

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

Date of Inspection	20th February 2012 – 2nd March 2012
Date of Joint Report	10th April 2012
Commissioning PCT	Sunderland PCT (NHS South of Tyne & Wear)
CQC Inspector name	Lea Pickerill
Provider Services Included:	City Hospitals Sunderland NHS Foundation Trust NTW Northumberland, Tyne & Wear NHS Foundation Trust South Tyneside NHS Foundation Trust
CQC Region	North East
CQC Deputy Director	Amanda Sherlock

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

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

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

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

Sunderland Council	
Safeguarding Inspection Outcome	Aggregated inspection finding
Overall effectiveness of the safeguarding services	Good
Capacity for improvement	Good
The 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 Regional Director, who has overall responsibility for this inspection programme.

The Inspection Process

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

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

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

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

Context:

Sunderland is a large city in the North-East of England, which comprises a city centre based around the mouth of the River Wear, and also includes the new town of Washington and the two former coal-mining towns of Hetton-le-Hole and Houghton-le-Spring. Sunderland covers more than 14,000 hectares including a coastline, a port, a university and 600 hectares of open space.

Sunderland has a population of 283,509 of whom 56,137 are children and young people representing approximately 20% of the overall population. After significantly falling during the 1990s, the birth rate has levelled off and in recent years there has been a slight upturn. In 2011, 5.8% of the school population was classified as belonging to an ethnic group other than White British (mostly Bangladeshi) compared to 22.55% in England overall.

Sunderland is ranked 41st most deprived out of 327 English local authorities and this places the city in the bottom quartile in comparison to all English authorities. In addition 25% of children and young people in Sunderland were defined as living in poverty

The Sunderland Children's Trust is a multi-agency partnership and chaired by the lead member. It is an advisory board for the Early Implementer Health and Wellbeing Board.

Sunderland's Local Safeguarding Children Board (LSCB) has had an independent chair since October 2008. The Board has reporting and accountability structures involving the Children's Trust, Risk and Resilience partnership, Youth Offending Board and the Child Poverty Board.

Sunderland Teaching Primary Care Trust (STPCT) is responsible for assessing the health needs of local people and commissioning the health services required to meet these needs. Sunderland Teaching Primary Care Trust, Gateshead Primary Care Trust and South Tyneside Primary Care Trust have been brought together under a single management team collectively known as NHS South of Tyne and Wear (SOTW).

STPCT commissions paediatric health services for children locally from City Hospitals Sunderland NHS Foundation Trust. Mental Health Services, including CAMHS, are commissioned from Northumberland, Tyne and Wear NHS Foundation Trust. Community Health Services, including health visiting, the family nurse partnership and school nursing, transferred to South Tyneside NHS Foundation Trust (STNHSFT) as part of the Government's transforming community services, on 1 July 2011.

Outcome 1 Involving Users

1. Young people, looked after have limited choice in venue for annual health reviews because they are mostly clinic based, however, where a young person is reluctant to engage, the designated nurse for looked after children makes every effort to meet with the young person and will carry out the health review at a location of their reasonable choice.
2. The involvement of children and young people in influencing commissioning and evaluating care is good. The “Eye” project is a Sunderland local participation project for children and young people to look at a wide range of issues and has been effective in influencing changes in care environment, in some recommissioning of services and in interviewing service providers on what they were proposing to change. Young people were also involved as part of the interview process for staff.

Outcome 4 Care and welfare of people who use services

3. The provision of sex and relationship education (SRE) across Sunderland has recently changed with a new package being rolled out across all schools. The SRE package forms part of a new approach to tackle risk taking behaviours and improve self esteem. Part of this approach is to deliver the “speak easy” course to parents and foster carers. This accredited course helps parents talk to their children about risk taking behaviours. It is too early to evaluate the impact of these changes; however, initial feedback from young people is good.
4. The partnership in Sunderland has recently introduced the C Card scheme and is making good progress in training professionals and youth workers across the district. Early indications are that the C Card is having a good impact and has been positively evaluated by young people. The launch of C Card is an integral part of the risk resilience model and is supported by working closely with colleagues in substance misuse services. Practitioners working in contraceptive and sexual health services (CASH) are enthusiastic about partnership working and are good advocates of the risk resilience approach. They feel the new approach has had an impact on the recent unvalidated data which shows a decrease in the number of teenage conceptions.
5. Young people have good access to effective CASH services. The service has recently been recommissioned and rebranded to give clarity to young people about their eligibility to access any of the family planning services across Sunderland. CASH services now offer testing for sexually transmitted infections and all clinics have staff qualified in genitor-urinary medicine (GUM) as well as a full range of CASH. The fitting of long acting reversible contraceptive is above national performance.

