

Review of health services for Children Looked After and Safeguarding in Darlington

Children Looked After and Safeguarding

The role of health services in Darlington

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Summary of the review

This report records the findings of the review of health services in safeguarding and looked after children services in Darlington. It focuses on the experiences and outcomes for children within the geographical boundaries of the local authority area and reports on the performance of health providers serving the area including Clinical Commissioning Groups (CCGs) and Local Area Teams (LATs).

Where the findings relate to children and families in local authority areas other than Darlington, cross-boundary arrangements have been considered and commented on. Arrangements for the health-related needs and risks for children placed out of area are also included.

About the review

The review was conducted under Section 48 of the Health and Social Care Act 2008 which permits CQC to review the provision of healthcare and the exercise of functions of NHS England and Clinical Commissioning Groups.

- The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.
- The focus was on the experiences of looked after children and children and their families who receive safeguarding services.
- We looked at:
 - the role of healthcare providers and commissioners.
 - the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
 - the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.
- We also checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, Working Together to Safeguard Children 2013.
- Where we found areas for improvement in services provided by NHS but commissioned by the local authority then we will bring these issues to the attention of the local public health team in a separate letter.

How we carried out the review

We used a range of methods to gather information both during and before the visit. This included document reviews, interviews, focus groups and visits. Where possible we met and spoke with children and young people. This approach provided us with evidence that could be checked and confirmed in several ways.

We tracked a number of individual cases where there had been safeguarding concerns about children. This included some cases where children were referred to social care and also some cases where children and families were not referred, but where they were assessed as needing early help and received it from health services. We also sampled a spread of other such cases.

Our tracking and sampling also followed the experiences of looked after children to explore the effectiveness of health services in promoting their well-being.

In total, we took into account the experiences of 63 children and young people.

Context of the review

Children and young people under the age of 20 years make up 23.8% of the population of Darlington. 8.5% of school children are from an ethnic minority group.

The health and wellbeing of children in Darlington is generally worse than the England average. Infant and child mortality rates are similar to the England average.

The level of child poverty is worse than the England average with 21.7% of children aged under 16 years living in poverty.

Commissioning and planning of most health services for children are carried out by Darlington CCG. Health visiting is commissioned by NHS England local area team. School nursing, contraception and sexual health services (CASH) and substance misuse services are now commissioned by the local authority.

Acute hospital services and community based services, including health visiting and school nursing are provided by County Durham and Darlington NHS Foundation Trust (CDDFT).

Child and Adolescent Mental Health Services (CAMHS) and adult mental health services are provided by Tees, Esk & Wear Valleys NHS Foundation Trust (TEWV).

The last inspection of health services for Darlington's children took place in November 2011 as a joint inspection, with Ofsted, of safeguarding and looked after children's services (SLAC). The report was published in January 2012. Recommendations from that inspection are covered in this review.

The report

This report follows the child's journey reflecting the experiences of children and young people or parents/carers to whom we spoke, or whose experiences we tracked or checked. A number of recommendations for improvement are made at the end of the report.

What people told us

We heard from:

Three young people in a foster placement who told us that they felt they had an established relationship with the children looked after nurse and felt comfortable having health reviews at their foster home and that they were able to have a say about who was with them.

Foster carers who told us that they regularly received copies of the health plans by registered post.

One foster carer said "My health visitor has been fantastic, I have been lucky in that it's been the same health visitor for the last two children. I nominated her for a local health visitor award as with previous siblings fostered, I couldn't have coped without her, a lot of attachment issues impacted on behaviours, she took on a lot of liaison with other agencies for us. She helped look after me, too, such as helping push for some respite care. She really went the extra mile for me."

Young people, looked after told us that they felt the children looked after nurse covered everything about their health needs.

One young person, looked after said "CAMHS are nice, you can have who you want in with you, if you don't like being on your own you can have someone with you."

Another young person said "The GP receptionists are really nice and so are the GPs though you see someone different every time, they fit you to be seen on the same day."

A group of young people and their foster carer told us *“At A&E, once they know you’re a child looked after or a foster carer with a child looked after, they keep you waiting around hours and hours while they contact children’s social care. If it’s out of hours they contact the emergency duty team then wait for a duty manager. There should be a better system so you’re not penalised and made to wait so long before seeing a doctor – or arrange wider prior consent.”*

A teenage mother who had just had her second baby, who had a child protection plan in place, said *“the midwives had been flexible around my appointments.”* And *“I felt more supported this time round.”*

New parents said *“Amazing, nothing has been too much effort. They (midwives) never seem stressed, they always have time and care for you.”* The new dad said *“the attention to detail and standard of care has been second to none. Staff kept me informed and someone always came to explain what was happening to me.”*

Another new mother said *“Sometimes it was hard to build a rapport with the community midwives because I didn’t always see the same one.”*

Whilst another new mother said *“I saw 3 different community midwives, but it didn’t make a difference; they read the notes before talking to me so they knew what was happening.”* *“Midwives explained the scans there and then to me and my husband, I was less worried and reassured that everything was ok.”*

“The community midwives were a really good team. Really understanding I could ring or text and someone was always available, I never felt alone. When I was in labour they kept encouraging me and made me feel as though I could keep going and they were nice to my birth partners and made them feel part of it.”

Parents attending the emergency department at Darlington Memorial Hospital with a small child in the children’s waiting area, returning after visiting the night before told us *“We haven’t been waiting long and feel we have been treated well. The doctor took time with our son and examined him thoroughly and we have come back today for a review. We are satisfied with the health service we get at the hospital”.*

The child's journey

This section records children's experiences of health services in relation to safeguarding, child protection and being looked after.

1. Early help

1.1 The provision of a clinical navigator at the emergency department (ED) registration desk is effective in facilitating young people in having prompt access to the appropriate level of treatment. Some cases may be signposted to the urgent care centre (UCC) or fast tracked into ED clinicians.

1.2 Receptionists at ED are aware of how to raise any safeguarding concerns with nursing staff. However, they are unable to physically observe the children's waiting room. Parents and children may be in this waiting area without being observed by staff whom are often busy treating other children in the dedicated cubicles. This could result in the deterioration of a sick child being missed or important signs of behaviour that could indicate safeguarding concerns.

