated into clear and effective health plans, with a lack of identification of overall objectives, timescales for delivery or identified professional responsible for ensuring that issues are followed up. An example from the case sample being; 'eye appointment for possible squint, timescale ongoing'. This also makes monitoring of delivery by social care and health professionals difficult, particularly where the child is placed out of area.

Outcome 6 Co-operating with others

28 The LSCB functions effectively and has secured the active engagement of most members at an appropriately senior managerial level. This is having a positive impact on services, including service design, for example the development of the new sexual assault referral centre (SARC) opened in October 2011 based on the Lancashire model. Clear information sharing protocols across the partnership are in place and effective.

29 The contribution of health agencies to the common assessment framework (CAF) is underdeveloped. Practitioners across health services are not fully engaged and this limits the potential success of preventative multi-agency working. Health professionals are not routinely making CAF referrals and are not contributing to or leading CAFs. Maternity staff have received CAF training but have no engagement in CAF processes.
The multi-agency referral and assessment conference (MARAC), its action planning and links with multi-agency public protection arrangements (MAPPA) are effective and health providers are engaged.

The attendance of health staff at child protection case conferences is good and subject to close PCT monitoring. Their contribution is valued and they feel part of the decision making process, leaving conferences clear on their role and responsibility in the protection plan. Health visitors, school nurses and community children’s nurses prioritise child protection and safeguarding activity and work well in partnership with other professionals.

Services for children with disabilities are good, operating an effective ‘team around the child’ model in partnership with parents. A recently appointed learning disability nurse at BTUHT is working closely with the special school nurse to co-ordinate visits and fast tracking to blood tests etc. and also facilitating palliative care for young people in partnership with the local hospice. These are recent improvements. Coordination of therapies and appointments is becoming more frequent and there is a clear pathway from early diagnosis with cooperative working between hospital services and the child development centre multi-disciplinary team. Services for looked after children with learning difficulties and/or disabilities as they move to adulthood are well co-ordinated through the monthly multi-agency group forum. Arrangements are being further strengthened through the transition’s working group which has parent representation and the provision of a neuro-muscular advisor funded through the strategic health authority. The authority has produced a clear transition document that is user friendly and contains a range of useful pictorial prompts and clues to support young people with learning difficulties and/or disabilities to understand and contribute to their planning process.

Until recently there has been insufficient involvement of the looked after children health team in overseeing the health provision for children placed out of the area. This is being addressed and information sharing is improving although there is more to do to ensure the health team have comprehensive records on each child. Connections between the health team and independent reviewing officers (IROs) are being strengthened, with IROs now represented on the health steering group which oversees service development and performance. The looked after children nurses and designated nurse are now being notified of all statutory reviews, facilitating their role in ensuring the child’s health needs are well represented and addressed.

Looked after children young people have access to good sexual health advice and support through a specialist advisor and are able to access a specialist local authority funded CAMHS which provides support to young people and foster carers, helping to sustain a number of fragile placements. Access to this service is through a multi-agency mental health looked after children meeting. However, the connection between this specialist CAMHS for looked after children and the looked after children health team and health steering group needs to be strengthened. The ‘triage’ system involving professionals from children’s social care, CAMHS, substance misuse, the police, community safety and others is particularly effective.
35 Young people in A&E needing CAMHS assessment are supported through the CAMHS crisis team with referrals through adult psychiatric service who undertake initial screening/assessment either in A&E or on the ward and refer to CAMHS if deemed necessary. The same pathway operates outside normal working hours. Provision of in-patient T4 beds at the specialist unit in Rochford is satisfactory with no capacity issues identified. Crisis bed is in place also at this unit and is used effectively. A transition protocol between child and adult mental health has been developed. There are service gaps for attention deficit and hyperactivity disorder (ADHD) and for young people with autistic spectrum disorder (ASD). Specialist CAMHs service for learning disability only operates up to age 12 and there is a significant gap for 12-18 year olds with learning disability which commissioners acknowledge.

36 The school health team mental health worker working with a number of local schools is delivering good outcomes for individual children but there is inequitable access to this support as it is not available to schools across the whole area.

