Care Quality Commission

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

Children Looked After and Safeguarding
The role of health services in Middlesbrough

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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 Middlesbrough. 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 NHS England (Cumbria and North East)

Where the findings relate to children and families in local authority areas other than Middlesbrough 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 2015.
- 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 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 61 children and young people.

Context of the review

The levels of child poverty within Middlesbrough are very high with 34.3% of children aged under 16 years living in poverty. As would be expected the associated health indicators are also poor, with Middlesbrough ranking as the worst in England for four indicators and significantly worse than the England average for 24 indicators in total.

Children and young people under the age of 20 years make up 26.0% of the population of Middlesbrough. 21.0% of school children are from a minority ethnic group. The health and wellbeing of children in Middlesbrough is generally worse than the England average. Infant and child mortality rates are similar to the England average.

The rate of family homelessness is better than the England average. Children in Middlesbrough have worse than average levels of obesity: 11.9% of children aged 4-5 years and 22.9% of children aged 10-11 years are classified as obese. In 2012/13, children were admitted for mental health conditions at a similar rate to that in England as a whole. The rate of inpatient admissions during the same period because of self-harm was higher than the England average.

Of 32 indicators produced by ChiMat for Children's Health, Middlesbrough performs significantly better than the England average for only two: children in care immunisations and family homelessness. Another six are not significantly different to the England average, however the remaining 24 indicators are significantly worse than the England average with Middlesbrough representing the worst score in England for four of the indicators: 16-18 year olds not in education, employment or training; first time entrants to the youth justice system; teenage mothers; and hospital admissions caused by injury, children 0-14 years.

There are still several sections of the JSNA under development. It notes that more than half of Middlesbrough's 0-15 year-olds live in parts of the town that are amongst the most deprived 10% of areas in the country.

Self-reported levels of smoking, drinking, sexual activity and use of illegal drugs have all increased over the past five years. Rates of hospital admissions for alcohol and drug-related issues amongst young people are significantly higher than national averages.

Amongst 0-17 year-olds in Middlesbrough the rate of hospital admissions for mental health conditions is higher than the national average and the rate of hospital admissions due to self-harm is almost double the national average.

Based on national measures, the rate of hospital admissions as a result of injury for children in Middlesbrough is 60% higher than the national average.

The Department for Education publishes figures for looked after children by local authority area. In 2014 Middlesbrough had 250 looked after children, of which 245 (98.0%) were up to date with their immunisations and had had their teeth checked by a dentist. This compares very favourably to England averages of 87.1% and 84.4% respectively for these figures. The 96.0% of looked after children in Middlesbrough who had their annual health assessment is also better to the 88.4% England average for this.

A strengths and difficulties questionnaire (SDQ) was used to assess the emotional and behavioural health of looked after children within Middlesbrough. The average score per child in 2012-14 was 13.2. This DfE score is considered to be normal and is lower than the England average score of 13.9.

Of the 150,251 residents of Middlesbrough, 149,256 are registered with NHS South Tees Clinical Commissioning Group (CCG); however it should be noted that very small numbers of residents (less than 0.5% of the population) are registered with NHS Hartlepool and Stockton on Tees CCG, NHS Hambleton, Richmondshire and Whitby CCG or unknown commissioners.

South Tees Hospitals NHS Foundation Trust is the largest hospital trust in the Tees Valley area and provides specialist regional services across the region, as well as parts of Durham, North Yorkshire and Cumbria. Acute hospital and Children's services are provided by The James Cook University Hospital and The Friarage Hospital.

Health visitor services are commissioned by NHS England (NHSE) and school nurse services are commissioned by Middlesbrough Borough Council (Local authority) and both are provided by STHFT.

Tees, Esk and Wear Valleys NHS Foundation Trust provides a range of mental health, learning disability and eating disorders services to people living across the County Durham, Tees Valley, Scarborough, Whitby, Ryedale, Harrogate, Hambleton and Richmondshire. Child and Adolescent Mental Health Services (CAMHS) for the Middlesbrough area are provided by this trust.

Commissioning and planning of most health services for children are carried out by South Tees CCG (STCCG). Primary Care services are commissioned by NHS England.

Contraception and sexual health services (CASH) are commissioned by Local Authority (Public Health) and provided by Virgin Healthcare

Child substance misuse services are commissioned by Local Authority and Public Health and provided by Platform, Middlesbrough.

Adult substance misuse services are commissioned by Local Authority and Public Health and provided by Lifeline.

Specialist facilities are provided by Tees Esk and Wear Valley (TEWV) and commissioned by NHS England

The services provided by Tees, Wear and Esk Valleys NHS Foundation Trust were inspected by CQC in January and February 2015.

The last inspection of health services for Middlesbrough's children took place in 2011 (published July 2011) as a joint inspection, with Ofsted, of safeguarding and looked after children's services. All of the outcomes that were inspected were assessed as adequate for five outcomes and good for one outcome (capacity for improvement). There were six recommendations from that inspection that 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

In midwifery services we heard from one new mother who told us that she had been cared for in the new induction suite and said:

"It was so much better; it had natural light, a much improved environment. Staff have all been friendly and willing to do anything, including making me toast at 3am."

Another new mother told *us:*

"Although I didn't always see the same midwife, the information was always the same, it was consistent. The only thing I could mention as needing improvement was I missed an appointment at 16 weeks and didn't get a reminder. The staff have given me loads of advice on what to do when we go home."

We heard about the school nursing service; one parent spoken to told us:

"Every month we have a meeting at my boys' school. The school nurse and epilepsy nurse are always there, even if there is nothing new to add. It's nice for me to see them and I know they are doing their best for him".

A parent whose children use CAMHS services told us:

"CAMHS have been very good over the years. He's had quite a few different CAMHS workers because he's been with them for so long, but they have all been good. They all keep me informed about what's going on".