(Recommendation 3.1)

1.3 The acute trust ED electronic system differs from the system used elsewhere in the hospital. It is continually being refined with the input of lead ED practitioners and a number of fields have been made mandatory to ensure more robust data collection and recording. The system does record the number of previous attendances to emergency care and notifications of attendance are sent to the GP, health visitor or school nurse.

1.4 The current ED electronic system does not promote the assessment of all children for potential non-accidental injury. The child protection risk assessment, which encompasses the national institute of clinical excellence (NICE) guidance, is a secondary screen and is not completed for all under 18s; this means that not all children and young people are recorded as being fully assessed for child protection concerns. The child protection risk assessment is only completed by the clinician if they have identified some safeguarding concern or there is a known vulnerability or if an alert has flagged on the system. This means that there is the potential for a non-accidental injury to be missed. **(Recommendation 3.2)**

1.5 The electronic system does flag if the young person is or ever has been subject to a child protection plan and although flags are never removed from the system they are greyed out to indicate past social care involvement. Practitioners routinely check with children's social care the status of any child about whom they have concerns.

1.6 Emergency department staff report good and prompt access to paediatric expertise from the ward to ensure that sick children receive care from appropriately qualified and experienced staff.

1.7 Where appropriate, young people aged between 16 and 18 years are given a choice as to whether they are treated in ED as a child or adult. However, all under 18s are subject to the paediatric ED documentation. This is positive and ensures that practitioners remain focused that they are treating a young person and not an adult.

1.8 Practitioners in the ED report the pathway enabling children and young people misusing substances to access early support from the provider, SWITCH, is working well. Young people are assessed at the ED triage using a screening tool which has been agreed with SWITCH and are referred to SWITCH with their consent. This was a recommendation from the previous safeguarding and looked after children (SLAC) multi agency inspection.

1.9 ED staff told us that young people, who are known to CAMHS and who self-harm, may be seen in the ED by CAMHS. However, usually the young person is admitted onto the paediatric ward where CAMHS will assess them. Children and young people needing urgent mental health assessment can be seen over a seven day period as there is a rota covering weekends. This is facilitating young people's access to prompt mental health support.

1.10 It was reported that the school counselling service is being reduced. A contributing factor being the move to academies that are more autonomous about services they commission. As a result of the reduced school counselling offer, referrals to CAMHS for counselling support to young people have increased. The specialist CAMHS service is not resourced to provide this and therefore there is a risk that young people may not be able to access prompt early help support and may develop higher levels of mental health need needing referral to specialist CAMHS.

1.11 Access to specialist CAMHS services for children and young people with moderate to high mental health need is good. Urgent cases are seen within five days and initial appointments for assessment are seen within six weeks for non-urgent referrals.

1.12 CAMHS practitioners ensure that young people are routinely seen alone as well as with parents and this was confirmed by one young person we spoke to. However, this is not well evidenced in case recording as there is no prompt question within the assessment proforma to ensure young people are given the choice. GPs told us that anecdotally the service is well regarded by young people and their families.

1.13 We saw examples of good, child centred and well considered risk assessments in CAMHS. Plans guiding the therapeutic intervention are based on child led goal setting and Routine Outcome Measures (ROMs) and are used routinely to enable the child and, where appropriate, their parents or carers, to measure progress and evaluate their own emotional journey. We saw examples of positive outcomes for the children and young people from the interventions.

1.14 Young people who have suffered sexual abuse or significant trauma with resultant mental health issues are well supported by the specialist Rainbows post abuse and trauma team.

1.15 There is an established transition pathway for young people engaged with CAMHS moving into the adult service and we heard a case example of good planning and support for a young person moving into the adult mental health service

1.16 Most women who are pregnant are referred to the midwifery services for their maternity care from their GP, although some do self-refer. A newly developed GP referral form has recently been introduced which includes significantly more detailed information around the expectant mother's social history and vulnerability. This helps midwifery services to provide a more targeted approach when arranging the first booking appointment for the expectant mother. The majority of booking appointments now take place in community bases, either at the hospital, GP practice or children's centres. This promotes easy access for expectant mothers.

1.17 In all cases seen, midwives completed a comprehensive risk assessment. This includes a pre-CAF with additional information on the family structure including details of any previous children that may no longer live in the family home. This is important as not fully understanding or exploring household composition is a feature in many serious case reviews.

1.18 Expectant mothers are given key contact details for midwives and maternity wards, along with a contact card that has pictures of the midwives. Women that we spoke to told us that they welcomed this as they could "put a face to the name."

1.19 Midwives reported that they are vigilant in seeking the opportunity to speak to an expectant mother alone to ask about the presence of domestic violence and recording this on the patient's notes. The trust policy requires that the question is repeated at least once more in pregnancy but in the records we looked at we could not find any evidence of this happening. Pregnancy is recognised as being a time when domestic violence can often happen for the first time or may escalate. The trust policy does not require a midwife to see an expectant mother alone for at least part of the booking. This is a missed opportunity to allow the woman to disclose any domestic violence or other personal information that she may not wish to share with others. **(Recommendation 3.6)**

1.20 A robust did not attend (DNA) policy is now in operation across midwifery services and any expectant mother who does not attend for an ante natal appointment is vigorously followed up. We saw examples of how this worked in some of the cases that we looked at and in one case the midwife made a home visit to persuade the mother to be to re-engage and continue with ante natal care.

1.21 Midwives in Darlington now carry out a home visit to check that the expectant mother is prepared for the arrival of the new baby. Midwives have welcomed the return of the home visit as they feel that this helps to identify any issues around the appropriateness of the home environment and identify any potential safeguarding issues that may impact on the new baby once discharged from hospital.

1.22 Health visitors and school nurses support the locality model of supporting families with children from birth to 19 years of age who live in Darlington. A number of different opportunities for supporting vulnerable families who live in a geographical locality are available, through the common assessment framework (CAF), including care packages delivered through the family intervention team (FIT), team around the family (TAF) and area practice and panel meetings.