6. Access to emergency contraception is good and is available at GP practices and family planning clinics, with an increasing number of pharmacists taking part. Prescriptions are also available from the local gynaecology ward at Sunderland Hospital, minor injuries unit, A&E and primary care centres. Young people cannot currently self refer for a termination, and all appointments are arranged through a dedicated termination of pregnancy co-ordinator. An options counsellor speaks to all young people under 18 who are seeking a termination to explore any additional needs or vulnerability. This helps to identify those young people who may be at risk of exploitation or require additional support.

7. Midwifery services safeguard unborn children well. Early assessment of vulnerability and risk takes place at the initial booking appointment which includes the details of both parents. This improved assessment is in response to a serious case review. There are further opportunities to revisit risk throughout the pregnancy, including a social contact at 16 weeks which usually takes place in the woman's home. This is good practice. The outcomes of the vulnerability assessment are shared with health visitors and general practice and, where appropriate, with social care. This means that practitioners involved with the pregnant woman are able to share information and plan any support.

8. A consultant led vulnerable womens' ante natal clinic is held regularly, with attendance at appointments closely monitored and any non attendance quickly followed up. Women who require additional mental health support during their pregnancy are seen at the clinic, as are any teenagers who are pregnant.

9. Good support is available to pregnant women who misuse substances or alcohol, with clear thresholds on when a pregnant woman is referred to the specialist substance misuse midwife for shared care. The specialist substance misuse midwife has good links with the local adult substance misuse team. The substance misuse team refer any woman who has disclosed a pregnancy to them direct to her clinic, which is held as part of the vulnerable womens' ante natal clinic.

10. Teenagers who are pregnant are well cared for as part of the midwives' generic case loads. Additional support is provided through the midwifery support workers led by the Public Health Midwife. Support workers assess the young person's needs and work with the local children's centres to put a plan in place to ensure that these are met. The provision of teenage ante natal clinics is patchy, though where these are available they are highly successful and provide good support as well as linking teenage parents into the young parents group. One young parent group proved so popular that the local children's centre now runs a young parent and toddler group for parents to graduate on to. The centre now works with the young parents and toddler group to help them provide support to the next set of new parents to be. Young fathers are able to stay with their partner and new baby on their first night as a family in hospital. This was asked for by new parents across Sunderland.

11. Health visitors and school nurses use skill mix to effectively deliver the full Healthy Child Programme up to age 5. Mothers are encouraged to breastfeed and nursery nurses offer additional support to mothers who experience problems. This support has been positively evaluated by new mothers.

12. A good package of co-ordinated and responsive support is available to families. The local children's centres run Connect courses for vulnerable families and these have been positively evaluated. Health visitors use a scoring tool to risk assess ante natal referrals and where additional need is identified then specialist health visitors provide intensive support to the family during the ante natal and post natal period.

13. All health visitors and nursery nurses in Sunderland use the Solihull approach to design and deliver packages of care to help vulnerable families as part of CAF, child in need or child protection. This means that families receive commonality in approach and continuity of advice. Training in the Solihull approach is ongoing within the school nursing service. Multi agency training is taking place on how to chair a CAF and there is a local authority team to support the process

14. An effective Family Nurse Partnerships has been working with vulnerable families for over three years. Recent successes are reduction in smoking during pregnancy, and an increase in the number of new mothers breast feeding. A significant achievement of the partnership and young people has been in the number of young mothers who re-entered and stayed in employment, education or training.

15. Well established and effective arrangements are in place to transfer families from the health visiting to school nursing service. Health visitors use a risk based scoring system to decide whether a paper transfer can take place or whether a face to face meeting is required. Health visitors and school nurses are confident in the significant benefit of carrying out the later developmental checks on infants as part of the Healthy Child Programme and that these checks had led to less unidentified and unmet need in infants starting school.

16. School health staff nurses and assistants form school health teams. School nurses work geographically and since the reconfiguration of teams there has been an improvement in the rate of immunisations. School nurses carry out height and weight checks as part of the National Child Measurement Programme and work with those children that are identified as having weight problems. School nurses are involved in delivering some parts of the new SRE programme as well as holding drop in "health" clinics in most schools. Training is ongoing to implement and establish the C Card scheme and most school nurses run some group work, for example on healthy eating, self esteem or personal hygiene. In addition, school nurses now undertake health profiles for school and the new entry into school assessments have been re-introduced. Work is ongoing to standardise the approach of how school nurses can effectively support education colleagues where there is a child with a health plan in their school.