"Respite care is really important to me. I get every Wednesday night and then another four nights per month to spend time with my other children. The CAMHS disability team are very helpful".

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 Children and young people who attend the emergency department (ED) at James Cook University hospital follow a clear pathway. We saw how receptionists are gathering the name and relationship to the child of the accompanying adult, the name of the health visitor or school and establish if a social worker is working with the family.

1.2 Those children and young people who leave the department without being seen are followed up appropriately by ED practitioners and this ensures that they get access to treatment.

1.3 Young people who attend the ED following an incident of alcohol or substance misuse are identified and followed up by the local substance misuse team. This provides an opportunity for young people to access early help and support.

1.4 Children attending the ED at James Cook University hospital are not cared for in an appropriate child centred environment. Although there is a small dedicated waiting area for children under 10, this is a small corner of a very busy ED and is often at capacity. This means that children are then expected to wait in the main ED waiting area which is not suitable. We saw doctors and nurses discussing patient care with parents and other adults with no regard to privacy or dignity. The trust has recognised the limitations of the current environment and there is well advanced interim plans to move the paediatric waiting and treatment areas to a more acceptable space for children. *(**Recommendation 2.1**)*

1.5 In the ED, pro-forma questions are used to assess adult attenders with risk taking behaviours regarding children and young people to whom they might have access. This is important information to ensure ‘hidden children’ living in the homes of risk taking adults are identified and can be better protected.

1.6 Within maternity services most expectant women in Middlesbrough book their pregnancy early. This means that women are able to access appropriate and targeted health advice at the earliest opportunity. However, records do not evidence that expectant women benefit from a comprehensive assessment of vulnerability and social risk which may impact upon the health and well-being of their unborn baby for example, exposure to domestic violence, drug use, mental health difficulties, other caring responsibilities, poverty and employment. *(**Recommendation 2.3**)*

1.7 GPs are not asked to contribute to any assessment of risk to unborn children and this is a significant gap in information sharing and multi-agency contribution to assessments. ***(Recommendation 2.3)***

1.8 We were told that midwives discussed domestic violence with all expectant women, however we did not see evidence of this in cases sampled. This is important because research shows that there is an increased risk of first time incidence of domestic violence in pregnancy. We saw repeated evidence of the midwifery health visiting notification form not being retained either in the woman's hand held notes or on any hospital record. ***(Recommendation 2.4)***

1.9 Health visitors report an increasing number of completed notification forms being received from midwives about women booking their pregnancy. However, the information is often inadequate and we saw no examples of the midwifery analysis of risk or the planning tool being completed. This lack of early identification, planning and sharing of information is leading to delays in vulnerable expectant women receiving timely support and has the potential for some risks not to be identified at all. ***(Recommendation 2.3)***

1.10 Arrangements are in place to ensure that any expectant woman who does not attend for her antenatal care is quickly followed up. In all cases seen we noted good compliance with this policy and effective follow up of such women. This helps to protect the unborn child.

1.11 Expectant teenagers are all referred to the family nurse partnership (FNP) who screen all referrals. Where it is recognised that children and young people in particular schools require more intensive care and support, including where teenage pregnancies are high or they are known to be undertaking risky behaviours, work is undertaken with partner agencies. Where there is capacity, teenagers that meet the criteria for the FNP are enrolled on the programme and outcomes are good. Those teenagers that are not engaged with the FNP by choice, are able to access the package of support offered by the local authority where targeted work takes place to prepare them for parenthood and ongoing education or into employment.

1.12 New families in Middlesbrough are supported well by their health visitor. A good range of early intervention packages are available, including accredited programmes to promote early attachment and bonding, baby massage, maternal mental health and weaning.

1.13 Families with children under five and who are new into the Middlesbrough area are contacted and a home visit offered. This is useful in supporting the new family with making local contacts and also identifying any existing or unmet need at the earliest opportunity.

1.14 Children and young people have good access to the school nursing teams across Middlesbrough. There is a good local offer for school nursing. The teams run regular drop in sessions in most schools and have an active health promotion role. Children who are home educated have access to a school nurse health assessment and a well-established process is in place to share information with the child health team to ensure that parents and carers are contacted to remind them about their child's immunisation and vaccinations.

1.15 In the school nursing services we heard about numerous examples of early help strategies undertaken by the school nursing services including targeted support in specific areas where vulnerabilities have been identified. For example, school nurses are able to provide holistic 'drop in' services to young people in conjunction with CASH professionals and youth workers to provide a range of contraception services, chlamydia and pregnancy testing and smoking cessation advice. We saw evidence of professional challenge and curiosity and tenacious follow through with partner agencies by practitioners when school nurses considered that the service provision was insufficient to meet need.

A young person had been refusing to go to school and the mother was struggling to manage the behaviour of the young person. The school nurse had reviewed the records and noted that there had been previous multi-agency involvement including referrals to both CAMHS and social care but the case had been closed. The school nurse collated information and reassessed the situation and tenaciously followed through to ensure that the young person was provided with help and support.

1.16 We examined assessments of young people in mental health crises undertaken by CAMHS practitioners in the crisis intervention team in ED and we found them to be comprehensive, detailed and risk based. Young people were routinely seen alone as well as with their parent or guardian according to their personal wishes.

1.17 In CAMHS services, practitioners routinely work with children and young people early in order to support their emotional health and well-being. We were advised that this includes tier two interventions as alternative service provision at this level within Middlesbrough is limited. Lack of adequate early service provision can potentially result in children requiring unnecessary access to tier three and four services often with less favourable outcomes as a consequence of early damage. *(**Recommendation 4.1**)*

1.18 CAMHS practitioners advised us that there are no gaps in service provision for young people aged 16 to 18 and that if a referral is made for service intervention for people within that age group they will be assessed within the target timeframes. Records examined confirmed that young people are given timely access to services.

