

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

Children Looked After and Safeguarding

The role of health services in Gateshead

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NHS England area:	North East
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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 Gateshead. 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 Gateshead, 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 50 children and young people.

Context of the review

NHS Newcastle North & East CCG, NHS Newcastle West CCG and NHS Gateshead CCG have agreed to work together as commissioners for the benefit of their local populations, known formally as the Newcastle Gateshead alliance. There is an aim to create one statutory body with Newcastle CCG by April 2015.

Children and young people make up 22.5% of Gateshead's population with 7.3% of school age children being from a minority ethnic group.

On the whole, the health and well-being of children in Gateshead is generally worse when compared to the England average. Both the infant mortality rate and the child mortality rate in Gateshead are comparable to the England average.

The rate of looked after children under age 18 per 10,000 children is 88.6 as at March 2014. The total number of children looked after is 358. Although there is a high proportion of looked after children within Gateshead, the numbers have fallen this year. Child and Maternal Health Observatory (Chi Mat) data reports that in 2013, the percentage of Gateshead's children in care with up to date immunisations was significantly better to the English average. The overall percentage of all Gateshead's children having MMR vaccinations and other immunisations such as diphtheria, tetanus and polio by aged two was significantly better when compared to the England average.

The indicator for the rate of A&E attendances for children under four years of age in 2011/12 was significantly worse than the England average. With regards to mental health, the rate of hospital admissions for mental health conditions was not significantly different to the England average. However, the rate of hospital admissions as a result of self-harm in 2012/13 was significantly worse when compared against the England average.

In 2013, the conception rate for under 18 year olds per 1000 females in Gateshead was not significantly different when compared to the England average. Conversely, the percentage of teenage mothers in 2013/2014 was observed to be significantly worse than the English average. Both breastfeeding indicators (breastfeeding initiation and breast feeding prevalence at 6-8 weeks after birth) were worse than average. Chi Mat also indicates that in Gateshead there are issues with childhood obesity in 10 to 11 year olds, hospital admissions due to alcohol specific conditions and substance misuse in 15-24 year olds.

A strengths and difficulties questionnaire (SDQ) was used to assess the emotional and behavioural health of looked after children within Gateshead. The average score per child in 2013 was 13.4. This score is considered to be normal. The average score over the last two years has generally remained consistent.

Commissioning and planning of most health services for children are carried out by Gateshead CCG and Local Authority (joint appointment of Children's Commissioner).

Commissioning arrangements for looked-after children's health are the responsibility of Gateshead CCG and the looked-after children's health team, designated nurse and operational looked-after children's nurse/s, are provided by South Tyneside NHS Foundation Trust. The designated doctor for LAC is employed by Gateshead Health NHS Foundation trust.

Acute hospital services are provided by Gateshead Health NHS Foundation Trust and Newcastle NHS Foundation trust. School nurse services are commissioned by Public Health and provided by South Tyneside NHS Foundation Trust.

Contraception and sexual health services (CASH) are commissioned by Public Health/Local Authority and provided by South Tyneside NHS Foundation Trust.

Child substance misuse services are commissioned by Public Health / Local Authority and provided by NECA (North East Council for Addictions)

Adult substance misuse services are commissioned by Local Authority and provided by South Tyneside NHS Foundation Trust.

Child and Adolescent Mental Health Services (CAMHS) are provided by Northumberland Tyne and Wear NHS Foundation trust, and are now locally called Children and Young Peoples service.

Specialist facilities are provided by Northumberland Tyne and Wear NHS Foundation trust and Children and Young Peoples Service.

Adult mental health services are provided by Northumberland Tyne and Wear NHS Foundation trust.

The last inspection of health services for Gateshead's children took place in January and February 2011 (published in March 2011). All the outcomes that were inspected were assessed as adequate. 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

Parents we spoke to in the maternity department told us:

"It's been fab, it has been like coming to baby boot camp, and I have learned so much about how to care for my baby".

"Everyone from the doctors to midwives to cleaners has been lovely and surpassed expectations".

One young mum who accesses the Family Nurse Partnership programme told us:

"My family nurse is like my best friend, I don't know what I would've done without her. I feel so lucky".

We heard from a family in the Emergency department at Queen Elizabeth Hospital:

"The ambulance crew were amazing; they talked to him and reassured him, usually he would be very scared but he co-operated with them and kept his mask on. We are just waiting to go home now, we were seen straight away when we got here, they gave him some medication and now he is better. Everyone has explained everything, can't fault it".

Young people who are looked after told us about the school nurses and LAC nurse:

"They're really good about respecting our confidentiality and sharing information."

"They tell me everything I need to know and are really good support."

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 Health visitors in Gateshead are supporting families well. They offer the enhanced healthy child programme, which includes an ante natal contact and also the four year pre-school development check. Health visitors carry out all the visits and this has resulted in those families who require additional support being identified at the earliest opportunity.