Outcome 7 Safeguarding

37 Learning from serious case reviews is incorporated into practice. Action plans are being developed to address the concerns and considerations arising from the recent SCIE review. Implementation and impact are being evaluated by the LSCB ensuring that improvements are reflected in practice and service delivery. Most health practitioners in lead safeguarding roles are aware of the CDOP, how it links to the LSCB and its impact on improving practice. The chair of the CDOP is currently strengthening the panel’s strategic links to the SCCN.

38 Frontline health staff are aware of their safeguarding responsibilities and risk assessment role and have good access to safeguarding policies and procedures to guide their day to day practice. Non clinical staff are able to given examples of when they have raised concerns with clinicians about parental behaviour towards children in the waiting area leading to referrals to social care which have resulted in safeguarding enquiries. Systems are in place to ensure named nurses can monitor referrals.

39 The designated doctor and designated nurse provide supportive leadership while increasing the challenge to providers for continuous improvement in delivery. Greater rigor is being developed, led by the designated nurse, about services’ response to non attendance at medical appointments and presentation of children for medical treatment where they are not registered with a GP, although this is not yet fully established across all services. Engagement of the walk in centre in health and social care safeguarding arrangements is progressing well with support from the designated nurse. A named nurse role in the PCT has been developed to work specifically with independent contractors to ensure they become fully compliant with safeguarding expectations. The attendance of health staff at child protection case conferences is good and subject to close monitoring through PCT governance arrangements.
40 Midwives within the maternity services have a good awareness of safeguarding risks and what indicators to look for. Effective pre-birth planning with social care is embedded in a multi-agency approach and an effective non attendance at appointments policy is in place. There is increasing awareness across maternity services of cultural issues including attitudes within some communities towards children born with disabilities.

41 Reception staff at BTUHT and the Orsett MIU demonstrated verbal awareness of safeguarding risk indicators they check at the point of registration when a child or young person presents for treatment. Risk assessment trigger questions are included on registration documentation when a young person presents at either service. There is good communication between the staff in MIU and A&E when children and young people may be transferring between the two services to compensate for information systems not being well interfaced. Staff report access to Thurrock’s out of hours social care emergency duty team (EDT) is straightforward and communication is positive with EDT attending hospital if requested.

42 At BTUHT a daily check on treatment notes for u18s is undertaken by the named nurse and reported through the clinical governance group. There is a health visitor liaison in place acting as a conduit between acute and community health services. The paediatric consultant receives daily reports on the outcomes from the daily treatment note checks and follows up any issues with doctors individually and through the A&E clinical governance group which meets regularly.

43 There remain significant concerns however about the BTUHT emergency department’s paediatric triage arrangements and how well effective safeguarding practice is embedded. Although improvements have been made, the Care Quality Commission (CQC) continues to undertake regular engagement with the Trust to monitor progress. The designated doctor and nurse are also closely engaged with the hospital to support improvement and CQC has been meeting trust directors regularly to address areas of concern and monitor the delivery of the improvement action plan.

44 GP engagement in safeguarding arrangements is encouraging. Out of 46 case conferences in the last 12 months, GPs attended 43 demonstrating commitment and effective multi-agency communication and co-operation. Each practice has an identified safeguarding lead, and uptake of training is closely monitored. There is effective use of the Time to Learn development forum for GP practices to develop understanding and safeguarding practice. The named GP is introducing a report template to facilitate consistent contributions to case conferences and is working closely with the designated leads to drive improvement. The designated doctor takes a lead role in delivering training. GP appraisals will address engagement in safeguarding although this has not yet been introduced. Training is also being delivered to GPs on the provision of healthcare for looked after children, with 80 GPs having accessed this training to date. It is too early yet to identify any positive impact resulting. Dentists are also being increasingly engaged with safeguarding arrangements. A PCT named nurse has been recruited to work with them and other independent contractors and two training sessions for dentists have been delivered with another planned and training for pharmacists has been offered.
Adult services for substance misuse, mental health and learning disabilities are discharging their children’s safeguarding responsibilities effectively with a good awareness of circumstances when a child may be at risk of ‘hidden harm’ within a household. This is particularly true of the assertive outreach mental health team who work with adults with severe and enduring mental health issues who may move households frequently. As a result of a serious case review, a joint working protocol is to be launched imminently to frame effective operational cohesion. The provision of a seconded worker from South Essex drug and Alcohol Service (SEDAS) into children’s services has been beneficial in raising understanding across services of issues of hidden harm. In adult learning disability services, the children’s safeguarding training requirement has been set at level one. The LSCB and SCCN may wish to consider whether this expectation is in line with that set in other services.