1.19 Young people in Middlesbrough have access to a Tees wide integrated contraception and sexual health service (CASH) and Genitourinary Medicine (GUM) service. There are no dedicated young people clinics. Young people are more likely to access services if they can access designed professionals appropriate to their needs and acceptable to them. Various factors are known to relate to young people's use of sexual health services including confidentiality, informal and friendly service, convenient location and times, availability of telephone advice and gender of staff. The potential for more targeted work in high schools across the district has been recognised and this will form part of future negotiation with the local authority and public health teams. *(We have brought this matter to the attention of the local public health England team.)*

1.20 Both young people's substance misuse workers and adult substance misuse workers reported good working relationships with other partner agencies within health including CAMHS and adult mental health services. This ensures that transitions for young people between services are on a continuum and they are ensured a continuity of service during transitions.

1.21 There are many examples of successful initiatives across Middlesbrough to target young people and risk taking behaviours. For example, Platform is the specialist commissioned drug and alcohol service within Middlesbrough. They provide specialist intervention to young people up to the age of 18 and their families who are struggling with substance misuse including alcohol. We heard evidence of good interagency working including supporting families through the CAF, Child in Need or Child Protection process.

1.22 School nurses told us that Platform also provides targeted work to groups of young people who are on the fringes of substance misuse or who are at risk of potential substance use. Platform's educational workers provide universal provision to schools and colleges, and also support the overall risk taking behaviours agenda. This ensures that there is a strong focus on early intervention and support to children and young people based upon local need.

1.23 In Middlesbrough, Platform provide a dedicated school and college substance misuse worker to deliver training to school staff such as teachers and bursars to help them provide appropriate support . They also discuss measures to reduce the risk of young people gaining access to drugs and alcohol, ensuring their policies and procedures in relation to substance misuse are up-to-date and what to do should they find drugs and alcohol in the possession of a young person.

1.24 The dedicated school worker also provides targeted work with young groups of young people, such as those who may have been excluded by their school. As a result of the input from the dedicated school worker, referrals by schools and colleges to Platform have risen by 120% this last year alone.

1.25 Platform has a ‘diversity plan’ in place to target children and young people living in sometimes hard to reach communities, such as travelling families, immigrant families and care leavers. It has not been possible to fully evaluate the benefits of the plan, but by promoting service provision (for example in youth clubs) it is hoped that children and young people will be made more aware of the services they can access.

1.26 Adult mental health services have a dedicated worker who acts as a single point of contact for all CAMHS work and links are being built with the Looked After Children (LAC) CAMHS nurse. There is a clear pathway for young people at age 17 years three months to gradually transfer to adult service provision. This is good practice.

1.27 In adult mental health services we heard about the new crisis assessment unit which ensures early help and a timely response for those presenting with an urgent assessment for mental health services or support. It is too early to comment on the impact of this service.

1.28 We saw the impact of Lifeline harm minimisation service in supporting adults and young people. We were informed of an initiative within adult substance misuse services called ‘safe haven’ whereby three lifeline practitioners work with the ‘Middlesbrough angels’, a team of community street support workers to support adults and young people who might be vulnerable because of risk taking behaviours such as consuming too much alcohol at night. Adult substance misuse services do not employ a specific practitioner to serve ‘hard to reach’ communities, such as immigrants to the area or travelling communities. We were advised however, that practitioners do routinely engage with community development workers. This includes attending an ‘eat and meet’ weekly event to promote service provision.

1.29 First Contact is the first point of contact for multi-agency professionals in Middlesbrough with an emphasis on making a positive, early response to offer help and advice and is working well.

2. Children in need

2.1 In midwifery, expectant women with identified vulnerability receive their ante natal care from the community midwife. There are, however, consultant led hospital antenatal clinics that women are signposted to where they are seen by a consultants with specialist interests. This helps to provide a more specialist, targeted approach to their ante natal care.

2.2 For those women with mental health concerns in pregnancy, a newly introduced perinatal mental health pathway has been rolled out across Middlesbrough which is helping practitioners to identify and refer expectant women to the most appropriate support.

2.3 Women with moderate to high mental health needs attend the joint consultant led clinic with a consultant obstetrician and a psychiatrist with an interest in perinatal mental health. We were told that those women attending this clinic benefitted from clear, detailed and person centred planning to cover the antenatal, birth and postnatal period. However, other vulnerable expectant mothers do not benefit from an individualised approach to birth planning and this is a gap. *(**Recommendation 2.3**)*

2.4 Health visitors demonstrated good liaison and information sharing with other professionals and tenacity in trying to engage and work with challenging and vulnerable families. Targeted work to support new mothers with mental health concerns was well evidenced and we saw health visitors using the perinatal mental health pathway to refer to more specialist services.

> *X had recently had a baby early and there were significant concerns about his physical development. X had moderate mental health needs for which she was prescribed anti-depressants by her GP. The health visitor became aware that X was not always taking her tablets and on one occasion had run out of her medication. The health visitor contacted the GP surgery and made an appointment for X to attend the surgery and obtain new supplies. The health visitor used the new perinatal mental health pathway to guide her in how best to support X with her emotional wellbeing and facilitated a referral to the local talking therapies. X was well supported by the health visitor who carried out listening visits and despite X disengaging from other professionals working with the family she did continue to engage with health visiting services.*

2.5 Children, young people and families who are supported through early intervention programmes, and where sufficient progress is not being made in achieving good outcomes, are discussed at locality forums. These multi-agency forums are made up of senior staff from agencies across the partnership and provide specialist targeted support, advice and consultation to practitioners. This helps practitioners to more effectively work together with the more challenging families to achieve positive outcomes.

2.6 We saw evidence in school nursing records of reviews of child in need (CIN) action plans and with clear tasks for school nursing services being adhered to. School nurses also provide targeted work to young people currently excluded from school, again with multi-agency partners, to support this vulnerable cohort. We saw good use of the significant events record (SER) being used by school nurses who use the ‘Rule of four’ to trigger a reflective discussion and consider any additional actions that need to be taken. This is good practice.