1.23 Health visitors are benefiting from the recruitment of additional staff into teams; case loads are now manageable and good progress is being made in the delivery of the ante natal contact. There is an expectation that all vulnerable families will be contacted in the ante natal period and we saw evidence of joint visits with midwives taking place on a regular basis to families that were identified as needing extra support.

1.24 School nurses are delivering the Healthy Child programme. All secondary schools have weekly drop-ins led by the school nurse and two secondary schools have sexual health clinics run by school nurses. A joint clinic with the youth service in an area of high demographic need has been successful and has been well attended by young people. The school nursing service is working to extend its early help offer and works closely with the CASH services who support young people about whom there are concerns. This is achieved through one to one sessions or group basis on topics such as girl empowerment, self-esteem or targeted chlamydia screening.

- *In a school, previously not offering a sexual health clinic, a young person has championed the need for this to be offered to pupils in an off-school site.*
- *As a result of the young person championing this, the school nurse has worked with the school and the children's centre situated opposite the school and developed a business plan which has been accepted. A new sexual health clinic operated by the school nurse is to be run in the children's centre. This will increase pupils' access to sexual health advice and support in a way the young people have chosen.*

1.25 Young people have improved access to CASH services in Darlington through a number of initiatives and services developments. However, out of term time, a number of clinics are not available and it is acknowledged that access and service take-up is more limited then. As the integrated CASH service has become better known, attendance by young people have increased although boys are very under-represented, particularly in contraception visits. A good and increasing proportion of young people are protected from unwanted pregnancies through effective promotion of long acting reversible contraceptives.

1.26 CASH services work flexibly across Darlington and County Durham and lead members of staff take responsibility for local areas. They are supported by effective information sharing arrangements across the area. We saw an example of how staff responded to intelligence from one area of the county about a small cohort of young people who were engaging in sexually risky behaviours outside school time. Working with police, agencies rapidly developed a targeted package of education for the school and the issues appear to have been resolved.

1.27 In cases where the child in need (CIN) threshold was not met, there was limited evidence of co-ordinated and effective team around the child/family approaches. We saw several examples of this lack of inter professional communication. This is a common feature of serious case reviews. Health practitioners are not always being proactive in ensuring good sharing of information and expertise to inform each other's work with a child or family and to ensure that an effective early help support package is in place. **(Recommendation 1.2)**

1.28 Most health visitors and school nurses have received CAF training and do act as lead professional when health needs for a child are identified. Managers reported that significant work has taken place with practitioners to encourage them to engage with other disciplines and families to ascertain who is best positioned to lead on CAF in individual cases.

2. Children in need

2.1 Children living in households where there are adults who engage in risk taking behaviours or who have mental health concerns and attend ED are not routinely identified. Adults are not always asked if they have parental responsibility or live in a household where there are children. There are few, if any, trigger questions to support ED staff in making effective child safeguarding risk assessments of adults when they attend for treatment. Practitioners have to use free text rather than there being mandatory fields in an assessment proforma. Notifications of adult attendances which go to GPs and other health professionals do not include any reference to children. There is also nothing on the notification for adults to ensure that child health administrators would direct these notifications to health visitors or school nurses for following up on potentially vulnerable children. **(Recommendation 3.4)**

2.2 The adult mental health initial assessments proforma used by adult mental health practitioners asks questions about children for whom the adult has parental or caring responsibility for, although this does not include questions about children in the household or with whom adult has frequent contact. Despite this lack of robustness in the proforma, we saw evidence of practitioners using inquisitive inquiry effectively, asking searching questions on potential safeguarding concerns or vulnerability demonstrating awareness of the importance of the "think family" agenda; though the recording of this information is not supported well by the current IT system.

2.3 The provision of daily police reports through the local multi agency safeguarding hub (MASH) of incidents via secure e-mail to adult mental health means that clients who are known to the service can be followed up quickly and information is passed promptly to other health professionals such as GPs.

2.4 When parents are in-patients for treatment of mental health problems, separate visiting facilities are in place at the hospital to enable good contact with children while protecting them from going onto the main ward.

2.5 Expectant mothers who have additional vulnerability through substance or alcohol misuse or peri natal mental health concerns continue to receive their midwifery care through the community midwifery service. Although there is a peri natal mental health pathway, this is not consultant led; the CCG and trust recognise this as an area for development. **(Recommendation 1.1)**

2.6 The use of comprehensive ante natal, labour and post natal plans to support expectant women with additional need is underdeveloped and the majority of plans seen did not contain sufficient detail on how midwives might recognise and respond to any emerging or changing need. **(Recommendation 3.7)**

2.7 Young people under 19 who are pregnant and do not meet the threshold for support by the family nurse partnership are supported well through the teenage pregnancy pathway. The recently developed pathway offers an enhanced and targeted package of support by the specialist teenage pregnancy midwife, the community midwife and the young person's allocated health visitor. Additional support is available to teenage parents through the midwifery led "Bump and Baby" group, age appropriate ante natal clinics and a young mum's group. All pregnant teenagers are offered targeted support from the local CASH services.

We observed a consultation between the teenage pregnancy midwife and a teenager who was pregnant. The midwife carefully explained the results of the ultrasound scan that had taken place earlier in the morning and checked that the young woman understood what she had said. They then talked about the need for a healthy diet and discussed referral to the smoking cessation service. The young expectant mother told us how she had watched the video message about "Baby Clear" showing how the mother's smoking crosses the placenta. The midwife encouraged questions from the father to be and also the grandmother.

2.8 Health visitors have received training on identifying and responding to peri-natal mental health issues. Where peri-natal mental health needs are identified, health visitors provide intensive support to new mothers and where necessary refer to adult mental health services in the post partum period.

2.9 Health visitors work closely with the family intervention team (FIT) and undertake joint visits with early years' practitioners and social workers. We saw examples of health visitors utilising early years' practitioners, nursery nurses and other team members effectively to support families well, providing advice, guidance and training to parents on issues around parenting, weaning, breast feeding and play.