1.2 Expectant parents benefit from being able to attend a locally delivered parenting programme called Pregnancy, Birth and Beyond. The programme is popular and well evaluated by parents, particularly fathers. Expectant parents are told about the course at their 20 week scan and the timing has recently been amended so that working parents can attend. We heard how the local pattern of need and subsequent demand for speech and language support in infancy has influenced the course content. This now includes information on the developing baby's brain and how parents can support this through structured play and stimulation to develop communication and interaction skills.

1.3 Within maternity services, there is some specialist midwifery support for expectant mothers who have complex substance or alcohol misuse. There are no specialist midwives to provide support to women with mild to moderate peri-natal mental health needs or for teenage mothers.

1.4 Teenagers who become pregnant can be referred to the Family Nurse Partnership (FNP) if they meet the entry criteria. However, the FNP programme is oversubscribed and many expectant teenagers therefore continue to receive their care from the community midwife. There is no teenage pregnancy pathway and these young people are not routinely offered enhanced ante natal appointments or attendance at dedicated clinics. Midwifery healthcare assistants do offer individual support for young mums for example one to one tours around the midwifery unit, and service users told us they find this very useful. However, there remains a gap in the specialist support available for young parents in the antenatal stage.

(Recommendation 2.1)

1.5 Midwifery healthcare assistants provide good practical support to expectant and new mothers. Recently a new parent craft class, New Beginnings, has been introduced to Gateshead and this is proving most popular with women and young people. The healthcare assistants also visit local children's centres to run regular sessions on breastfeeding and infant feeding to ensure ongoing support once new parents have left hospital.

1.6 The Midwifery process which includes a pre booking appointment at the GP surgery and then a home booking in appointment is effective in engaging expectant mothers at an early stage. It allows practitioners to make an assessment of home conditions, potential risk or additional support needed by the 12 week stage. Assessments we saw were detailed, however there is more to do to expand questioning around domestic violence, opportunities to see women alone and to cross reference information with that held on GP primary care records. This would ensure support is fully informed by information held about vulnerabilities in other health areas. (**Recommendation 2.2**)

1.7 We saw some good examples of practitioner liaison between midwifery and other disciplines, with the use of the "AN1" and "AN2" cause for concern forms. In cases seen, these forms were bridging the gap that exists in formalised information sharing due to the absence of multi-agency Safeguarding Maternity Liaison meetings in Gateshead. However some staff reported that they do not always receive the forms, therefore there is more work to do to ensure health workers have an opportunity to share information consistently about their work with vulnerable families. (**Recommendation 2.3**)

1.8 New teenage mothers are supported well in the community. Health visitors attend the Young Women's Project to offer support on a weekly basis and, in the past, have run parenting programmes in the centre.

1.9 Health visitors have benefited from the recent training and increased awareness on exploitation and child trafficking and had recently identified families of concern who were living in a house of multiple occupation without the appropriate passports and documentation. Referrals to the appropriate services had been made and these families are now being supported.

1.10 Health visitors routinely create genograms to explore and record the family structure and household composition. This allows practitioners to understand and assess risk and is regarded as good practice as a common recommendation in serious case reviews.

1.11 Both the health visiting and school nursing teams consistently receive and record attendances of children at local emergency and urgent care departments in Gateshead, ensuring they have the most up to date information on health activity within a family. However, attendances at neighbouring hospitals, both for planned and urgent care is not communicated, meaning there is a significant information gap for families who choose to attend a different setting and also those attending for specialist care e.g. childhood cancers. This means all health practitioners are not fully informed of the health needs and potential risk to families and children. (**Recommendation 1.1**)

1.12 In all cases we reviewed, children and young people attending the Emergency Department (ED) at Queen Elizabeth Hospital were seen quickly. Registration paperwork collects demographic details and also records who is accompanying the child. We saw some excellent examples of safeguarding risk assessment, with effective identification of vulnerabilities for the child and family, and appropriate community follow up to ensure their ongoing needs would be met.

1.13 Young people aged between 16 and 18 years are usually seen in the adult ED, however the use of paediatric paperwork reminds staff that these young people remain vulnerable and that practitioners should remain vigilant to any safeguarding issues. For those young people aged between 16 and 18 that need a period of admission at the Queen Elizabeth hospital, an agreed protocol is in place. This includes an oversight of their care by Gateshead Health NHS Foundation trust's named nurse to ensure they are safeguarded.

1.14 There is an informal pathway for ED practitioners to follow if a child or young person leaves the department prior to receiving care. However, this is not sufficiently detailed and there is the potential for confusion about best practice in ensuring the safety and wellbeing of a child or young person who has not received treatment. (**Recommendation 2.4**)

1.15 Robust arrangements are in place to review all attendances by children and young people up to 18 years and copies of all attendances are notified to health visitors, school nurses and the GP. The named nurse effectively identifies and follows up with health visitors and school nurses those children and young people who need extra support or input following their attendance at the ED.

"D" was brought into the ED by the ambulance service following an overdose at home. The ambulance crew noted that there were young children in the house at the time and that although they were safe with another adult, they would likely be affected by what they had witnessed. The ED staff completed a "Cause for Concern" form and the health visitor was contacted, who subsequently undertook a home visit to the family to offer additional support options for the children.