2.7 Children and young people who attend the ED are safeguarded well. ED staff are trained appropriately to level three and there is clear guidance to staff on how to respond to any safeguarding or child protection concerns. We saw staff consistently demonstrating professional curiosity and who accessed the weekly safeguarding meeting to discuss those children and young people about whom there were concerns that did not meet the threshold for referral to children's social care. We saw examples of good outcomes for children and young people who were discussed at those meetings.

J is a 15 year old boy who was in a local foster placement. J kept attending the ED as a consequence of risk taking behaviours, including taking drugs, excess alcohol and fighting. ED practitioners were concerned at his repeated attendance and vulnerability and discussed his care at the 'Tuesday meeting'. Contact was made with the LAC health team and his social worker, and as a consequence he was moved into a more appropriate foster placement.

2.8 Within ED, compliance with the current arrangements for carrying out the safeguarding triage for non-accidental injury are not sufficiently robust. The trust recognises this and the process will be strengthened with the introduction of the new Symphony IT system that is due for implementation. In the interim, the consultant lead for safeguarding within ED continues to monitor and report on any breach in protocol.

2.9 The CAMHS support for children and young people who attend the ED following an incident of self-harm or other mental health problem has improved. A new CAMHS crisis team has been created and this has promoted a more rapid assessment of these vulnerable children. The introduction of the multi-disciplinary integrated care pathway document provides a comprehensive care record that follows the patient from the ED onto the paediatric ward or discharge.

2.10 Children and young people that are admitted to the paediatric ward awaiting a CAMHS assessment are not benefitting from a formal risk assessment of their physical environment or emotional health. For example, paediatric wards have areas that present potentially unsafe access to glass, ligature points and barricading possibilities. Children and young people presenting with increasingly complex mental health needs, particularly eating disorders and recurrent self-harm or impulsive self-harm do not receive any specific intermediate assessment in order to mitigate risk to self or others. *(**Recommendation 2.2**)*

2.11 The 'think family' approach is at an early stage within adult substance misuse services but work in this area is progressing. There are plans to employ a Lifeline service practitioner to concentrate on family focussed work to consider the wider impact on families of adults undertaking risky behaviours. This will be a useful addition to safeguarding vulnerable young people who might otherwise be hidden within families.

The young person in this case was living with an eating disorder. She attended the ED following an incident of self-harm following an argument with her parent. Although a referral was not made by ED staff at the time of admission we did see that a CAMHS practitioner did make a referral the same day.

We examined the referral made and saw that although it contained situational detail and some family history, it did not clearly highlight risk to the child, either current risks or perceived risks or if professional interventions were not put in place.

Work is ongoing with the young person and her parent who had previously displayed little support for their child as a result of their not understanding the illness.

Family work by CAMHS has resulted in the young person and their parent working well with health professionals and the risk of further self-harm is now considered low.

3. Child protection

3.1 Children and young people are referred appropriately to children's social care when practitioners identify any safeguarding or child protection concerns. The quality of examples of referrals to children's social care seen across Middlesbrough health services were good with a proportionate amount of information that supported decision making by partners. All referrals are copied to the safeguarding team for review and notified to either the health visitor or school nurse. Reports sampled that are presented to child protection meetings were seen to be comprehensive and detailed, clearly articulating risk.

3.2 Within ED, records are flagged to highlight any local child that has a child protection plan in place or if the child is looked after. This alerts ED practitioners of the need to consider additional vulnerability as part of their assessment.

3.3 ED practitioners are vigilant in identifying the children of those adult patients who attend the department following risk taking behaviours or who have acute mental health concerns. The adult pathway for mental health presentations and deliberate self-harm contain a dedicated section on safeguarding to prompt the practitioner to explore with the patient the existence of children and any risk. However, this was not being completed in a few cases where the patient was a young adult: We were unable to identify if this was because there had been an assumption that the young adult did not have any children or whether the question had been asked and they had confirmed that they had no children.
*(**Recommendation 2.14**)*

3.4 Vulnerable exploited missing and trafficked (VEMT) multi-agency meetings have good representation from health services. Children and young people who are identified as at risk by VEMT are flagged on the CASH and substance misuse electronic systems. This means that those children and young people who are most vulnerable continue to be safeguarded through a well co-ordinated multi-agency approach to their care.

3.5 We observed good recording of risks to children and young people and planned actions arising from those recognised risks. School nurses told us they routinely receive information from the VEMT in relation to children and young people at risk of sexual exploitation in their schools. This is useful and important information to better inform school nurse interactions with vulnerable young people.

3.6 Young people accessing local CASH services are screened for potential CSE and other vulnerability each time they attend their appointment. This provides the opportunity for an in-depth discussion with the practitioner around their social circumstances and also their emotional health and wellbeing. We saw evidence of good escalation of any concerns that a practitioner may have around the potential safety of a young person with good use of the local safeguarding and child protection processes.

3.7 Young people in mental health crises who need in- patient specialist care are admitted to the Newberry young person's in-patient unit in Middlesbrough. The unit is modern, bright and very well presented having been designed in consultation with young service users. The 14 bedded unit provides care and support for young people in crisis, but also caters well for their families who are encouraged to partake in the care and support of resident young people. Families are encouraged to take part in a Calgary assessment process and receive weekly telephone contact from CAMHS practitioners or more regularly if they request it. Practitioners, psychologists and consultants meet with families regularly and they also routinely receive copies of all reviews undertaken of the young person's mental health. This is a good practice example of supporting the child in their family.

3.8 In adult mental health services, we saw evidence that safeguarding is embedded in practice utilising a whole family approach to case work.