The recent SARC development, Oakwood Place, Brentwood, serves five authorities across South Essex through a single Essex-wide pathway and operated by private company G4S, is very positive. Providing local support to victims of sexual assault in a sensitive environment, its effectiveness and performance measurement is developing. A new paediatrician rota is in place since April 2012 encompassing all the local authorities served. This had been problematic in getting cover in the past although Thurrock paediatricians were on the rota already. It provides good access to local forensic services, ensuring that evidence can be obtained to support a successful prosecution as well as providing an improved service for non-acute cases. The SARC is managed by a forensic examination trained nurse. A second specialist nurse is being recruited but there have been some delays in getting a full staff compliment and therefore the service is currently by police referral only. This is expected to be resolved by September and once fully staffed, self-referral will also operate. If a young person attends, GP and designated nurse in the relevant area are notified. If it is a chronic/historic case the paediatrician also notifies the named nurse in community services. Data on the uptake of service is being reported to the designated SCCN lead and will be disaggregated to provide data for each of the three LSCBs, this has not yet happened however. Oakwood Place is subject to routine monitoring meetings involving SCCN representatives, police, the crown prosecution service and paediatricians. Not all stakeholder services are clear on how the SARC operates and what services are provided however.

Thurrock has independent sexual violence advisors (ISVA) in place and counselling and therapeutic aftercare services are well provided through South Essex rape and incest crisis centre (SERICC) and services for young males have been commissioned from CARA, a provider from North Essex.

Outcome 11 Safety, availability and suitability of equipment

There is a clear pathway whereby equipment for children with disabilities is accessed with any funding issues being promptly resolved based on identified clinical need. Therapists from the multi-disciplinary team for disabilities give good support to school staff in accessing, using and maintaining equipment.
A specialist paediatrician provides a weekly clinic for non forensic cases at the SARC making good use of the facilities and specialist equipment including colposcope as this is not provided at BTUHT.

At Basildon & Thurrock University NHS Foundation Trust (BTUHT) the children’s A&E department environment and facilities have been recently improved. Action is in hand to further improve the environment as trust managers acknowledge the need for changes to the children's A&E reception as only half the door is currently visible to reception staff. Discussions with architects are in hand to address this concern raised as a result of a recent incident. Resusitaire, neonatal blood pressure and other required equipment is in place in the resuscitation area next to the nursing station. Equipment is checked daily and subject to routine and spot checking and routine reporting to board. Further equipment identified as necessary has been ordered and staff are awaiting delivery.

The interactive environment is having positive benefits for young people with autistic spectrum disorder (ASD) or attention deficit and hyperactivity disorder (ADHD) in calming them in what can be a challenging environment and thereby facilitating treatment.

Environmentally, Oakwood Place the new SARC operated by private company G4S is a good quality provision, although there is a single reception point to both chronic and acute cases, which requires careful management by the staff. Police are required to phone ahead to ensure the facility is able to receive a young person who may have just been subject to a traumatic assault and this protocol is becoming embedded practice. The discrete suite of facilities for interviews, examination and showering helps to ensure a positive experience for those young people attending the weekly chronic sexual assault clinics.

Outcome 13 Staffing numbers

There are capacity issues within the health visitor service although progress is being made on the delivery of the health visitor implementation plan to ensure the service can meet government expectations set out in Call to Action. This necessitates a 49% increase in the workforce by 2015. Twenty-six new health visitors will be qualifying in September with 33 more the following year. Teams are developing skill mixing but the service is not yet fully staffed to establishment.

Health visitors for mental health and domestic violence provide specialist support and work well within multi-agency arrangements. The mental health visitor also provides support with the young mums’ support worker to teenage mothers in schools to support their continued engagement with education.
Outcome 14 Staffing support

55 The safeguarding children’s clinical network (SCCN), which includes the Thurrock designated and named professionals, provides a supportive forum for all designated and named professionals across the wider health economy in Essex County. Local Operational Group (LOG) Meetings are held quarterly, which includes all providers from the South West Essex health economy. The LOG provides a forum for the PCT and partner health providers to exchange information and identify safeguarding issues for children within the health services across SW Essex. The second half of the meeting is used for the group’s action learning set.