1.16 We also saw some cases where effective paediatric liaison safeguarded the children of adults who attend ED with risk taking behaviours, though the current triage does not support the routine recording of children in households when adults attend. In one case, we saw an adult who attended ED following a collapse related to substance misuse, and the triage form did not explore if he had any children. This means that there is a missed opportunity to identify potentially vulnerable children at an early stage. (**Recommendation 2.5**)

1.17 We saw evidence of families where domestic violence has been discussed at the Multi-Agency Risk Assessment Conference (MARAC) being flagged on the Gateshead Health NHS Foundation Trust's IT system. This helps to alert staff and safeguard children and young people in those families as both the victims and perpetrators are identified across records, ensuring appropriate support can be put in place.

1.18 Arrangements to identify and refer to the local young people's alcohol and substance misuse team are effective. The ED has recently been successful in identifying funding for service development, and specialist workers will be present in the department between 8.30pm to 12.30am on Friday and Saturday evenings to provide direct support to those young people who attend following alcohol misuse.

1.19 Young people have good access to integrated CASH services across Gateshead in either dedicated young people clinics or in generic clinics from Monday to Friday, including after school clinics to facilitate attendance. Emergency contraception is available seven days a week from either the walk in centres or local pharmacists. Any young person under 16 years who is seen in CASH services and is seeking a termination of pregnancy is usually seen by the specialist nurse for teenage pregnancies who offers one to one support and advice. Evaluations from young people who use the clinics demonstrate a very high level of satisfaction with the service.

2 Children in need

2.1 The peri-natal mental health pathway supports women with high and complex peri natal mental health needs, however the support available to women with mild to moderate need is less well developed. The development of individual birth plans detailing relapse indicators is an area for development to help support expectant mothers during ante natal, labour and post natal care. (**Recommendation 2.6**)

2.2 Discussion and identification of vulnerable expectant mothers is limited to scheduled midwifery team clinical meetings which take place monthly. These discussions are not part of a standing agenda item and are not attended by other health or social care practitioners. This is a missed opportunity to provide a co-ordinated response to women with complex needs. (**Recommendation 2.7**)

2.3 Health visitors take an active part in the regular multi-agency GP practice safeguarding meetings. We saw evidence that vulnerable families were discussed and how this led to a consistent approach to supporting them. However, some GP practices do not currently schedule these multi-agency meetings despite this being a recommendation from a recent serious case review. There is more work to do to find solutions to support practices which are currently less able to achieve this regular liaison. (**Recommendation 4.1**) .

2.4 Health visitors routinely offer an ante natal contact to all expectant mothers. Where the midwifery “AN2” cause for concern form highlights additional need, such as mild to moderate history of mental health or depression, then health visitors can offer a 6-8 week solution focussed cognitive behavioural therapy intervention. Nursery nurses employed as part of the health visiting teams are also deployed to deliver targeted programmes of work with families, such as baby massage for mothers who misuse substances or where there are some mental health concerns. These have been robustly evaluated and have resulted in increased attachment and bonding between mother and baby.

2.5 School aged children and young people on child in need and child protection plans automatically receive a comprehensive health assessment by the school nurse within ten days of the child’s multi-disciplinary meeting. The assessment is based on the British Association for Adoption and Fostering (BAAF) format and acts as a diagnostic tool to assess needs and also to inform future level of service involvement with the family. In records we saw, both the assessment and plans on files were comprehensive and clearly identified family needs along with the aims of the school nursing team intervention.

2.6 Vulnerable young people, including young people who are looked after, who need additional support to access CASH services can be seen by the specialist nurse for teenage options. The nurse offers an outreach service and works intensively with young people to help them engage with services and reduce risk taking behaviours. The nurse has close links with the young women’s project and with local secondary schools and often runs groups on reducing risk taking behaviours and healthy relationships.

2.7 The Child and Adolescent Mental Health team, known locally as Child and Young person service (CYPS) have worked hard to reduce waiting times for initial assessment appointments. The Intensive Community Treatment Service (ICTS) out of hours crisis team is highly valued and offers significant levels of support for all service users. We saw cases where practitioners used a high level of persistence and assertive outreach in order to ensure responsive support was offered over a long period of time. In some cases this reduced the length of time required for inpatient stays.

2.8 A recently introduced care pathway ensures that children and young people who attend the ED following self-harm or other mental health needs are assessed and treated in line with NICE guidance. Practitioners we spoke to felt that the pathway worked well and in cases that we reviewed we found examples of good care.

2.9 A strong perception remains in many teams that access to the tier 3 CYPS service is subject to long waiting times; however in cases sampled, none had experienced significant waits for the initial assessment appointment. The implementation of a Commissioning for quality and innovation (CQUIN) target over the last 24 months has ensured most children and young people are being seen within twelve weeks for an initial “choice” appointment, with an overall target of six weeks. Despite this, there can still be a delay between assessment and treatment start that is of concern and recent changes to the CQUIN target should ensure that children and young people will not wait longer than 12 weeks from referral to treatment.

2.10 In cases we saw in CYPS, assessments and plans were comprehensive, highlighting known risk and protective factors, with appropriate analysis and clear identification of next steps to ensure children and young people are achieving progress.