3.9 Adult mental health staff conduct a home visit as standard for all cases as a means of assessing what is happening in the home environment and to validate information. Checks are made against parenting and caring responsibilities and the welfare of children considered as a standard working practice. When an adult service user is identified as having a child or children for whom they have caring responsibilities, a procedure and tool known as PAMIC (potentiality for the adult's mental ill health to impact on children) has been developed to assist practitioners in thinking about the impact, protective factors and risks to children.

3.10 Adult mental health services track and appropriately escalate concerns where children are involved. We saw good record keeping in mental health services with clear references to safeguarding of children as a first consideration. We observed the team holding a daily meeting which is an open meeting for any clinician to discuss any emerging concerns in respect of individuals and families that they are working with. Safeguarding of children is discussed as a standard agenda item in all cases. Care plans were dated, clear with contingency around what should be done in the event of non-compliance and who should be informed. Plans seen were signed and dated by both practitioner and parents.

3.11 All discharges from adult mental health services are planned in conjunction with other professionals as part of a multi-agency discussion and take into account the safeguarding of children.

3.12 Good partnership working with children's social care is helping to ensure that pre-birth conferences and discharge planning meetings take place in a timely and effective way. Midwives contribute appropriately to child protection meetings and most reports seen were comprehensive and clearly summarised the practitioners involvement with the family and any concerns they may have. In all cases seen, the reports prepared by midwives for child protection conferences had been shared with the expectant woman prior to the conference taking place. This is good practice.

3.13 Early referrals to children's social care are encouraged where drug and alcohol misuse are identified. The babies of those expectant women who are identified as needing protection are safeguarded well. The specialist safeguarding midwife retains good oversight of all cases referred to children's social care and a paper record is created which is kept on labour ward. The paper record contains copies of antenatal alerts, referrals to children's social care, any associated child protection conference reports and minutes and any plans to protect the baby at birth.

3.14 Health visitors and school nurses routinely attend child protection meetings and provide reports. School nurses we spoke with told us that they have good working relationships with other health professionals in Middlesbrough. Where it is recognised that children and young people in particular schools require more intensive care and support, including where teenage pregnancies are high or, young people are known to be undertaking risky behaviours, work is undertaken with partners such as substance misuse workers from Platform, CASH workers and CAMHS.

CAMHS practitioners spoken with were well aware of the multi-agency risk assessment conference (MARAC), the system for discussing and deciding actions in relation to domestic violence, and how to refer into it. In one case tracked we saw how the mother of a young person who was the subject of a child protection plan disclosed at a core group that she had been the victim of recent domestic violence.

In this instance we saw how the CAMHS practitioner recorded in detail the disclosure and then her discussions with the mother of the young person about risks to her and her child. Consent was sought from her to make a referral to the MARAC so that support and actions could be considered. However, on this occasion consent was not given and the referral was not made.

Even though the case was not referred to the MARAC, we did examine detailed notes made by the CAMHS practitioner and an updated risk assessment and care plan highlighting measures in place to protect the young person should incidents of domestic violence continue. This was all in agreement with the parent which is good practice.

3.15 Records examined show that young people's substance misuse workers provided by 'Platform' are trained well to recognise and report concerns regarding child sexual exploitation (CSE). A referral to VEMT was seen to be comprehensive and detailed in highlighting the practitioners concerns and risk to the young person concerned. However, the same level of articulating risks was not visible in all records.

3.16 Adult substance misuse practitioners advised us that they routinely receive minutes from child protection meetings We saw that on receipt of this important information, electronic records are updated accordingly so that practitioners can take into account decisions made at those meetings to better inform their working with risk taking adults with access to potentially vulnerable young people. However, in comparison, we saw no evidence of correspondence from social care to GPs in relation to child protection meetings or outcomes. This is a gap in information sharing to ensure best outcomes for children. *(**Recommendation 2.15**)*

Baby X was the subject of a child protection plan since his birth. He was being cared for by his paternal grandmother and he had been registered with her GP practice. Consent to share information between health professionals had not been obtained.

Although Baby X's patient record was appropriately flagged with an alert to show a child protection plan was in place, there was nothing on his record to indicate his mother's history or any information from the health visitor or children's social care. There was no copy of the child protection plan or conference minutes and the GP had not been contacted to provide any information to child protection conference.

Mother had a learning disability and there were other important factors about the mother's health that was important for the GP to be aware of and this was not available to him to inform any consultations.

4. Looked after children

4.1 Middlesbrough's looked-after children can now expect to have their health needs assessed and reviewed in a more timely way and to a much higher standard than that seen at the time of the previous inspection in 2011. However, records showed that some initial and review health assessments were not always completed within timeframes. We were advised that this is due to the large number of cases of young people in care and lack of resources to undertake those reviews. *(**Recommendation 2.11**)*

4.2 There is currently one specialist LAC nurse in post for Middlesbrough with a colleague working part time in Redcar. There are high numbers of children in care with a large proportion placed out of area. The staff member is working hard to maintain the service but without adequate support. The situation has placed additional non-clinical responsibilities on the LAC nurse who is unable to undertake quality assurance and development work.

4.3 Resource shortfall is compromising quality assurance and capacity to develop the service. The current provision of service is role dependent without contingency and this is a risk. We were told that there is a new LAC database that has been developed that will pull data through and record key information. The system was due to be piloted in June 2015 but has been deferred due to capacity. *(**Recommendation 2.11**)*

4.4 On files we saw good recording of family details, ethnicity, religion and dates of birth but family medical history not always detailed. This is a missed opportunity as the absence of this information can have a lifelong impact upon the child's journey through placement into adulthood. *(**Recommendation 2.9**)*

4.5 We saw signed consent by parents but most initial health assessments seen did not clearly show that the ‘voice of the child’ had been heard during the assessment. Not obtaining and recording the voice of children and young people in the initial health assessment process is a missed opportunity to engage them in the process and ‘set the scene’ for future interventions. Plans are not always SMART with clear timeframes and areas of responsibility. *(**Recommendation 2.10**)*

4.6 We saw good examples in development work and consultation with young people in care. Young people leaving care in Middlesbrough are offered a comprehensive health summary by way of a ‘passport’ as developed in consultation with young people in care. The passport is tailored to each individual young person according to need. For example, a young person who does not smoke is not provided with unnecessary smoking cessation literature. All young people leaving care are advised of their family health histories (where known), immunisation status, how to register with a GP and dentist and who to contact in LAC should they require any more information. Any information material pertinent to the individual young person is also provided in a format that best suits their personal needs.