17. Paediatric A&E is open to children and young people 24 hours a day, seven days a week. Current arrangements are that all children up to 13 years of age are seen in the paediatric A&E; any young person between the age of 13 and 16 attend A&E with an injury are seen in adult A&E, up to 16 years old with a medical condition are treated in paediatric A&E and between 16 and 18 all attendances are treated in adult A&E. Adult A&E do not use paediatric forms for all attendances under 18 and this means that in a busy department there is a likelihood that the approach to a young person's care may not be child focussed.

18. Effective processes are in place to identify and safeguard children and young people who attend urgent care and the walk in centre. The numbers of repeat attendances are noted on the casualty card and on the electronic record. A&E staff have good access to the list of children who have a child protection plan in place for both Durham and Sunderland local authorities. These are regularly updated and kept securely on the IT system. Practitioners working in the walk in centre have arrangements in place to access the list through A&E. If a child or young person, looked after attends A&E, then this is noted and the looked after child health team are alerted through paediatric liaison. Posters are clearly evident in the paediatric A&E to inform parents, carers and children that information may be shared with other professionals.

19. The A&E team have developed an appropriate triage tool to assess children and young people for non accidental injury and safeguarding concerns that meets the requirement of the NICE guidance. Whilst practitioners were confident that the tool was used well, there has been no audit to check on compliance.

20. If A&E staff are concerned about any child protection issues, there is good access to senior paediatric medical staff. A consultant paediatrician is available within A&E between 9.00am and 10.00pm with good on-call arrangements outside of these core hours. All A&E staff spoken to were confident in how to make a referral to the Sunderland Children and Families team and referrals are routinely copied to the named nurse. Feedback on referrals from children and families team is variable, however, the A&E department has a good monitoring system in place to follow up on any referrals and report this back to the named nurse.

21. Children and young people who attend A&E following an incident of self harm are supported well. Mostly all young people under 16 are admitted to the paediatric ward for a period of "cooling off" unless they have a specific self harm care plan. Young people between 16 and 18 are usually admitted to the observation ward under the care of the A&E consultant until they are seen the next day by the self harm team or CAMH services.

22. A wide range of therapeutic services are available in Tier 2 CAMHS provided by a multi disciplinary and multi agency workforce, mainly made up of specialist nurses specialist teachers, counsellors and primary mental health workers. There is a small team that are dedicated to working with infants aged under 5, and carrying out some ante natal support work. Tier 2 practitioners work directly with children and families as well as carrying out indirect work on training, advice and consultation to universal practitioners. The team are able to meet requests for training, however, children can wait up to approximately 18 weeks to access the 5 plus year service and for early years 0-5 the waiting time is up to 20 weeks. This means that some children and young people are waiting for an unacceptable length of time before they can access early support.

23. Pathways of working between Tier 2 and Tier 3 were well established prior to the recent re-structure and it is recognised by the teams that these will need renegotiating. Staff meet on a weekly basis to discuss clinical issues and if the need for core CAMHS is identified as part of a CAF, then these referrals are escalated immediately which means that children can access core CAMHS quickly.

24. Core CAMH services have recently been re-commissioned and are in the midst of change. Current arrangements are for two teams covering 0-16 and then 16 – 18 years. The teams are multi disciplinary and accept either telephone or paper based referrals. Waiting times vary according to the care pathway; however, no-one waits for more than 18 weeks to be seen. As part of the changes to the services the teams are moving to the Choice and Partnership Approach (CAPA) and recruitment is underway for a new staffing structure. Care pathways are in the midst of development and very recent progress is evident in the implementation of a single website and a single telephone number as points of access. This means that referrers and families will be able to contact the CAMH service much easier.

25. As part of the new arrangements, a new Intensive Community Treatment Service (ICTS) has been commissioned which will run from 8.00am to 10.00pm, Monday to Friday and from 10.00am – 6.00pm on weekends and bank holidays. Child Psychiatry on call and Learning Disability Psychiatry on call is available outside all the ICTS operating hours. The Adult Intensive Response Team will provide additional support to children and young people outside of the ICTS operating hours with the support of the on call child psychiatry. Northumberland, Tyne & Wear NHS Foundation Trust are about to start a pilot on an intensive response team for adults and universal crises team with a programme of intensive child training. However, these enhanced services are new and have yet to demonstrate impact.