56 Appropriate arrangements for the supervision of named professionals by the designated doctor or nurse are in place and for the most part, these work well. The designated doctor has found it difficult to establish regular 1:1 supervision with the named doctor at BTUHT however and is in dialogue with the trust on how to secure arrangements. The designated nurse provides 1:1 supervision for the SARC nurse manager separate from the performance management relationship with the SCCN designated lead for the SARC service.

57 Safeguarding training is being prioritised to ensure staff are trained to levels commensurate with their operational responsibilities and in most areas this is progressing well, including in adult services. The SCCN is raising expectations that most frontline health staff will achieve level three competence. Monitoring of uptake across the health community by providers and designated team is rigorous. However, performance on training in Basildon & Thurrock University NHS Foundation Trust has been low against the trust’s standard, particularly in paediatric services, and is subject to an action plan for improvement. In the paediatric A&E department, nurses feel well supported by the education lead and named nurse. Team study days for nurses led by the education lead nurse and the named nurse every six weeks are valued by nurses and address practice issues and case examples. The inspection identified that nurse practitioners were not given the opportunity to meet together in a whole group setting but were split into two groups. This detracted from their ability to develop practice in a whole team/peer group setting. This issue was addressed promptly by hospital managers during the inspection.

58 Community health services operated by NELFT, maternity and the minor injuries unit (MIU) have established routine, planned safeguarding supervision and reflective practice processes. For example, NELFT staff in the MIU receive regular safeguarding supervision from their named nurse on a 1/4ly to 6 monthly basis. At BTUHT, although staff value the ad hoc access to supervision provided by the safeguarding team through the named nurse, a comprehensive and effective safeguarding supervision system as set out in Working Together 2010 is not in place encompassing clinical and non-clinical staff. This should ensure all staff have access to regular, accountable and recorded supervision either group or individual. This should be to an agreed agenda, reviewing agreed actions from the previous session and reviewing the process. All staff, clinical and non-clinical, should attend at least group supervision and reflective practice opportunities on a regular basis.
The new chair of the LSCB plans to develop performance management arrangements across the agencies which will help to improve safeguarding outcomes. The designated doctor and nurse for safeguarding are fully engaged with performance and practice management developments through the LSCB and the SCCN. One of the key roles of the SCCN is to ensure a safe transition and transfer of safeguarding responsibilities to clinical commissioning groups (CCG) and ensure that the CCGs have a full understanding of their roles and responsibilities in safeguarding children.

Although well supported by the designated looked after children nurse, leadership within the service is underdeveloped and effective performance management is at an early stage. The provider, NELFT, reports quarterly on healthcare provision for looked after children to the trust board although there is no annual looked after children health report produced. Overall there is not yet a strong whole system approach between the health and social care partners to ensuring the timely delivery of quality assured healthcare to looked after children, although this has been identified and is being addressed. Joint health and social care performance management and quality assurance processes are being put in place. These include a suite of local quality and performance indicators, an effective charging policy and stronger contracting arrangements to assure future good quality health care delivery to young people placed outside the area. This is a recognised priority area for development. A letter setting out these new arrangements is being sent to all local authorities nationally.

Connections between the health team and independent reviewing officers (IROs), historically underdeveloped, are being strengthened with IROs now being part of the health steering group which is driving improvements. Information sharing is improving although there is more to do to ensure that the looked after children health team are well informed of the health assessments and provision undertaken by health professionals for children placed in other areas in order to ensure healthcare to this vulnerable cohort is properly secured.

The looked after children nurses are skilled, aware of the service’s areas for development and committed to taking forward improvements, undertaking some quality assurance activity e.g.; legibility on hand written health assessments. They lack the seniority to deliver a comprehensive quality assurance process, particularly for external placements, however as this role would normally be undertaken by a designated doctor or nurse. The clinical director has recently met with the looked after children nurses and agreed to address any quality concerns raised by them with the relevant agencies or clinicians, in lieu of a designated doctor. A longer term resolution to the assignment of the designated role is needed however.