2.11 The Adult Mental Health team (AMH) carry out home visits regularly to complete assessment of home environment. Detailed risk assessment tools are in place with an additional risk assessment for service users who are in any contact with children and young people. The AMH team employ a strong Think Family approach and are fully engaged with all aspects of the child protection and child in need process. Cases seen within the review showed clinicians to be proactive and assertive in seeking out liaison with other professionals working with the service user, and care plans included parenting targets and care of baby. This holistic approach to meeting the needs of service users and their families is to be commended.

“S” booked her pregnancy and during the initial appointment with the midwife disclosed that her partner, “A”, had been in prison but was unaware of the detail around the conviction. The community midwife discussed the disclosure in safeguarding supervision with the named nurse who contacted the police. The police advised that A had a significant history of domestic violence with his previous partner whilst she had been pregnant. The police and named safeguarding nurse agreed to invoke “Claire’s law” and made a joint visit to S to advise her of the detail around A’s past. S made the decision to end her relationship with A and has been attending a domestic violence programme. She has been well supported by children’s social care and the midwife in preparing for her baby and their new life together.

3 Child protection

3.1 Health visitors and school nurses prioritise and routinely attend strategy and child protection meetings, contributing significantly to decision making about the type of support most likely to result in positive outcomes for the child. All newly qualified staff reports for conference are quality assured by the South Tyneside NHS Foundation trust safeguarding team.

3.2 Health visitors and school nurses always share conference reports with families prior to the conference taking place. The Independent Reviewing Officers check with families that this has happened. In some records seen we were able to see evidence that not only had the report been discussed with parents, but that the report had been amended to reflect their comments. This means that families are engaged in the process and have had their voice listened to.

3.3 Health visitors and school nurses complete an information sharing form whenever they have contact with a family that is a significant event, such as attending a child protection conference or following a visit where concerns have been identified. These information sharing forms are then copied to professionals that are involved with the whole family as appropriate, for example, with the GP, the social worker or the midwife. This ensures information is exchanged with all relevant parties and support can be put in place quickly. In one case seen, where the school nurse was not actively involved with the older sibling of a younger child who was accessing Health Visitor support, this information sharing form highlighted new family information that would likely impact on the needs of the older child, to the school nurse. Subsequently, follow up support was put in place to ensure their needs were considered, allowing them to access some social support in school.

3.4 All young people under 16 who attend CASH services in Gateshead are assessed effectively for vulnerability using a well-established proforma. Where this initial assessment identifies concerns, an enhanced risk profile is completed which leads to a sensitive, but in-depth assessment on areas of a young person's life that may indicate exploitation. We saw how both the initial assessments and the more in-depth risk assessments were being completed appropriately and leading to referrals to children's social care for support and protection.

3.5 The specialist CASH teenage pregnancy options nurse is a member of the local Missing and Exploited Group looking at identifying and working with exploited children or those at risk of exploitation. She acts as an effective conduit of information between the group and the local CASH service to help ensure young people are identified as being at risk and kept safe. Awareness of exploitation has been a feature of Level 3 safeguarding training that practitioners working in CASH services have recently accessed.

3.6 Effective processes have recently been implemented to ensure the acute hospital information system in Queen Elizabeth Hospital ED now electronically flags children in Gateshead who have a child protection plan in place. This further supports staff's risk assessment in the acute healthcare setting. However not all community providers receive an updated list of children on child protection plans and some staff reported they felt this would be a useful addition. (**Recommendation 5.1**)

3.7 Improvements in practice and quality of referrals made to Children's Social Care from NTW teams are at an early stage since the Safeguarding team in Northumberland, Tyne and Wear (NTW) Foundation Trust have implemented a system to check Children's Social Care (CSC), Multi-agency public protection arrangements (MAPPA), and MARAC referrals generated by the CYPS and AMH teams. This aims to check how risk has been articulated and provide staff with specific advice and support in these complex cases. However files we sampled highlighted there is more work to do to ensure consistency within and across teams.

3.8 We saw strong evidence of the support given on referral cases by the NTW safeguarding team, along with escalation and professional disagreement procedures if required. Since implementation of a referral audit, 94% of recent MARAC referrals from CYPS and AMH are now discussed at the MARAC meeting. However there is more to do across all providers to ensure referrals to CSC are not simply a chronology of events and clearly articulate risk, impact and expected outcome to other agencies. (**Recommendation 5.2**)

3.9 Strong arrangements are in place to ensure both the adult substance misuse team and adult mental health teams are engaged in formal child protection proceedings. We saw a commitment to attend meetings from the substance misuse team in addition to providing a written report to ensure the specific information would be correctly recorded and shared appropriately. Within the adult mental health team, we saw evidence in one case of the worker adding their unique contribution by advocating for the service user and helping other professionals have a clear understanding of realistic expectations to have of the client. This included information on how to communicate most effectively during the meetings, and how the presentation of the mother's mental health condition may impact on how other professionals would interpret her engagement with the child protection process.