2.10 GP practices across Darlington now hold regular safeguarding assurance meetings which health visitors, midwives and school nurses are invited to attend. These meetings were introduced in response to a recommendation from the previous SLAC. These meetings discuss vulnerable families to ensure that their needs are identified and met through a co-ordinated package of support. These work well and attendance is reported to the CCG, though we did note that attendance by midwives and school nursing was less frequent. We saw the minutes of one meeting at which one family was discussed in relation to a pattern of non-attendance at medical appointments and the impact of this on the wellbeing of the children.

2.11 North Durham CCG developed a Child safe trigger tool which has been shared with the remaining CCGs in Durham and Darlington. The tool prompts GPs to instigate a more in-depth review of a child or young person's vulnerability when they receive information from any source that would indicate a child has suffered a trauma. The review would consider other potential safeguarding issues such as DNAs and patterns of attendance. The tool has been recently launched in Darlington and has not yet been fully implemented across the patch.

3. Child protection

3.1 We saw how a young person who had attended the ED and not stayed to receive treatment was followed up promptly and effectively by health practitioners with good support provided by the police. However, the missing patient policy in place at the acute hospital does not refer to the local safeguarding children's board (LSCB) policy and the arrangements to respond to children and young people who leave the ED before accessing treatment is not clearly defined or understood by ED practitioners. (**Recommendation 3.5**)

3.2 An established DNA policy in TEWV ensures that children's social care are informed when a child on child protection plan or identified as at risk is not brought to appointments or their responsible adult does not attend their adult mental health appointment.

3.3 The recording of concerns and actions taken by ED staff in support of referrals to the MASH is weak. We saw evidence of how practitioners are recording concerns and actions taken on the referral form and not on the child's ED record. The referral form is usually scanned onto the ED record, however, the child's ED record is the most appropriate place for the contemporaneous recording of this detail. (**Recommendation 3.3**)

3.4 Health practitioners referring to the multi-agency safeguarding hub (MASH) are not routinely assessing vulnerability or articulating risk sufficiently clearly. Referrals sometimes do not state what action practitioners are recommending. Instead, the referral is often a chronological description of events. Children's social workers are not health experts and will not always understand the implication of what is being described. Poor quality referrals may lead to delays and challenges in decision making that could impact on the timeliness of an intervention with a family where there are concerns. Although referrals to children's services are routinely copied to CDDFT named nurses and practice issues are addressed during supervision, there is no routine and systematic approach to quality assurance to drive forward a programme of improvement. **(Recommendation 1.3)**

3.5 Some health practitioners are using referral forms as a means of sharing information with MASH rather than these being formal referrals. This is resulting in potential confusion as to the nature of the communication.

3.6 Practitioners can refer families about who they have concerns to the local MASH. All referrals should be screened and risk assessed by the multi-agency team which is resourced by health practitioners. However, in some cases we reviewed, the full benefits of the MASH are not being utilised. Cases are not routinely being risk assessed by the partner agencies and requests for reports are informal rather than following the documented process.

3.7 Midwives and health visitors meet on a monthly basis to discuss those families where there are concerns and joint visits between midwives, health visitors and children's social workers are a common feature in the files we looked at. This promotes good information sharing and a joint approach to supporting vulnerable families. Midwives can refer expectant mothers about whom they have safeguarding or potential child protection concerns relating to the unborn baby at the earliest opportunity

3.8 Midwives place an electronic alert on the IT system to identify if there are any concerns around child protection or other vulnerability. For newborns protected through a child protection plan, the baby's electronic record is flagged. This helps alert other health agencies across Darlington who may need to treat the baby, either as a routine or urgent case, that a child protection plan is in place.

3.9 Health practitioners we spoke to were aware of the local escalation policy to help resolve issues of professional disagreement and reported that this worked well. All practitioners demonstrated good awareness of how to seek advice and guidance from their organisation's safeguarding team.

3.10 Attendance at child protection conferences and core groups is closely monitored by the LSCB and overall attendance by health practitioners is good; with significant and sustained improvement in the attendance of midwives. Managers set clear expectations that practitioners will participate and attend child protection forums and core groups. Health visitors and school nurses operate a "buddy" system so that practitioners can be represented by a colleague if they are unable to attend.

3.11 It is not clear that invitations to child protection and CIN meetings are always being effectively directed to the appropriate practitioner in TEWV by children's social care. There is no central mailbox system within teams to enable appropriate channelling of invitation to practitioner or ensure representation at key meetings, although the trust's safeguarding team is encouraging this. This means that some child protection conferences may not benefit from input by adult mental health practitioners who may be, or have been working with the adult in the family. TEWV safeguarding team are copied into all invitations and follow up with the practitioners involved (**Recommendation 4.1**)

3.12 A GP template exists to help guide GPs in completing reports for child protection conferences, however, these are not being used consistently by GPs. The quality of child protection conference reports we saw was variable, with some key information on the parent's history and risk taking behaviour not included. GPs we spoke to suggested that the request for information for conference could be more detailed around the nature of concerns being expressed as they felt this would allow them to prepare a more targeted response.

3.13 All practitioners were aware of the need to share child protection conference reports with families prior to the conference taking place. Families we spoke to confirmed that they received copies of the reports and that health practitioners discussed the content with them prior to them going to the conference.

3.14 The local CASH service refer any child under 13 years to children's social care as they recognise national and local LSCB policy that these children cannot give consent. All young people under 18 years of age are assessed for vulnerability using a specific assessment form, with a more detailed assessment taking place for those under 16. In all cases we saw this had been completed appropriately and comprehensively and safeguarded young people well.

3.15 The CASH service now has a flagging system which enables staff to draw attention to any young person where there is an identified issue or additional information that the practitioner needs to be aware of. We saw a case example where the flag was being used to indicate that appointments for one young person must be booked with a named practitioner. However, there are no clear criteria for what the flag is used for and it cannot be interrogated or used for any quality assurance or performance management. This is recognised as an area for improvement by the service.

4. Children Looked After

4.1 Children and young people who become looked after by Darlington local authority are not receiving timely assessments of their health needs. The children looked after (CLA) nurse attends the weekly Darlington access to resource panel (DARP) where all cases of children and young people who are being considered as suitable for coming into care are discussed. This allows the CLA nurse to quickly identify the social worker involved to facilitate, as early as possible, the obtaining of consent for the initial health assessment. The CLA nurse also monitors and follows up any outstanding or delayed consents for assessments.