26. Northumberland, Tyne and Wear NHS Foundation Trust have a policy on not admitting young people into adult wards which is good practice. Local in patient care is available for children with learning disability and young people with mental health problems. Transition arrangements for young people into adult mental health services are managed well. The referral letter is sent to adult services when the young person is 17 so that the transition meeting takes place at 17 ½ in line with trust policy. .

27. Effective services support children and young people with disability and complex health needs. Families with children who demonstrate challenging behaviour are supported well by the multi agency Quest Team. The Quest Team provide an assessment and treatment service, as well as providing consultation to other professionals working with the children. Comprehensive care plans and good links to leisure link workers enable young people with challenging behaviour to access activities and short breaks. This service is instrumental in supporting families to avoid additional stress and family breakdown.

28. Children's community nurses offer good support to children with complex health needs. The team work flexibly and are successful in enabling children to remain at home rather than receive care in either a children's hospice or hospital setting. The children's community nurses work in close partnership with the local paediatricians as well as respite and short break providers to ensure that those children who need enhanced support are still able to access these opportunities.

29. Health visitors and school nurses are able to access additional support from the Specialist Health Practitioner for children and young people with additional needs. The specialist health practitioner also works closely with paediatricians to follow up non attendance at clinic appointments, this means that parents and carers of children with disabilities are encouraged and supported in attending health appointments.

30. Transition into adult services for those young people with learning disabilities is improving. Recently appointed learning disability transition workers are primarily involved in identifying and signposting families and young people into adult services that are able to meet their needs. The impact of this work has not yet been evaluated. The local authority "Future's Team" works with young people with disabilities to ensure that their care plans remain person centred. The children with disabilities team complete comprehensive care plans for children and young people that they are involved with and these are reviewed regularly by either social workers or social work assistants, depending on the complexity of the case.

31. Access to short breaks is good. All requests are assessed by a panel according to the level of need identified in the care plan. A comprehensive range of short breaks are available and these have been developed in conjunction with parents, carers, children and young people. A well established adapted skiing trip to France takes place annually and some young people now act as mentors to children with disabilities who take up the offer of horse riding as a short break activity.

32. Health outcomes for children and young people, looked after are good. Eighty five percent of children had an annual health check, and 88.6% had their teeth checked by a dentist. Both of these represent an increase over the previous year and placed Sunderland slightly above the national average. Ninety six and a half percent of children looked after had their immunisations up-to-date at 31 March 2011 and this is significantly higher than national average. However, health promotion and advice is limited to universal services and discussion during annual health reviews. There are no drop in clinics that young people, looked after, can access that can provide specific advice on obesity, healthy eating and making positive choices.

33. All initial health assessments and the majority of health reviews are carried out by a team of consultant paediatricians and associate specialists from City Hospitals Sunderland. Initial health assessments and health reviews are mostly carried out in time and effectively identify the health needs of children and young people. The designated nurse for LAC has worked hard to ensure that initial health assessments are not delayed because of lack of parental consent; however, current arrangements still do not include consents for health assessments in the placement pack used by social workers. This delay remains one of the key reasons for the cancellation of clinical appointments for initial health assessments.

34. Effective arrangements are in place to ensure that children and young people, looked after and placed out of Sunderland have access to timely and appropriate health assessments. The designated nurse for looked after children reviews all health summaries and plans once complete, however, there is currently no formal quality assurance process in place to ensure that assessments and plans are routinely of good quality. There is good involvement of the Consultant Psychologist for Looked After Children in the planning of specialist placements where CAMHS service are required. This means that the placement is able to meet the emotional health needs of the young person.

35. The Consultant Psychologist for Looked After Children offers a good service to ensure that the emotional health needs of children in care are identified and well met. Strength and Difficulties Questionnaires (SDQs) are routinely completed on all children coming into care and the scores are considered by the consultant psychologist for Looked After Children, alongside the initial health assessment, to assess the child's emotional health and wellbeing and to look for any previously unidentified mental health need. This process is repeated at least annually to ensure continuous assessment. A well regarded consultation service is offered to social workers, foster carers and residential home staff and the consultant psychologist offers brief interventions with children and young people where appropriate. The CAMH service in Sunderland has recently been re-commissioned and the new service is developing care pathways to ensure that looked after children have rapid access to appropriate mental health services.

36. Foster carers were anxious about the future of the assessment and consultation service currently offered to young people, foster carers and other professionals which has clearly contributed well to maintaining placement stability for this vulnerable and often challenging group of young people.