3.10 Within cases seen at inpatient adult mental health services, staff were confident in initiating the CAF process and were appropriately supporting and facilitating parents access to services, in readiness for discharge. There is more work to do with the community AMH teams to facilitate this kind of support however it is anticipated the recent recruitment of a "Think Family" worker in the safeguarding team will help to support staff in achieving this.

Child C is currently on a child protection plan. The health visitor received the “AN1 and AN2” cause for concern notification form from the midwife as during the pregnancy allegations were made by the older daughter about potential neglect in the family and a strategy meeting was held by CSC. The health visitor attended the strategy meeting and the family were discussed at an initial child protection conference whereby all the children were placed on a child protection plan, including the unborn child, under the category of neglect. Mum engaged well with professionals and the baby was born and discharged home. Progress in meeting the objectives of the plan was good, school attendance of the older children improved and routine checks and immunisations for the baby were up to date. The family were stepped down to child in need, with a plan to close the case. However, around this time, the health visitor was unable to gain admittance to the home to carry out the 9 month development check. Following four failed appointments, the health visitor remained concerned, sought advice from the trust safeguarding team and referred the family back to children’s social care. A core group meeting was held as previously arranged to close the case. However, following the health visitor’s renewed concern, a decision was taken to progress to Section 47 enquiries which are now ongoing and the children are receiving additional support.

4 Looked after children

4.1 In the majority of files seen, initial and review health assessments were carried out within statutory timescales. However, sometimes the circulation of completed initial health assessments was delayed because of administrative functions and this means that the assessments and health plans were not available for the LAC Review meeting.

4.2 We did see evidence of some health needs minuted as part of the LAC review process that had not been transferred onto the review health assessment; therefore there is a lack of assurance that all children and young people’s needs are being fully met. (**Recommendation 1.7**)

4.3 We saw some completed initial health assessments (IHA) that were not signed by the medical practitioner. This is poor practice and is outside NHS record keeping guidance. (**Recommendation 2.9**)

4.4 The quality of contributions from GPs and school nurses continues to increase as the importance of health needs of children who are looked after and their vulnerability is highlighted. The GP and health visitor or school nurse are contacted prior to IHA's and asked to contribute to the initial health assessment. However, in some cases seen, not all this vital information was routinely being used as part of the initial health assessment and thus not transferred into the subsequent health plan. This means that the initial health assessment and health plan may not be robust and fully meet the child's current or future needs. (**Recommendation 1.4**)

4.5 At present GP's are not asked to contribute to review health assessments (RHA). Reliance is on the foster carer to inform of any changes to health, meaning that valuable information may be lost if the GP is not asked for any up to date information prior to health assessments being undertaken or when a change of placement occurs. (**Recommendation 1.5**)

4.6 The voice of the child in review health assessments is underdeveloped. We saw variability in files sampled, with some files seen only reflecting the foster carer's views. This is a missed opportunity for practitioners to demonstrate engagement with the child and to express their individual needs.

4.7 All the young people we spoke to confirmed that they were routinely asked where they would like to attend for their review health assessment. Some preferred the assessment to take place in school and others were clear that they wished to be seen at home and this preference was consistently accommodated. The young people told us that they felt the school nurses and LAC health nurses were easily accessible and also confirmed that they were routinely asked if they wished to be seen alone for their review health assessment and they always received copies of their health plans. One young person said "the school nurse and LAC nurse is there if you need them anytime."

4.8 Children and young people who are looked after do not have enhanced access to direct specialist intervention services in CASH. The teenage pregnancy and options nurse located within the CASH team is highly regarded and undertakes positive work with vulnerable young people and those who are looked after in particular. This has bridged the gap in specialist LAC service and is a very positive service development.

4.9 The recently implemented LAC consultation pathway in CYPS enables carers to benefit from the opportunity for reflective discussion with consultant psychologists, in order to provide a new focus to the foster carers support and work with young people. This evidence based indirect practice model for children and young people who are looked after and need CYPS intervention is a welcome addition to the generic service and allows more rapid access to CYPS for carers who support young people with mental health needs.

4.10 The introduction of the CYPS carers training groups have been well received and are up skilling foster carers in developing their understanding of attachment issues and counselling strategies. This is helping carers to more appropriately support the young people in their care, and helping to prevent placement breakdown.

4.11 SDQs are not being well used to inform the assessment or monitoring of children's emotional health and wellbeing. The current practice of recording only that the SDQ has been completed, means this has become an administrative function completed by the local authority rather than having any meaningful impact on the wellbeing of the children. Opportunities to use SDQ's to allow young people to participate in tracking their own emotional growth are being lost. (**Recommendation 1.6**)

4.12 Within CYPS provision for looked after children, there is currently an inequity in services due to historical commissioning arrangements. The commissioning specification for the tier 3 CYPS service includes requirements to provide a tier 2 service for vulnerable groups. The reconfiguration of this service over the last 18 months should have ensured those children and young people who are looked after had an effective pathway to tier 2 support via the CYPS service. However cases seen within this review highlighted that children and young people who are looked after were not able to access this type of support readily within the CYPS service. This means that there is an inherent risk that children who are looked after who would benefit from tier 2 type intervention have not been able to access such a service or not have their needs met appropriately; as they currently fall outside the scope of the Gateshead open access tier 2 service known as the Emotional and Wellbeing team. (**Recommendation 7.1**)