4.2 There are still significant numbers of children and young people entering the care system in Darlington who are not receiving their initial health assessment within the statutory timescale. The CCG are monitoring the service closely and receive exception reports when timescales are breached. This has now been escalated to Darlington LSCB and senior managers across the partnership. (**Recommendation 2.3**)

4.3 All initial health assessments for younger children are carried out by either the medical advisor for fostering and adoption or a trainee paediatrician under the guidance of the medical advisor. The initial health assessments we saw were of good quality and reflected the voice of the child well.

Child M is aged 17 and became looked after earlier this year. There was a four week delay between M becoming looked after and the CLA health team being made aware. M's parents had not given consent for the initial health assessment and the social worker was reluctant to obtain consent from the young person as she was considered to have a mild learning disability. The file does not show any evidence of a frazer competency assessment or any other assessment of capacity.

The delays in notification and in obtaining consent significantly delayed M receiving her initial health assessment. As part of the escalation policy the children's social care service manager signed consent

However, as part of M's initial health assessment with the CLA nurse, she is asked to sign her consent and does this. Interestingly, M had also signed consent for previous health assessment in earlier periods in care. The file does not indicate that M had refused an initial health assessment with a paediatrician or explain why the CLA nurse carried out the assessment.

4.4 Some initial health assessments for young people aged over 14 years were being carried out by either the CLA nurse or the youth offending service (YOS) nurse. This is not in line with statutory guidance as these practitioners are not suitably qualified practitioners able to undertake comprehensive health needs assessments. The assessments we saw, completed by these practitioners, demonstrated skill in drawing out and recording the voice of the child; conveying a sense of the individuality and personality of the child and covering emotional health well. However, without a full physical examination by a suitably qualified registered medical practitioner, the assessment cannot be comprehensive and this is not acceptable routine practice. **(Recommendation 2.2)**

4.5 We heard how the nurse led initial health assessments are only carried out for young people who have previously declined an appointment with a paediatrician. There was nothing on the young person's record to indicate this, nor any rationale for delegation of these assessments. We found no evidence of any risk assessment or any notes of consultation with a medical practitioner prior to or after the assessment had been completed.

4.6 There is a lack of detailed parental health histories or information in most initial health assessments and review health assessments seen. Birth parents are invited to attend initial health assessments but few do. We saw how the practitioners carrying out the assessments made some attempt to obtain histories from foster carers accompanying the child or from hospital records, however, this was not comprehensive and often anecdotal. The "loss" of this information can have a long reaching detrimental impact on young care leavers moving into adulthood. **(Recommendation 2.4)**

4.7 Few assessments set out the reasons the young person had come into care or their legal status. This is part of a child or young person's history and should be available to the practitioner carrying out health reviews and assessments.

4.8 Most health reviews are carried out by health visitors and school nurses and the quality of the assessments were variable; though in all cases seen good attention was paid to recording the ethnicity and language spoken by the child. Those undertaken by the CLA nurse are good; there is a clear link to the previous health review and progress or changes are discussed with the child. The CLA nurse and the YOS specialist nurse clearly know some of the cohort of looked-after child very well. This enables the child to have an open discussion about their health and well-being and is well documented in the health assessments undertaken by these practitioners. Young people we spoke to told us they felt confident in speaking to the CLA and YOS nurses about any health issues.

4.9 General Practitioners are not routinely invited to contribute to the initial and review health assessments, though health practitioners completing the assessments do have access to the GP record through the electronic patient record. GPs and foster carers are routinely copied in to the health summary and the health action plan and this was confirmed by the foster carers we spoke to. **(Recommendation 2.4)**

4.10 Strengths and difficulties questionnaires (SDQs) are not being used to effectively monitor a young person's emotional health and wellbeing. Only foster carers are asked to complete the SDQ and these are not routinely considered during any health review. Young people are not asked to complete a questionnaire and this is a missed opportunity to engage and involve a young person in their own health care.

4.11 Children and young people looked after have good and timely access to dedicated CAMHS support. However, basic information on CAMHS involvement with a child or young person looked after is not shared with the CLA health team and this means that the health reviews cannot be complete. **(Recommendation 2.4)**

4.12 Some foster carers and children told us that they sometimes experienced delays in the local emergency department whilst children's social care were contacted for confirmation about who could consent to treatment. However, we were also made aware of a recent scheme whereby some foster carers were provided with a card which they could then show to a medical practitioner or at the ED to discreetly indicate a child's looked after status. This was felt to be positive and useful by carers.

4.13 Young people who are looked after receive good support from the local CASH services. An outreach nurse is available to provide guidance and treatment in venues that are both safe and convenient to any young person who finds it difficult to access the universal service. Any young woman, looked after or who has recently left care and becomes pregnant is considered a priority for the local Family Nurse Partnership. This means that they have access to an intensive programme of support to prepare them for parenthood.

4.14 Health plans developed by the CLA nurse are comprehensive and reflect well the initial health assessment or health review, however, this good practice was not evident in all cases seen. Health planning is an area for development, as most plans are not sufficiently SMART. Actions are sometimes attributed to named individuals but timescales are often vague and no measurable objectives are set. **(Recommendation 2.5)**

4.15 The CLA nurse reviews all health assessments and reviews on children and young people looked after by Darlington but placed out of the local authority area. There is no formal mechanism to indicate that the assessment has been quality assured. Discussions are ongoing to introduce "payment by results" when commissioning external health assessments to ensure that children and young people placed out of the area receive a quality comprehensive health assessment and subsequent health services to meet their needs. **(Recommendation 2.6)**

4.16 Young people leaving care are provided with a letter detailing their final review health assessment and a summary of their health needs. Historically young people were consulted on the development of a health passport, however, the young people at that time were ambivalent about the project and this has not been progressed since then. **(Recommendation 2.7)**

Management

This section records our findings about how well led the health services are in relation to safeguarding and looked after children.