37. Young people, looked after are able to access information, advice and contraception from an associate specialist paediatrician who works as part of the looked after children health team. They are also able to access universal CASH services if they are confident to do so. Teenagers who are looked after and pregnant that wish to continue with their pregnancy are referred to the local Family Nurse Partnership or are supported by the teenage pregnancy midwife. The council's data shows that numbers of looked after young people and care leavers under 20 who are become pregnant are higher than the national average. There is no multi agency sexual health protocol and care pathway for looked after young people in place.

38. The local Youth Drug and Alcohol Service (YDAS) is available to support young people, looked after, who are concerned about their substance or alcohol misuse. Whilst there is no dedicated looked after children worker, there is good support offered by the Young People's Nurse who works in the YDAS and the Youth Offending Team. It was recognised that there had previously been a higher than average drop out from treatment for young people, looked after. Link YDAS workers are now allocated to each children's home to train staff in dealing with presenting issues and to engage with the young people prior to their treatment. This has led to an improvement in the percentage of looked after children successfully completing treatment from 50% in 2010/11 to the current position of 70%. The local substance misuse screening tool is not used routinely in the annual health reviews and this is a missed opportunity to identify substance misuse early.

39. The involvement of health practitioners involved in the looked after child reviews and pathway planning is weak and it is recognised that the current arrangements for providing a complete health summary to young people when they leave care is an area for development. Early work is taking place with young people to explore what health information they feel would be appropriate and how this should be provided when they are ready to leave care.

Outcome 6 Co-operating with others

40. The A&E have implemented a "Chaser for Children" protocol which means that if a GP or the walk in centre refer a child to A&E and the child has not attended the A&E within four hours, then contact is made with the parents or carers to find out what is happening. There is a clear pathway for practitioners to follow which can include liaison with children and families services. This is particularly good practice.

41. There is very good and highly effective paediatric liaison. All attendances by children and young people up to 18 years old are routinely screened by paediatric liaison nurse and notified to the GPs, health visitor or school nurse and if a child is looked after, then the notification is also copied to the designated nurse for looked after children. Additional liaison also takes place for those attendances where safeguarding concerns have been raised, with regular detailed updates on any referrals and conversations taking place with professionals across the partnership, including the local substance misuse service, CAMHS, children and families service and public health nurses.

42. Clear and effective referral pathways to the local drug and alcohol team make sure that any young person who attends the A&E through either alcohol or substance misuse is notified to YDAS. There are good relationships between YDAS and CAMS to ensure a co-ordinated approach to the care of those young people with a dual diagnosis of mental health and substance misuse problems.

43. Good partnership between midwifery services and the children and families team ensure timely child protection plans are in place where appropriate. This means that health and social care services can plan and co-ordinate care when the baby is born and that parents are clear about what to expect. This approach is reinforced by the team approach to midwifery services in Sunderland where the same team care for the woman throughout their ante natal, labour and post natal care.

44. The planning and implementing of enhanced early intervention services in health has coincided with the developments in the Sunderland local authority and there are now early signs of the two services coming together to provide a cohesive package of early intervention and support to vulnerable families which has been facilitated well by the health co-ordinators. Health visitors work closely with children's centres and all activities are delivered in children's centres, including baby days, baby massage, and tasty treats. Health visitors identify need for early support and target families appropriately by referring them into the many courses available through their local children's centre.

45. The Community Safeguarding Team effectively share information on families with a child protection plan in place with GPs, health visitors and school nurses to ensure that professionals working with families have the most up to date and relevant information.

46. There are a number of multi agency and multi disciplinary fora which encourage and demonstrate good partnership working to ensure that the needs of children with disabilities are identified and met. Joint clinics are a regular feature in the community paediatric services. This means that the needs of the child are assessed and met with as little disruption as possible and that care and treatment is well co-ordinated.

47. The looked after children health team are integral to the training of foster carers, with sessions regularly taking place on attachment problems that children may present with, as well as developmental milestones of children and young people and dealing with challenging behaviour. The designated nurse for looked after children provides training to health visitors and school nurses on the health needs of children and young people looked after to ensure that they are confident in the latest legislation and know what additional services are available to support this group of children and young people. The consultant psychologist for LAC has run sessions with residential home staff on understanding and managing behaviour.

Outcome 7 Safeguarding

48. The arrangements for the line management and resourcing of the designated safeguarding children professionals are appropriate and meet the requirements of Working Together 2010. The designated nurse has recently increased her involvement in commissioning to ensure safeguarding children is a key feature of any contract. The designated nurse meets with the named nurses in Sunderland regularly and together they are developing an audit cycle to explore safeguarding practice across the area.