4.7 In files we saw evidence of the use of strength difficulty questionnaires (SDQ). Children looked after benefit from a dedicated CAMHS service and we were advised that there are currently no looked after children waiting for a CAMHS assessment. In a joint venture with Redcar CAMHS, a practitioner is now placed within the leaving care team to assist in the transition process from young people’s services to adult. It is too early to evaluate the benefits or success of this service.

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 In records examined, where drug and alcohol problems were present with adults, we saw that reports contained adequate details regarding the presenting problems and cooperation with drug and alcohol workers. However, reports prepared by practitioners did not always adequately articulate risks that the adults might present to children and young people. Practitioner predicted risk is important information to inform child protection work.

5.1.2 A named nurse for safeguarding children heads a small team of safeguarding specialist nurses, including the safeguarding midwife and a safeguarding nurse, who supports and trains trust staff in safeguarding children and child protection. The named doctor is a consultant paediatrician as recommended in the intercollegiate guidance.

5.1.3 Although CAMHS are represented at the monthly VEMT meeting, decisions made are not routinely copied to the trust's safeguarding team. We were advised that practitioners are advised of events if they hold a case currently under discussion but it is then their responsibility to inform the safeguarding team. This is a missed opportunity for the safeguarding team to maintain good oversight of cases held by practitioners where there are clear concerns, such as CSE. Minutes from those meetings would better inform safeguarding supervisors of risks to vulnerable young people in Middlesbrough.

5.1.4 In GP practices visited we found that vulnerable families were not always flagged appropriately on IT systems used. This is because of a lack in clarity and shared understanding and agreement about which codes to use. For example, in two practices visited we found no evidence of coding around domestic violence being used to alert GPs to potential risks. *(**Recommendation 1.3**)*

5.1.5 Information sharing between health visitors and school nurses and GPs remains a key area for development. In practices we visited there were no formalised meetings between GPs and health visitors to discuss vulnerable families. Files seen demonstrated that GPs were not always asked to contribute to child protection meetings or to the initial and review health assessments of children looked after. *(**Recommendation 2.9**)*

5.1.6 A newly introduced programme of joint meetings between community midwifery managers, health visitor team leaders and the family nurse partnership is starting to explore issues around implementation of the joint midwifery health visitor ante natal pathway and referrals to the family nurse partnership. Partners recognise that the pathway is a new process and yet to be fully implemented.

5.1.7 The South Tees hospitals NHS FT children safeguarding team has successfully introduced a duty nurse rota system in which a member of the team is based for part of the day in the ED. Although not yet formally evaluated, anecdotal evidence is that this increased presence in much appreciated and is helping to further strengthen the good safeguarding awareness demonstrated by ED staff.

5.2 Governance

5.2.1 Governance arrangements for child safeguarding within the South Tees hospitals NHS FT provide the trust with good assurance on safeguarding practice. The safeguarding lead for safeguarding reports to the deputy director for nursing and she has good access to the director of nursing who is the trust board lead.

5.2.2 The role of the designated doctor is narrow and requires expansion of responsibilities to reflect the wider remit of child protection expertise in developing child protection systems and services. *(**Recommendation 1.1**)*

5.2.3 South Tees foundation trust participates in the Middlesbrough Local Safeguarding Children Board (LSCB) multi-agency audit programme; recent audits continue to demonstrate good communication across agencies with a strong focus on the child's voice. This was borne out in discussions with staff who demonstrated a sound commitment to working together.

5.2.4 At the time of the review there was no named GP in Middlesbrough and this is an NHS England responsibility. In conjunction with NHS England, the CCG has, despite strenuous effort, continued to be unable to recruit to the post of named GP. The CCG acknowledge the importance of the post and the CCG Chair has agreed to act as the named GP on an interim basis. This is a new development and the impact of this decision is not yet known. *(**Recommendation 1.2**)*

5.2.5 The CCG continue to support general practices across Middlesbrough in fulfilling their responsibilities to safeguard children. The senior safeguarding children's officer is carrying out a rolling programme of support visits to all general practices to work with the GPs and staff so that they are able to demonstrate compliance with national and local guidance.

5.2.6 GP practices visited had good arrangements for ensuring that all documentation in respect of safeguarding and child protection, when provided, were reviewed by the child's GP. We were shown how documentation was appropriately stored on both the electronic patient record and also the paper copy file. This means that the GP has access to information during their consultation.

5.2.7 There are flagging systems in place to identify children who are or have been subject of child protection plans. The safeguarding team have an agreed system with school nursing to ensure that SystmOne flags are updated within one day of the change of status. This ensures that records are up to date and the status of the child in the family clear. However this was not the case in all records seen in other areas. In one GP practice flags were showing some children as still being subject of child protection plans since 2008, this no longer being the case. It is important to ensure client files contain all up-to-date information pertaining to the planned care of young people so that informed decisions can be taken.

5.2.8 The South Tees NHS Foundation Trust (ST NHS FT) safeguarding team use SystmOne to record safeguarding and child protection activity. This is supporting timely information sharing with school nurses and health visitors. Although many GPs across Middlesbrough use SystmOne some practices do not consent to share the electronic record with the safeguarding team. This means that there can be a delay in accessing information.