5.1 Leadership and management

5.1.1 NHS England area team continue to make progress with implementing and supporting safeguarding assurance. A local safeguarding forum has very recently been established, as part of the quality surveillance framework, with terms of reference agreed. NHS England area team are represented on the local LSCB and safeguarding children is discussed as a standing agenda item on the quarterly assurance meetings with the CCG.

5.1.2 Good dialogue between the NHS England area team and the CCG strengthens the interface between commissioning primary care and the CCG responsibility for quality improvement. Darlington CCG support primary care well and NHS England area team transferred the baseline funding for the named GP transferred over to the CCG and has continued to maintain this arrangements. Although there is currently a gap in the named GP, cover appropriate arrangements have been put in place whilst the substantive post-holder returns to practice.

5.1.3 Darlington CCG is appropriately constituted, with good and active lay member involvement that includes Healthwatch. A recent Audit North inspection has recommended a minimal number of actions to strengthen governance in safeguarding practice and these are now being addressed. Darlington CCG is now working collaboratively with the local authority, and although governance and accountability at executive level remain with each organisation, there is joint attendance and sharing of agendas. This is helping to identify and respond to the needs of the local community.

5.1.4 The designated nurse for safeguarding meets regularly with the public health lead to discuss changes to the NHS landscape and ensure that safe practice continues across health services including, for example, the transfer of CASH services to the local authority. The designated nurse for safeguarding is also the designated nurse for children looked after. The designated doctor is employed for five sessions per week across County Durham and Darlington and is also providing interim cover for the named doctor for County Durham and Darlington NHS Foundation Trust. Arrangements to recruit to the post of named doctor within the acute trust are well advanced.

5.1.5 Darlington CCG commissions the local “Investing in Children” organisation to research and obtain young people’s views on service provision. We heard of how self-harm will now be one of the LSCBs local priorities and the young people’s views will directly impact on service commissioning and delivery. The CCG hold regular “Dragons Den” type events on an annual basis and this year it has allocated money to fund local initiatives with a focus on children and young people.

5.1.6 The CCG facilitates regular GP practice safeguarding leads meetings which is a forum for practice leads across Durham and Darlington to share good practice and provides a regular development opportunity, though not all leads are clinicians. A recent forum looked at domestic violence and was delivered by a local police representative and acute trust’s domestic violence co-ordinator. The CCG are now supporting GPs across the area in developing coding to identify perpetrators, victims and children in households.

5.1.7 There is health representation on the Multi Agency Looked After Child Panel and good progress is being made in the development of the Children Looked After Health Profile which should be available by Autumn 2014. This will support targeted commissioning and evaluation on the impact of health services to this vulnerable cohort of children and young people.

5.1.8 The capacity of named professionals within the County Durham and Darlington NHS Foundation Trust needs review to ensure that the post-holders are able to fulfil the requirements of their posts as detailed in *Working Together 2013* and the *Intercollegiate Guidance 2014*. We are aware that the trust is in the midst of reconfiguring the structure of safeguarding teams across the organisation and the CCG continue to monitor closely the progress made.

5.1.9 Following the transfer of the named professionals for community services into the CDDFT there has been a period of re-structure and there are a number of current and imminent vacancies. Interim arrangements are in place to cover these key roles until such time that substantive appointments can be made. Current arrangements to cover the role and responsibilities of the CLA nurse as described in the intercollegiate guidance, including quality assurance of out of area placements, are unsatisfactory.

5.1.10 CQC Inspectors were also concerned about the current capacity of the named nurse role within the acute hospitals to provide comprehensive leadership and ensure continuous improvement of safeguarding practice, particularly in the ED. This impacts in several areas, including being unable to provide safeguarding supervision to safeguarding leads across the trust. It is difficult to identify how they can lead on an effective improvement agenda or establish a robust safeguarding governance frame work in the ED, though a task and finish group has been set up to explore practice within this clinical area.

5.1.11 The named nurse for safeguarding for community services within Darlington is employed 0.5 whole time equivalent and is supported by a full time band seven specialist nurse. The team are co-located in the police station within the MASH. The current IT arrangements do not support the team in their work and lead to compromises which are not efficient or best use of practitioner's time. It is not possible to see how the small team can support community services in Darlington and fulfil the duties of the health representative on the MASH; this impacts on the named nurse's availability to provide supervision, quality assurance and audit work.

5.1.12 Subsequent to the previous SLAC inspection at Darlington, the trust recruited to the post of specialist midwife in safeguarding. The specialist midwife has now been in post for a year and has made a significant impact on the improvement of safeguarding practice within the service. This includes development of specific care pathways for vulnerable expectant mothers and updated guidance and policies to reflect learning from serious incidents and serious case reviews, locally and nationally.

5.1.13 CQC inspectors observed the CDDFT's safeguarding committee meeting at which safeguarding children and adult practice across the trust was scrutinised and reported on. There was good feedback provided to those attending from the recent LSCB meetings and robust discussion took place on agenda items such as training and outcome from audit.

5.1.14 The named nurse in TEWV is providing effective leadership across adult mental health and CAMHS. They have established a link professionals meeting for all the lead safeguarding practitioners in trust area teams. This enables link professionals to share common issues, good practice and complex case studies. It is effective in promoting continuous practice improvement. Attendees' feedback to the named nurse on the impact of this network has been positive, with staff welcoming the increased focus on compliance with training standards.

5.1.15 Primary care in Darlington have benefited from effective support by a named GP, however, there is currently a gap in cover arrangements. The designated nurse is providing practice development support and for those GPs who need additional case-based advice the named GPs from neighbouring CCGs are providing assistance until the substantive post-holder returns to practice in the autumn.

5.1.16 We saw some good liaison between CAMHS, adult mental health, children's social care and midwives and were told that generally, communication between disciplines is good. Family intervention team workers and CAMHS practitioners routinely undertake joint work. However, the picture is not consistent. There is evidence of practitioners making efforts to engage with social workers and other practitioners but there is more to do to ensure there is strong multi-disciplinary information sharing and effective communication between professionals from different services. We saw little evidence of engagement between adult mental health and health visitors in cases where those services were potentially the key agencies involved with a vulnerable family or young child/infant at risk.