4.13 Health care summaries provided to care leavers have been developed over the past two years. The brief summary document provided gives basic information but is not comprehensive or attractive to young people. No service user involvement has been undertaken to inform future service development or ascertain young people's thoughts on what they need at the point of leaving care. (**Recommendation 1.2**)

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 The named GP, designated nurse and designated doctor for LAC are working together to improve safeguarding training delivered to GPs. Adaptations from a full day to a half day session to facilitate engagement and attendance has led to significant increases in uptake over the last 2 years. Face to face training has also been developed for administration staff and GP registrars across Gateshead, which takes place every six months.

5.1.2 Aside from the training, there is more work to do to develop GP contribution and engagement in both proactive safeguarding processes and formal child protection arrangements. This includes the implementation of more robust arrangements for regular multi-disciplinary practice meetings across all practices to include midwifery, health visiting and school nursing.

5.1.3 Currently, GP contribution to child protection conferences via provision of a child protection report is low, at 27%. This is despite the implementation of an electronic reporting template having been devised for EMIS to help facilitate GP contribution. No specific qualitative audits have been undertaken to examine the reasons for this. (**Recommendation 4.2**)

5.1.4 The named GP is working with local authority representatives to investigate ways of increasing GP contribution and some changes have been made such as child protection meeting notifications being sent to a secure email address in practices rather than by post to expedite notice.

5.1.5 The named GP is not yet attending any LSCB groups however this is under consideration. This means there is limited ability to link in with local developments and practice improvements. (**Recommendation 6.1**)

5.1.6 We heard about long standing issues with communication, information verification and sharing of the “AN1” cause for concern forms between midwifery services and GP practices. GP’s highlighted concerns that there is an over reliance on midwives recording information given by expectant mothers without a follow up process in place to verify and cross reference this information. GP involvement is regarded by some GP’s as limited in pregnancy and in some cases they reported not knowing a woman was pregnant. Lack of information sharing between midwifery and GPs was a feature of a recent serious case review that is awaiting publication at the time of this review.

5.1.7 All practices have an identified safeguarding lead however aside from one event last year where a small number of leads attended of leads attended; there are no formal arrangements in place for the leads to access additional training or support in safeguarding. (**Recommendation 4.3**)

5.1.8 Gateshead has a higher than average number of babies being subject to unborn plans. This means that the support offered by midwives to these vulnerable families, including attendance at the resultant child protection meetings, is significant. The LSCB reported that midwifery attendance at conferences was becoming an issue. Gateshead Health NHS Foundation trust have responded quickly and positively, by increasing the number of midwifery posts to ensure midwives have capacity to fulfil their duties.

5.1.9 We are aware of the impending changes in structure to the CYPs teams following the recent commissioning changes, whereby children in Gateshead will now be seen as part of a Newcastle Gateshead model rather than aligned to Sunderland and South Tyneside as previously. We have been assured that robust transfer of caseload plans are in place over an extended period to ensure quality of care is not compromised during caseload handover.

5.1.10 Historic issues related to lengthy CYPS waiting times have been resolved following a Commissioning for Quality and Innovation (CQUIN) target, and the implementation of a clinical network model of working aims to support staff with more complex cases and develop staff confidence with specialist support. However, despite the waiting times for referral to initial assessment now being within six weeks, the assessment to treatment waiting lists have significantly increased. We are aware of the impending implementation of a revised CQUIN to target this and whilst we saw evidence of the organisational commitment to this, we saw some cases where the impact of the CQUIN has negatively affected the team's ability to fulfil other commitments. For example, in some cases seen, practitioners were no longer able to prioritise attendance at initial child protection conferences as it would result in the cancellation of clinical appointments, and therefore impact on the treatment waiting list target times. Both NTW NHS Foundation trust and partners are aware of this and alternative arrangements need to be considered in order to ensure CYPS can effectively contribute to the child protection process on a consistent basis. (**Recommendation 3.1**)

5.1.11 In cases seen within CYPS, communication and liaison was inconsistent and underdeveloped between some services, in particular between CYPS and community services as health visiting and school nursing. This negatively impacts on all health professionals involved providing cohesive support to ensure young people's needs are being met appropriately. (**Recommendation 3.2**)

5.1.12 Limited arrangements are in place for the named doctor role within Gateshead Health NHS FT. The current post holder is employed for one session which does not meet the requirements of Intercollegiate Guidance. The named doctor, though in post since 2012, has also not accessed the recognised training. (**Recommendation 2.8**)

5.1.13 Thorough risk assessment and management oversight is hampered by the adult mental health team not having a database of service users who have children/contact with children or those where children are on a child in need or child protection plan., Staff are currently reliant on service users volunteering this information, which does not actively support their risk assessment. (**Recommendation 3.3**)