5.2.9 CAMHS case files for children and young people currently the subject of child protection measures are subject to specific audit and supervision. Checks are also undertaken to ensure whether all documentation is up to date. However, we heard from practitioners that they are routinely having to 'chase up' the minutes from meetings and in one case we saw that a core group meeting had been held in late December 2014 and in May 2015 those minutes not yet received. ***(Recommendation 2.5)***

5.2.10 There has been a good response to 'call to action' health visitor recruitment campaign and the trust has successfully recruited to full establishment. Succession planning is ongoing within the school nursing team to ensure that new practitioners will be in post to minimise the impact of a number of staff who are identified as leaving the service; mainly to undertake health visitor training.

5.2.11 Managers in health visiting and school nursing have good oversight on delivery of the healthy child programme. Robust performance monitoring ensures that key visits take place and compliance is very good. Managers audit health visitor records as part of a practitioner's ongoing development. This helps to ensure accurate record keeping, in line with local and national Nursing and Midwifery Council (NMC) standards. We saw appropriate use of the significant events record to provide chronologies and most records included the voice of the child.

5.2.12 School nurses in Middlesbrough use SystmOne to record all contact with children and young people in their care. There is currently no system in place for them to create, use and update a SMART care plan on the system that can be reviewed and updated on a regular basis. However, in records examined we did see that school nurses were effectively documenting risk and associated plans within SystmOne records but not in a standardised format. We were made aware of ongoing plans to implement better care planning on the IT system as soon as final decisions as to an effective method are found. ***(Recommendation 2.7)***

5.2.13 CASH and GUM services are provided by Virgin Care and are fully integrated into the local health safeguarding structure. Policies and procedures reflect local arrangements and we observed good relationships with other providers and commissioners of health services.

5.2.14 The integrated CASH services currently assess all young people under 16 who attend their clinics for vulnerability. The service is introducing extended appointment times for all under 18s to support practitioners in carrying out this more extensive assessment. A new screening tool has been developed to reflect local and national best practice and we were told that it is about to be introduced imminently.

5.2.15 Young people who attend CASH outreach clinics have a paper record which is kept at the local base and not the main site. The detail of the consultation and screening assessment is not kept on the IT database and this means that the e-record is not complete. *(We have drawn this to the attention of the local public health England team.)*

5.2.16 We heard that the local area is at the early stages of discussion around the implementation of the national child protection information sharing (CPIS) project. This is an NHS England initiative that when fully implemented will provide a national alert system that identifies any child who is a looked after child, a child who is subject to a child protection plan or any pregnant woman whose unborn baby is subject to a pre-birth protection plan.

5.2.17 Record keeping within midwifery services are weak. Expectant women retain their hand-held notes and there is no reliable, systematic way for a midwife to record and retain important information and any potential confidential information. Chronologies are not used, even in the most complex safeguarding and child protection records. Temporary records created by some midwives and kept in GP practices are subsequently destroyed once the baby has been born.
*(**Recommendation 2.7**)*

5.2.18 In midwifery records examined, we often found no reference to child protection or safeguarding activity. There is an over-reliance on the paper safeguarding file that is kept by the trust's safeguarding team. The only indication that such a file may exist is a tick box on the hand held notes to alert a practitioner that more information is held. The Trust have been receptive to our discussions and concerns and have already started work to address the concerns raised. We are confident that the issues raised will be addressed in a timely manner.
*(**Recommendation 2.7**)*

5.2.19 A newly installed IT midwifery system has recently been installed, however, because community midwives do not have easy access to IT this record currently consists only of the demographic details and is not updated until the women delivers her baby. There is currently no IT solution being explored to support good record keeping within midwifery services. *(**Recommendation 2.7**)*

5.2.20 Following the recent CQC Compliance Inspection in December 2014 the trust is increasing the availability of ED consultant cover and the recruitment process is underway. Currently, the ED consultant is available between 8.00am and midnight and a consultant paediatrician is on call.

5.2.21 Children and young people attending the James Cook hospital ED are not always cared for by registered children's nurses. The trust does not have sufficient numbers of registered children's nurses to be able to roster a children's nurse for each shift, and so they are rostered to be on duty at the busiest times. At other times care is provided by adult nurses who are trained in paediatric life support. Additional funding has been identified to provide additional training opportunities to further increase the number of paediatric advanced nurse practitioners to help prepare for the forthcoming urgent care centre. *(**Recommendation 3.1**)*

5.2.22 CAMHS practitioners told us that invitations to attend important child protection and child in need meetings were general received in a timely manner from children's social care by way of a generic email address. The email highlights to senior practitioners what cases will need to be seen in safeguarding supervision and what practitioners need to report to and attend the meeting.

5.2.23 In adult mental health services, the teams are fully staffed with an experienced and appropriately trained workforce. The team have recently won an award for making a difference in terms of the patient journey, improvements, tracking, staff supervision and key performance indicators. We were told that there are no problems with recruitment and that any vacancies are quickly and easily filled.

5.2.24 Many staff told us that they are proud of their work and felt part of a wide workforce that is well led by their operational managers.

5.3 Training and supervision

5.3.1 The training needs analysis has been developed for staff across Middlesbrough to include audit and to cross reference with learning lessons and Serious Case Reviews (SCRs). This is good practice and demonstrates that staff are being trained and developed in accordance with local need and contemporary issues.

5.3.2 We heard and saw evidence of a robust management follow up to address the lack of compliance with staff attending safeguarding training. Staff that we spoke to had all completed level three safeguarding training which reflects the intercollegiate guidance of 2014 and demonstrates that the trust is working towards trajectory which is now contractually secured.