(Recommendation 1.2)

5.1.17 In response to significant capacity pressures in the school nursing team last summer, some health visitors have extended their role to take on some school nurse functions. Additional training has been provided through a skills gap analysis, including modules on smoking cessation and sexual health. Practitioners in this step over role are assessed for competency to ensure they are able to provide a safe and effective service. We heard that capacity pressures have now eased and a vacant post has been filled. Child sex exploitation is a priority for the LSCB this financial year. An active multi agency group on missing and exploited children group (MEG) meets regularly to identify and report on existing and potential exploitation of children and young people in Darlington. An impressive spidergram chart highlighting individuals and locations of concern is regularly updated and shared appropriately across the partnership. This is some of the most advanced data collection and intelligent use of information seen in these CQC CLAS reviews and is helping to keep young people safe in Darlington.

5.2 Governance

5.2.1 Health representation of the LSCB and the sub groups is good. The local performance group is chaired by the CCG designated nurse. A rigorous programme of multi-agency audit is identifying areas for development and is driving improvement in safeguarding children practice across the area. Recent work has included core group audits, the child protection invitation process and response to neglect.

5.2.2 Assurance on safeguarding children practice across health provision in Darlington is through the CCG quality and innovation committee and the quality review group. Providers attend regular meetings with the commissioning support unit and the CCG, providing regular updates on their performance in line with the agreed key performance indicators. There is a programme of regular commissioning visits with the most recent including paediatric services. This identified areas of good practice and heard positive feedback from parents, carers, children and young people.

5.2.3 The new electronic ED record does not facilitate robust assessment and recording of vulnerabilities in families or prompt the practitioners to carry out the triage for non-accidental injury as recommended by NICE. There appears to be a lack of guidance on the system to steer practitioners in what and how they should record. Overall, there is an over reliance on the individual practitioner having the skills, knowledge and experience to under-take a comprehensive and effective assessment while recording very little for managerial oversight. This creates a significant risk that young people may not have all safeguarding risks and vulnerabilities identified when they are discharged from the ED.

5.2.4 In the adult ED pathway, there is a significant risk that not all child safeguarding issues are being fully and routinely considered, risk assessed and fully documented and effective notifications made to ensure proper community follow-up. Trust strategic managers and the board cannot be assured that safeguarding arrangements in the ED are robust and that children are being effectively safeguarded. **(Recommendation 3.4)**

5.2.5 In recognition of needing to strengthen safeguarding practice and arrangements in the ED, a task force group has been set up by an ED staff nurse and the CDDFT acute services safeguarding. The group is identifying its work programme and priorities and it is too early to identify the impact.

5.2.6 As practitioners in TEWV are unable to upload or scan documents, reports and correspondence from other agencies onto the electronic record system, child protection plans, CIN and other key documents steering the practitioner's work with the child or adult are kept in a separate paper file. This includes referrals made to MASH. This creates risk that key documentation will go missing or will not be immediately available to practitioners. Also, the current arrangement does not facilitate effective operational manager's quality assurance oversight. **(Recommendation 1.5)**

5.2.7 Similar concerns about governance and record keeping are prevalent within the health visiting and school nursing services. Key documents such as child protection plans and records of meetings are not routinely uploaded or scanned onto the community health information system. This could result in key information not being easily accessible to other community practitioners and operational managers. **(Recommendation 1.5)**

5.2.8 Some case recording in health files across all services did not contain sufficient detail of practitioner actions, records of content of meetings and outcomes or decisions. There is little evidence of managerial audit or monitoring of recording practice and how it reflects actions taken by the case worker. **(Recommendation 1.4)**

5.2.9 It is difficult to obtain current performance information from the CLA information system. Performance is monitored through six monthly audits by the CLA nurse and there is no routine quality assurance process to drive continuous improvement within the service. The decision to change the form from the British association of adoption and fostering (BAAF) paperwork to a more locally developed record for review health assessments which has fewer prompts and domains to complete has led to some practitioners not recording a full holistic assessment. **(Recommendation 2.6)**

5.2.10 Since the serious case review for child A, progress has been made across primary care in Darlington in strengthening safeguarding systems, for instance, the GP safeguarding lead has worked with GP practices to establish a common coding and flagging system to bring to the practitioner's attention those children with a child protection plan in place or who are looked after.

5.3 Training and supervision

5.3.1 There is a high use of obsolete child protection terminology in a number of health services and on case records examined, with a number of examples of children being referred to as being “on the child protection register or delisted” This terminology is out of date and calls into question the learning from safeguarding training and familiarity with current child protection processes.

5.3.2 The CCG are monitoring training in all provider organisations and although there is increased uptake this remains an area of concern across all providers.

5.3.3 Safeguarding training within the CDDFT is not fully compliant with the intercollegiate guidance March 2014. The modular approach taken has inherent weakness in some of the options provided. **(Recommendation 2.1)**

5.3.4 Following the previous SLAC inspection, the local young people’s drug and alcohol misuse service, SWITCH, provided training for the ED staff which was well received. However, there is high staff turnover in the ED and it is not clear whether there has been consideration of the need to repeat this as part of any training needs analysis.

5.3.5 Safeguarding training within midwifery services is closely monitored through the practice development midwife and other colleagues. Good compliance has been achieved, with enhanced requirements in terms of what specific training the team will accept as meeting the service’s specific needs

5.3.6 There is a good preceptorship programme for new midwives with a competency framework on safeguarding children practice. This means that midwives are supported well in the development of their knowledge and skills in child protection.

5.3.7 CDDFT are commissioned to provide six protected learning events to GPs across Durham and Darlington; the latest event concentrated on learning from the most recent serious case review and was delivered, in part, by the local police. The CCG have good and improving arrangements to monitor and support GP and practice staff attendance at safeguarding training.

5.3.8 There are improvements in the supervision arrangements for practitioners working with vulnerable families and employed by the CDDFT. However, there remain gaps in key clinical areas such as the ED. De-briefing and reflective practice sessions arranged for ED clinicians following a child death were arranged and were valued by those who participated. However, supervision is an area for development as currently, practitioners are not sufficiently supported to discharge their safeguarding responsibilities through regular supervision as set out in *Working Together 2013*. **(Recommendation 3.8)**

5.3.9 The CDDFT named nurse is providing group supervision to the sexual health team and to community health practitioners between three and six monthly. Supervision is not always protected and there are occasions when sessions are cancelled. Following the previous SLAC inspection, the named nurse in Darlington community services has developed an Excel Spreadsheet and targeted those who had not accessed supervision regularly and most practitioners are now up to date.