49. The arrangements for the line management and supervision of the designated nurse for looked after children are adequate. However, there is no designated doctor in post for looked after children and young people. This means that there is no senior medical health practitioner who has the strategic influence and oversight on the health of children and looked after in Sunderland.

50. Increasing progress is being made in supporting general practitioners to meet their responsibilities in safeguarding children. Safeguarding leads have been identified in all GP practices across Sunderland. Support is made available to the safeguarding leads to help develop good and effective safeguarding systems within their own practices. There is, however, variability in the impact of the role so far, and there has not yet been the opportunity for the leads to meet as a group to look at how safeguarding can be promoted across primary care.

51. The named GP is new in post and is starting to positively impact on the contribution of primary care into child protection conferences. A new report template has been produced that is available electronically for GPs to complete and there are plans to audit its implementation. GPs spoken to during the inspection told us that they welcomed the template and that it had made completion of reports much easier and efficient.

52. Appropriate systems are in place to identify the health records of looked after children in primary care and for those children where there is a child protection plan in place. There is considerable variability in how GP practices are sharing information with health visitors, school nurses and midwives. All GP practices have been allocated a named health visitor, however, not all are having regular multi disciplinary meetings to discuss vulnerable families. Some health visiting teams have processes in place to check that meetings do take place regularly.

53. General Practitioners told us that feedback on referrals to the children and families team had improved and now most referrals were responded to in writing to let them know what action had been taken. Historically, there had been problems in sharing information between primary care and partners and whilst much of this has been resolved, there is still a lack in clarity about what information is appropriate to share in responding to requests for MARAC.

54. The named doctor for safeguarding children at Sunderland City Hospitals NHS Foundation Trust is employed for two sessions per week and is actively involved in training of staff across the organisation as well as providing clinical advice and support. The named doctor attends regular senior meetings with colleagues from health and social care to ensure that the interface between health and social care continues to work well. This group also sets the agenda for the monthly multi agency group which helps to ensure that operational policy and working relationships are aligned and complement organisational practices across the partnership. The trust has a lead anaesthetist for safeguarding children/child protection however, at the time of the inspection, he had not been provided with a role description and had not attended level 3 safeguarding training.

55. The named midwife is also the lead midwife for the trust, though the resourcing of the named midwife is not specified within either job description. The named midwife is part of the named safeguarding children team, though has a different structure for her accountability in the named midwife role.

56. The arrangements for the line management, resourcing and training of the named nurse for safeguarding children within the Sunderland City Hospitals NHS Foundation Trust do not meet the requirements as stated in Working Together 2010 or the intercollegiate guidance 2010. The named nurse is directly line managed by the Matron for paediatrics who in turn is line managed by the business manager for paediatrics who then reports to the divisional manager for family health. This management structure inhibits the effectiveness of the named nurse to influence and champion safeguarding children practice across the organisation.

57. The named nurse for Sunderland City Hospitals NHS Foundation Trust is supported by a team of safeguarding link staff who meet regularly to discuss information sharing, new guidance and legislation as well as supporting safeguarding practice across the organisation. However, the link staff do not have a formal role description and their performance in the role is not linked to the trust's appraisal system.

58. The named nurse is copied in to all referrals to children and families services which enables her to monitor activity across the organisation. Feedback on the quality of referrals is provided informally back to health practitioners to help a continuous cycle of improvement. The named nurse is about to complete an audit on the referrals and there are plans to develop the audit to look at outcomes of the referrals by social care. However, attendance at child protection conferences is monitored through informal networks and although it is reported as good, there is no substantive performance data to confirm this.

59. Appropriate arrangements are in place for the resourcing and line management of the named professionals for community services delivered by the South Tyneside NHS Foundation Trust. There is a full time safeguarding children named nurse who is supported by an equivalent 3 whole time safeguarding nurse advisors as well as a trainer and a specialist health visitor.

60. The safeguarding children community team ensure that all referrals made to the children and families service are entered onto a database, these are then tracked to ensure that the outcome is recorded and the referrer informed. Routine checks are made on outcomes of referrals and that the referring practitioner is satisfied with the action taken. Well established and effective mechanisms are in place to ensure that community health staff attend child protection conferences and overall attendance is good.

61. The community safeguarding team scrutinise all referrals and provide feedback where appropriate. An extensive record audit is carried out annually where two records from each practitioner are examined. This effectively monitors the quality and practice of health care staff and is reflected in the good quality of the records seen during this inspection

62. The Northumberland, Tyne & Wear NHS Foundation Trust has made significant investment and improvements in the arrangements for safeguarding children across the organisation. A new safeguarding public protection team has been established, dedicated Senior Nurses for safeguarding children appointed for the North and South divide of Northumberland, Tyne and Wear NHS Foundation Trust.