5.1.14 Cases seen across disciplines highlighted some concerns in both the use of the agreed escalation policy and the timeliness in uptake and information sharing between agencies. Some health practitioners we visited are holding high levels of risk on cases, particularly where early help and support would be beneficial to prevent escalation of need. In some cases, there was good evidence of documentation of health concern and the individual team based training is valued as a way of talking through these cases in detail and supporting practitioners to escalate. However the use of escalation policies and thresholds for professional disagreement needs to be re-iterated and clarified for all staff with appropriate supervision and support in place in order to do this consistently. (**Recommendation 5.3**)

5.2 Governance

5.2.1 Information sharing in the GP practices we visited was generally effective. Regular meetings with their local health visitors along with detailed notes of discussions about vulnerable families ensured strong communication between teams. Although midwives and school nurses were invited to meetings, their attendance was more sporadic. In one practice we saw confirmation that a record was made in the patient notes that this multi-disciplinary discussion had taken place. This multi-disciplinary approach to identifying and supporting vulnerability in families helps to co-ordinate care and provide consistency in response.

5.2.2 The named GP and health visiting manager have worked hard with local GP practices to promote the learning from serious case reviews around electronic flagging of vulnerable families, uploading of information sharing forms and facilitating the quarterly multi- disciplinary safeguarding meeting.

5.2.3 Alerts were being used consistently in GP practices we visited to identify vulnerable families, including families of concern, children who had a child protection plan or those children that were looked after. In one practice we saw how families that were discussed at MARAC were identified; though this was less robust at a second practice. The identification of social vulnerability of a child helps the GP to consider these issues in the context of the GP consultation.

5.2.4 Health visitors and school nurses have a robust paper based set of notes. They use the ROPE methodology to evidence their work with families and all notes seen contained chronologies of significant events which is good practice.

5.2.5 Caseloads for health visitors are manageable and there is close monitoring of performance to make sure that key visits as part of the healthy child programme take place.

5.2.6 Learning from a serious case review has resulted in the implementation of new paperwork to prompt midwives to make additional enquiries about household composition and new partners at key points throughout the pregnancy. The launch of this new paperwork is imminent.

5.2.7 The implementation and systematic use of the “IR3” data reporting mechanism for all safeguarding concerns has allowed the named safeguarding team at Northumberland Tyne and Wear NHS Foundation trust to be more proactive in monitoring safeguarding activity. This ensures appropriate follow up and actions have been undertaken for children and young people. Whilst primarily ensuring positive outcomes are achieved for children and young people, it also makes safeguarding activity quantifiable, assisting with identification of recurring themes in particular areas of the borough. This leads to the safeguarding team resources and training being targeted most appropriately.

5.2.8 In general we saw persistence on the part of adult mental health workers in communicating with children’s social care and escalating as appropriate to ensure children and young people are kept safe. However in one case seen, despite a number of referrals raised over a short period of time by AMH workers, acceptance of the referral occurred after a police referral. More robust dialogue is required between agencies, along with work on the quality of information contained in referrals.

5.2.9 Health practitioners are able to invoke a multi-agency escalation policy where there are areas of professional disagreement. Practitioners we met with told us that this generally works well, however, some felt this could be improved by more regular contact between senior managers in health and social care to explore and discuss issues around threshold management, staffing levels and organisational changes.

5.3 Training and supervision

5.3.1 Increasing capacity in the Northumberland, Tyne and Wear Foundation trust safeguarding team has led to significant training development and increased numbers of safeguarding referrals, as the CYPS and AMH teams are more aware of how to record and report concerns. The trust acknowledge that staff awareness of formal processes and higher level safeguarding is now embedded and are now focusing on raising practitioner awareness of early help and intervention that is available locally.

5.3.2 The recent recruitment of a pilot “Think family” worker based within the NTW Foundation trust safeguarding team is a crucial part of this strategy. The role aims to signpost staff in adult teams to early help services and support that is available locally, with a remit to scope what’s out there for families and then support them to access these services. This enables practitioners involved with families with additional needs to be supported beyond the formal child protection arena and help provide earlier intervention to families in need.

5.3.3 Think family training in NTW Foundation trust encompasses case examples whereby early intervention went well. The safeguarding team have also provided child sexual exploitation training after tracking themes for safeguarding advice requests around this subject. Although the level 3 training is not compliant with inter collegiate guidelines, it has been verified and endorsed by the LSCB following practitioner feedback on the challenges in attending LSCB training due to frequency and location. This creative way of developing training has seen compliance levels rise from 30% to 90% over the last three years.

5.3.4 Capacity issues due to organisational restructure over the last 6-9 months have significantly impacted on the South Tyneside NHS Foundation Trust safeguarding teams’ ability to deliver the planned supervision programme for school nurses and health visitors. Cases sampled highlighted the impact on the reductions in service, including the cessation of records of telephone safeguarding consultations, non-attendance by the team at MARAC meetings and inconsistent distribution of information sharing forms to frontline staff.