5.3.10 The paperwork used in supervision does not support evaluation and planning of next steps and this information is not transferred into the client record. This means that the client record is not a complete record and is also not consistent with the CDDFT policy on record keeping. Some practitioners we spoke to did not know that they were expected to record this detail on the client record.

(Recommendation 3.8)

5.3.11 Following the previous SLAC, all midwives now access regular supervision on safeguarding children practice; a record of the supervision is kept on the hospital client record and a copy of the detailed supervision notes are held by the practitioner.

5.3.12 TEWV have responded positively and promptly in addressing CLAS recommendations from the Stockton CLAS review. All adult mental health practitioners with routine contact with children or families have undertaken level three training commensurate with their roles and responsibilities. Practitioners and managers in adult mental health told us that they have found this training very beneficial. It has raised their understanding of how to assess child safeguarding issues effectively while working with the adult.

5.3.13 The safeguarding named nurse for TEWV provides regular safeguarding training for the trust board members to support effective governance within the trust.

5.3.14 CAMHS and adult mental health practitioners receive mandatory three monthly individual supervision with a member of the safeguarding team if they have cases where there are child protection plans in place. Group supervision and reflective practice sessions also take place. Practitioners make good use of supervision and practitioners spoken to valued the support they got from supervision and prioritised this in planning their work.

5.3.15 CAMHS provide training for foster carers on the teenage brain and on attachment. CASH services also support foster care training. This helps to equip foster carers in understanding and supporting those vulnerable children and young people in their care and helping to improve placement stability.

5.3.16 The former CLA nurse carried out training with health visitors and school nurses as part of the LSCB training on the health needs of children looked after. Until recently, the CLA nurse also provided individual supervision to health visitors and school nurses who had responsibility for a child or young person, looked after, as part of their caseload. This individual support has been withdrawn whilst a permanent member of staff is recruited to the post and CQC has been assured that individual supervision sessions will be re-established once the vacancy has been filled.

Recommendations

1 Darlington CCG, County Durham & Darlington NHS Foundation Trust & Tees, Esk & Wear Valley NHS Foundation Trust should:

- 1.1 Explore the development and implementation of a consultant led peri-natal mental health pathway that also includes services for those women with mild to moderate mental health needs during pregnancy and postpartum.
- 1.2 Ensure that there is effective liaison and sharing of expertise between health professionals in early intervention, child in need and child protection cases including the undertaking of joint visits as appropriate
- 1.3 Assure themselves that health practitioners are trained in writing referrals to children's social care and that those referrals appropriately assess and articulate risk to enable social workers to make well informed decisions.
- 1.4 Assure themselves that health practitioners are trained and understand national and local guidance on record keeping and that local health records contain appropriate detail on concerns and action taken by practitioners when working with families.
- 1.5 Ensure that paperwork relating to safeguarding and child protection is available as part of the electronic patient record to enable practitioners to access the complete record when working with their client.

2 Darlington CCG and County Durham & Darlington NHS Foundation Trust should:

- 2.1 Review the content and evaluation of safeguarding children training within the trust to ensure it reflects the intercollegiate guidance 2014.
- 2.2 Develop with social care partners an agreed protocol on the completion of initial health assessments to protect those young people, who, by exception may receive a partial initial health assessment by a health professional other than a registered medical practitioner.
- 2.3 Work with partners to urgently review the process for initial health assessments for children looked after, to include how health providers can support colleagues in obtaining parental health histories.
- 2.4 Ensure that initial health assessments and health reviews include all relevant information from health agencies who may be involved in working with the child or young person, including the child's GP.

- 2.5 Ensure that health plans developed from initial health assessments and health reviews contain SMART objectives.
- 2.6 Implement robust and challenging quality assurance and performance management process with clearly defined performance indicators to ensure that the effectiveness of the health assessment and review process to improve the health of children looked after.
- 2.7 Ensure that young people leaving care are provided with a full leaving care health history.

3 County Durham and Darlington NHS Foundation Trust should:

- 3.1 Improve the observation of children and young people waiting to access emergency care at Darlington Memorial Hospital.
- 3.2 Ensure that all children are assessed for potential safeguarding and child protection concerns when attending for emergency care at Darlington Memorial Hospital.
- 3.3 Ensure that the paediatric ED record is a complete, contemporaneous record of care, including the assessment of safeguarding or child protection concerns and any action taken.
- 3.4 Ensure that the adult ED electronic proforma supports the early identification and recording of children of adults who attend the department. The pro forma should also facilitate any subsequent child safeguarding risk assessment that may be required.
- 3.5 Ensure that the trust's missing patient policy clearly references action to be taken if a child or young person leaves the emergency department before treatment is complete and that practitioners are aware of what action to take.
- 3.6 Ensure that women are routinely asked about the prevalence of domestic violence in their relationships at key times during their pregnancy and in the immediate postpartum period.
- 3.7 Ensure that women who are booked to deliver their babies at Darlington Memorial Hospital are supported by robust, individual birth plans that where, appropriate, contain details of any relapse indicators so that practitioners are able to identify and respond to changing need.
- 3.8 Improve the awareness and arrangements for all staff working with children who are protected through a child protection plan or with vulnerable families to receive supervision that reflects national guidance. This should include the recording of supervision on patient notes so the records reflect discussion and any planning that has been agreed.

4 Tees, Esk & Wear Valley NHS Foundation Trust should:

- 4.1 Ensure that a robust pathway for responding to requests for practitioners to attend child protection meetings is in place to ensure that mental health services are appropriately represented.

Next steps

An action plan addressing the recommendations above is required from Darlington CCG within **20 working days** of receipt of this report.

Please submit your action plan to CQC through childrens-services-inspection@cqc.org.uk. The plan will be considered by the inspection team and progress will be followed up through CQC's regional compliance team.