63. Good progress is being made in the awareness on the “Think Family” approach adopted by Northumberland Tyne and Wear NHS Foundation Trust. Adult mental health staff in adult substance misuse and early intervention psychosis have suitable assessment processes in place to identify and record details of any children in families that they are working with, as well as any children that a service user may have contact with. The introduction of the “Keeping Children Safe” assessment tool is becoming increasingly well embedded across Sunderland. All teams interviewed were clear that child protection was a priority and attendance at child protection conference across organisations was described as good. A multi agency hidden harm working group meet regularly to discuss issues facing practitioners and this is well regarded by those staff that receive support. The group also helps to identify common issues which are then fed into local training events.

64. The awareness on the impact of domestic violence on children within families is well understood across health services. A specialist health visitor is the lead on MARAC within community services and she works closely with homeless families to ensure continuity of care and support. The family nurse partnership concentrate on the impact of domestic violence as part of their work with vulnerable families. However, health visitors and school nurses do not routinely receive notifications of domestic violence in families where children are present and this means that they do not have a complete understanding of families they are working with.

65. Adult A&E staff are confident in understanding the impact of adult behaviours on children in the family and routinely make referrals to children and families where adults have attended the department following domestic violence or drugs and alcohol incidents.

66. The City Hospitals NHS Foundation Trust support the MARAC process but at the time of inspection this support was not formally documented. Staff are trained in identifying domestic abuse and know where to refer victims to but rely on community health staff based in the South Tyneside NHS Foundation Trust for any referral to MARAC and for any updates on cases discussed.

67. Effective, but complex arrangements ensure an effective Child Death Review Committee consider all child deaths across South of Tyne. There are local review groups for each of the three local authorities as well as an overview panel. A child death steering group considers and monitors any trends. Recent work has influenced safer sleeping practice and more recent work is being undertaken on an increase in car seat injuries. A policy is being developed around increasing the efficacy of the rapid response and bereavement support

68. Appropriate arrangements are in place to ensure that child protection medicals are carried out by suitably qualified paediatricians. All cases of suspected acute sexual abuse are seen and assessed at the local specialist, child friendly, unit in Newcastle.

Outcome 11 Safety, availability and suitability of equipment

69. Families have good and timely access to a wide range of aids and adaptations, with funding for duplicate equipment available to enable children and young people to access support both at home and in school. This means that children and young people do not have to make a choice about where they can access the equipment or have to travel with the equipment on a daily basis.

Outcome 14 Staffing support

70. Training in safeguarding children within Sunderland Hospitals NHS FT is good for Level 1, though only 66% of identified staff at Level 2 and 28% at Level 3 have completed their training. The named nurse has provided a number of bespoke training sessions as well as offering formal training events but take up is variable.

71. There are good arrangements in place to provide group supervision in safeguarding children practice in A&E and paediatric wards. However, the current policy for midwifery staff to access to group supervision does not comply with the guidance in "Working Together 2010." There are no arrangements in place to monitor uptake of supervision across acute services and there are no appropriately trained supervisors. Also, supervision is not routinely recorded in patient notes.

72. Training in safeguarding children across community health services provided by South Tyneside NHS Foundation Trust is good. A comprehensive training needs analysis has been completed which shows that 88% of health visitors have been trained at Level 2, 82% of school nurses at Level 3, with areas for improvement noted in minor injuries and community dental services.

73. Good arrangements are in place to support new healthcare staff working in community services through a range of preceptorship, mentoring and monitoring of attainment of competencies. A "new starter" document contains a range of safeguarding information and competency framework and all new health visitors and school nurses are seen regularly during their first three months to ensure that they are competent and confident in child protection work.

74. Safeguarding supervision is effective in supporting community based health staff to maintain high quality practice when working with vulnerable families. All supervision notes are stored in case notes and uptake of supervision is carefully monitored.

75. Good progress is being made in supporting GPs to attend safeguarding children training. Eighty two percent of GPs have been trained at Level 2 and 34.5% at Level 3. Availability of training and other topical safeguarding issues are included in a GP newsletter that is sent to all GP practices in Sunderland.

76. Northumberland Tyne and Wear are in the process of transferring over community mental health practitioners from their previous organisation. The trust continues to make good progress with training staff in safeguarding children. All new staff now undertake level 2 training after induction via e learning or face to face and the new trainer is visiting the local LSCBs to look at how Level 3 training can be developed across this very large trust.