5.3.5 The reduction in administration capacity has also significantly impeded the South Tyneside NHS Foundation Trust’s safeguarding team’s ability to assure all practitioners receive safeguarding documentation in a timely fashion to ensure plans are actioned; and this requires urgent review. We have been informed that the team is now back to full complement however as it now also has a remit for adult safeguarding, we are not assured capacity will be sufficient and this requires stringent monitoring. (**Recommendation 1.3**)

5.3.6 Newly qualified health visitors and school nurses in South Tyneside NHS Foundation Trust benefit from an excellent preceptorship as part of a safeguarding module which aims to nurture staff into safeguarding work. This includes monthly supervision, shadowing, and observational practice assessment as part of a detailed competency framework for safeguarding children practice. This means that these staff, once they have completed their preceptorship, are competent practitioners that are able to identify and respond appropriately to safeguarding and child protection concerns.

5.3.7 The quarterly child protection forum which is due to be reinstated in South Tyneside NHS Foundation Trust includes representation from CASH services, Family Nurse Partnership, Substance Misuse team, School Nursing, and Health Visiting. It acts as a vehicle for the safeguarding team to update community services on what is happening locally, including recommendations from serious case reviews, feedback and new developments. Whilst attendance is voluntary, practitioners we spoke to highlighted its value in developing their knowledge and confidence when working with safeguarding issues, in order for them to better support families in Gateshead.

5.3.8 All staff employed by South Tyneside NHS Foundation Trust now access level 2 safeguarding training as mandatory. Face to face training has been introduced following feedback from staff and poor uptake of e-learning. Level 3 arrangements for clinical staff and particularly for newly qualified staff are robust.

Recommendations

- 1. Gateshead CCG and South Tyneside NHS Foundation Trust should ensure;**
 - 1.1 That robust communication systems are put in place to ensure notification of all acute planned and urgent care attendances of Gateshead children are sent to community health teams
 - 1.2 That a detailed service user involvement strategy is developed for children and young people who are looked after
 - 1.3 That capacity issues within the safeguarding team, including administration support is addressed
 - 1.4 That information provided for initial and review health assessments from GPs and Community Health Services is comprehensively transferred to health plans
 - 1.5 That GPs are routinely asked to contribute information to review health assessment
 - 1.6 That SDQ scores are monitored for changes between review health assessments
 - 1.7 That a robust process is put in place to ensure information is transferred from LAC review meetings to review health assessments.

- 2. Gateshead CCG with Gateshead Health NHS foundation trust should ensure;**
 - 2.1 That a pathway for specialist midwifery care for teenage pregnancy is considered
 - 2.2 That a protocol for midwifery staff to cross reference information held on primary care records is introduced, including attendance at GP safeguarding practice meetings.
 - 2.3 That monitoring and audit of the “AN1” and AN2” forms is undertaken to assess consistency in use and ensure comprehensive information sharing between health disciplines
 - 2.4 That the protocol for children and young people who leave the Emergency department prior to treatment is revised

- 2.5 That paperwork within the adult emergency department is updated to include information on children within the family
 - 2.6 That individual birth plans within midwifery are updated to include “signs of relapse” indicators for pregnant women with mental health needs
 - 2.7 That arrangements for multi-agency maternity liaison meetings are put in place
 - 2.8 That the Named Doctor role is reviewed in terms of capacity and training requirement
 - 2.9 That all medical professionals involved in undertaking initial health assessments routinely sign the assessment forms in accordance with NHS guidelines
- 3. Gateshead CCG and Northumberland Tyne and Wear NHS Foundation Trust should ensure;**
- 3.1 That following the new CQUIN target, the contribution of the CYPS team to child protection conferences is monitored
 - 3.2 That pathways are put in place to strengthen communication and liaison between the CYPS team and other health professionals such as GPs, Health Visitors and School Nurses.
 - 3.3 That the Adult Mental Health team establish and maintain a database of service users who have contact with children.
- 4. NHS England Area team in partnership with the CCG should ensure;**
- 4.1 That General Practice arrangements for the multi-disciplinary safeguarding meetings are monitored to ensure consistency in all practices across Gateshead
 - 4.2 That a qualitative audit is developed following the implementation of the Child protection report template on EMIS to enable GPs to provide a consistent contribution to child protection conferences.
 - 4.3 That formal arrangements are developed for GP practice safeguarding leads to access specific supervision and training events.

5. **Gateshead CCG with Gateshead Council, Gateshead Health NHS Trust, South Tyneside NHS Foundation Trust and Northumberland Tyne and Wear NHS Foundation Trust should ensure;**
 - 5.1 That all providers receive an updated list of children who are subject to child protection plans
 - 5.2 That training and audit is undertaken to develop the quality of referrals made to Children's Social Care.
 - 5.3 That escalation policies and professional disagreement procedures are clarified for all staff, with supervision arrangements put in place to support this.

6. **Gateshead CCG should ensure that**
 - 6.1 The Named GP attends the relevant LSCB groups and subgroups.

7. **Gateshead CCG with Gateshead Council, South Tyneside NHS Foundation Trust and Northumberland Tyne and Wear NHS Foundation Trust should ensure;**
 - 7.1 That the provision and commissioning of tier 2 and tier 3 children and young people's mental health services are reviewed to account for the needs of looked after children.

Next steps

An action plan addressing the recommendations above is required from Gateshead 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.