The looked after children nurses are not routinely informed of statutory looked after children reviews and are therefore have been unable to oversee the attendance or input of health visitors and school nurses. Attention given to reviewing the delivery of health plans at statutory reviews is inconsistent and to address this, a new template for health reports to looked after children reviews has been developed.
There is more to do to ensure that performance on universal health outcomes for the whole looked after children cohort is managed effectively across the health & social care partnership. The picture is improving but remains challenging in some aspects. Case records inspected showed immunisations being up to date but health leads for the service acknowledged that health and social care data needed strengthening to ensure accurate correlation. Front line health practitioners, foster carers and social care staff do take action to ensure the universal health needs of individual looked after children are addressed. Eighty-eight percent (107/122) of looked after children and young people placed in Thurrock, not inclusive of out of area, had a dental check in the last year. Currently performance on immunisations is low with only 72% delivery against the England average of 79%.

Performance on universal health outcomes for the wider child population is an ongoing area for development. Child obesity levels for reception children stand at 11% compared to an England average of 9.4% and Essex average of 8.6%. for year six the differential is similar at 25.1% compared to England average of 19% and Essex average of 17.7%. Hospital admission rates for alcohol specific conditions per 100k for under 18s is high at 22.8 against an England average of 61.8 but below the Essex average of 32.4. Hospital admissions for mental health conditions standing at 123.1 per 100k for 0-17 years is high compared to the England average of 109.4 and Essex average of 98.

Outcome 20 Notification of other incidents

No issues have been raised during the inspection in relation to notifications. Currently NPSA data definitions for abuse (which includes notifiable incidents as defined by the regulations) are broad. New guidance is to be provided to trusts reiterating the definitions of classifications following the NHS commissioning body taking over control of NPSA.

Outcome 21 Records

Overall, the health records for looked after children are not adequate, containing insufficiently comprehensive or consistent health and social care information to enable the looked after children health team to be assured that their needs are fully identified and met. There are some positive features however with the voice of the child being well reflected in most health assessments. There are few health chronologies in health records setting out key life and health events and which could be used to develop health histories to be given to care leavers. In some cases, it was unclear what had led to the young person being taken into care. As a result, this intelligence was not routinely available to inform the health professionals undertaking assessments on on-going work with the individual. Case records also show that attention given to reviewing the delivery of health plans at statutory reviews is inconsistent.
Strengths and difficulties questionnaires (SDQs) used within CAMHS are not shared with the looked after children health team and opportunities are missed for SDQs to inform practitioners undertaking RHAs or to help looked after children to track their own personal emotional development.
Recommendations

Immediately

- NHS South Essex, the police, forensic service providers (G4S) and the local authority should ensure that the SARC pathway is fully understood across all sexual health services and other points of referral. (Ofsted July 2012)

Within 3 months (from report)

- The local authority, NHS South Essex, North East London NHS Foundation Trust, Basildon & Thurrock University NHS Foundation Trust, South Essex Partnership University Foundation NHS Trust should ensure that health providers are fully engaged in the CAF and make appropriate referrals. (Ofsted July 2012)

- NHS South Essex and Basildon & Thurrock University NHS Foundation Trust should ensure that clinical and non-clinical staff in paediatric services have access to regular, planned supervision and reflective practice opportunities as set out in 'Working Together to Safeguard Children’ 2010. (Ofsted July 2012)

- NHS South Essex and North East London NHS Foundation Trust should ensure that health plans for looked after children set out clear overall health and well-being objectives, timescales and accountabilities for delivery. (Ofsted July 2012)

- NHS South Essex, the council and North East London NHS Foundation Trust should ensure that looked after children’s health records contain comprehensive social care, health and well-being information. (Ofsted July 2012)

- NHS South Essex, the council and North East London NHS Foundation Trust should ensure that the health and well-being of all looked after children are subject to an effective quality assurance and performance management system resulting in improved universal health outcomes. (Ofsted July 2012)

- NHS South Essex, the council and North East London NHS Foundation Trust should ensure that there is effective communication and service cohesion between the looked after children health team and specialist child and adolescent mental health and substance misuse services facilitating the delivery of good outcomes for individual children. (Ofsted July 2012)

- NHS South Essex, the council and North East London NHS Foundation Trust should ensure that the CICC is fully engaged in developing effective health promotion and support to care leavers and is facilitated to hold health and social care to account for undertakings set out within the Pledge. (Ofsted July 2012)

- NHS South Essex, the council and North East London NHS Foundation Trust should ensure optimum use of strengths and difficulties questionnaires in the provision of the health and wellbeing of looked after children, including their use by young people as appropriate.
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.