77. Northumberland Tyne and Wear NHS Foundation Trust is making good progress in rolling out safeguarding children supervision across the trust and has recently placed an advertisement for training supervisors. Once these supervisors have been recruited and trained, then all practitioners working with families where there is a child in need or child protection plan in place will receive one to one supervision.

Outcome 16 Audit and monitoring

78. The NHS South of Tyne & Wear has recently established a safeguarding policy for commissioning services that will continue to enhance Section 11 audit work. The Executive Director for South of Tyne NHS is meeting with the Strategic Health Authority to explore the development of a dashboard for safeguarding, with the development of key performance indicators that can be used across the district.

79. Governance on safeguarding practice across South of Tyne & Wear is good. The associate director for the PCT sits on the Sunderland LSCB and chairs a commissioner only safeguarding strategic forum that meets monthly. The forum is attended by the 3 designated doctors and 3 designated nurses, public health directors and the PCT Medical Director. Clinical commissioning leads have started to attend. Safeguarding practice and compliance with contracts are monitored through the commissioning groups which meet monthly on a locality basis. In addition, the commissioner only safeguarding forum monitors the commissioning strategy, action plans on serious case reviews, etc and comments on changes to service provision, eg. recent CAMHS. A workforce assurance tool is due for implementation in April 2012/13 which will report on additional key performance indicators around staffing levels and other safeguarding activity.

80. Community services for Sunderland were transferred to South Tyneside Foundation Trust as part of the transforming community services agenda. Current arrangements for providing board assurance on safeguarding practice within community services is through the Safeguarding Operational Group which reports to the Board of Directors and the Patient Safety Committee. The executive lead is the Director of Nursing and Patient Safety and is devolved to the Safeguarding Strategic Lead. The trust has a separate Safeguarding Children Operational Meeting for acute services. It is recognised that there is a need to bring together the two safeguarding groups to ensure a continuity and consistency across the organisation. In addition, the strategic safeguarding lead currently has no management responsibility for safeguarding practitioners, this is held by another business manager. This means that there is the potential for communication to be disrupted which continues to be a feature in many serious case reviews.

81. The new combined Safeguarding Operational Group in South Tyneside Healthcare NHS foundation Trust is responsible for hospital and community safeguarding and whilst this is reflected in their revised terms of reference, it does not currently drive the agenda for safeguarding practice across the organisation. For example, there is no formal work plan, though the named nurses do have a scheme of work that they wish to carry out over the next year.

82. City Hospitals NHS Foundation Trust is well represented on the Children's Trust Partnership and Sunderland LSCB. The trust board receive annual training on safeguarding children as well as the annual safeguarding children annual report.

83. Board assurance on safeguarding children within Sunderland City Hospitals NHS Foundation Trust is currently limited by the lack of a robust set of performance indicators on safeguarding practice across the organisation. However, recent changes to the reporting structure through the internal safeguarding committee should provide the trust board with improved assurance.

Recommendations

Immediate

NHS South of Tyne & Wear to review the arrangements for the designated doctor for looked after children to ensure that the requirements as laid out in the Statutory Guidance on the Health of Looked After Children are fully met.

Within 3 months (from report)

Northumberland, Tyne and Wear NHS Foundation Trust to ensure that revised pathways of care are effectively implemented for children and families who need specialist services from CAMHS (Ofsted, March 2012)

Sunderland City Hospitals NHS Foundation Trust to review the establishment, capacity, resourcing and line management arrangements for all its named professionals.

Sunderland City Hospitals NHS Foundation Trust to ensure that staff within the trust attend mandatory safeguarding training at a level appropriate to their role.

Sunderland City Hospitals NHS Foundation Trust to ensure that midwives access one to one supervision in safeguarding children practice.

Sunderland City Hospitals NHS Foundation Trust to review its formal commitment to the local MARAC process to ensure that, where possible, all victims of domestic violence are identified and supported.

South Tyneside NHS Foundation Trust to review the Terms of Reference for its internal Safeguarding Committee to ensure that it is able to effectively co-ordinate and report on safeguarding activity across the whole organisation.

The NHS South of Tyne and South Tyneside NHS Foundation Trust to work with partners to identify how appropriate information sharing on incidents of domestic violence in families where children are present can be facilitated.

The NHS South of Tyne and South Tyneside NHS Foundation Trust to work with the Sunderland leaving care team to ensure that young people leaving care are provided with a comprehensive summary of their health care.

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.