5.3.3 The paediatric ward staff have not recently accessed training in caring for children and young people with mental health needs or who have self-harmed. This is important as they regularly care for this group of vulnerable children whilst they are waiting for CAMHS assessment**.** *(**Recommendation 2.13**)*

5.3.4 Named professionals within the trust have good access to training and supervision. The specialist midwife has received enhanced training and has delegated operational responsibilities of the named midwife who is also the head of midwifery. However, the preceptorship for newly qualified midwives is not sufficiently robust to equip this group of staff to confidently and competently work with the most vulnerable and challenging families. *(**Recommendation 2.12**)*

5.3.5 Good progress is being made with GPs and their staff attending safeguarding children training. GPs are aware of the need to undertake level three safeguarding training and the CCG are actively monitoring attendance. In GP practices we visited we found that there is an over-reliance on identifying practitioners through the title of their job description rather than the duties that they undertake. For example, in one practice, the nurse was only trained in level two safeguarding, whereas she carried out all the infant immunisations and therefore had substantial contact with new families and level three training may have been more appropriate.

5.3.6 Substance misuse workers from both young people's services and adult services were mostly seen to be safeguarding trained according to intercollegiate guidance. Newly employed practitioners were 'well on their way' and working towards being trained to level three safeguarding using training as approved by the LSCB.

5.3.7 Practitioners working in CASH have all accessed level three safeguarding training.

5.3.8 It is important that staff working with children and families are effectively supervised to support them and to promote good standards of practice in safeguarding children: The South Tees health foundation trust reported that in April 2014 a new model of safeguarding children supervision was introduced to the organisation. Based on the Tony Morrison 4x4x4 model of reflective supervision. An evaluation of the new model was undertaken in January 2015 which found overall there was an overwhelmingly positive response to safeguarding supervision, this was confirmed by staff that were spoken to and who were subject to the model.

5.3.9 In adult mental health and CAMHS services we saw evidence of good supervision practices with all front line practitioners receiving supervision every four weeks. The sessions are planned and diarised a year in advance and the expectation is that sessions will be prioritised and attended. In adult mental health services a Red, Amber, Green (RAG) rating system is used to review cases and allocate workload to ensure that case work is manageable and within capacity. This is good practice and in line with the recommendations of 'Working Together to Safeguard Children 2015'.

5.3.10 In CAMHS an electronic record shows which cases open to CAMHS practitioners are the subject of child protection measures and it highlights when safeguarding supervision is required. Practitioners are then provided with a form on which they complete basic details such as a brief case summary, current risk factors and what professionals are currently working with the young person. A date is then fixed for safeguarding supervision to take place. We saw that decisions made at supervision go on to inform the young person's care plan and this is good practice. We further examined evidence of decisions being taken at supervision being discussed with young people and families so that they were given opportunities to agree or disagree with those decisions.

5.3.11 In some services practitioners receive monthly supervision where all cases of concern are discussed. Managers also routinely randomly pick other cases to see if safeguarding has been appropriately considered at all times. This is seen as good practice. However, any actions required following the supervision are not routinely recorded on client notes in all services as per best practice guidance. *(**Recommendation 2.8**)*

5.3.12 Health visitors and school nurses new into post are provided with more frequent supervision for the period of their preceptorship. This helps to ensure that workers are supported in their role in providing services to vulnerable families. We heard how supervision continues to be the core business of the safeguarding team within the ST NHS FT and we saw evidence of how this approach is continuing to drive forward the quality of work carried out by health visitors and school nursing.

5.3.13 The specialist midwife carries out supervision for all community and hospital midwives and this is recorded in the safeguarding team notes. There has been a gap in the specialist midwife receiving her safeguarding supervision due to recent changes in the safeguarding structure across Middlesbrough and this is being addressed.

Recommendations

1. NHS England and NHS South Tees CCG should:

1.1 Expand the role of the designated doctor to include the wider remit of developing child protection systems and emerging themes.

1.2 Evaluate and monitor the interim arrangements for the named GP and continue to prioritise the recruitment to the post.

1.3 Support primary care in standardising user codes to identify vulnerabilities in families.

2. NHS South Tees CCG, South Tees Hospital NHS Foundation Trust should:

2.1 Implement the plan to improve the facilities of the urgent care and emergency care provision to ensure they provide appropriate facilities for children and young people, including waiting areas and areas for private discussions.

2.2 Ensure that children and young people with mental health problems who are admitted to the paediatric wards awaiting a CAMHS assessment are subject to a formal risk assessment of their emotional needs and physical environment.

2.3 Ensure that a clear pathway is put in place to provide a comprehensive assessment of risk to assess vulnerability in all pregnant women and to safeguard unborn babies. Assessments should include information held by GPs and outcomes shared with lead professionals to ensure that birth planning for vulnerable women is strengthened to reflect their individual needs and wishes

2.4 Ensure that midwives discussions with women about domestic violence are recorded and retained in records.

2.5 Health practitioners need to be vigilant and chase copies of documentation to ensure their files are complete.

2.6 Ensure that the pilot for the proposed database for LAC is implemented to ensure that information in respect of LAC children is co-ordinated.

2.7 Improve care planning approaches and documentation to support outcome focussed plans on SystmOne and improve the governance arrangements.

2.8 Ensure that discussions and plans discussed in supervision are clearly documented in the patient records.

2.9 Ensure that GPs contribute to initial and review health assessments for children in their practice and that family medical history of looked after children is recorded and transferred onto the health assessment documentation as part of initial health assessments.

2.10 Ensure that all children in care have timely and high quality, holistic assessments and reviews of their physical, emotional and mental health needs informed by SMART health plans which reflect the child's voice.

2.11 Ensure that there is adequate resource within the role of the LAC specialist nurse service so that there is sufficient capacity to undertake commissioned services, including quality control, timeliness of health assessments and development work.

2.12 Ensure that the preceptorship for newly qualified midwives is strengthened to ensure competence in working with complex vulnerable families.

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2.13 Ensure that paediatric nursing staff have are provided with training in caring for young people with mental health difficulties and those who self-harm.

2.14 Ensure that children and young adults are asked about caring responsibilities as part of information gathering when accessing services.

2.15 Ensure that GPs are included in child protection meetings and provided with details of outcomes.

3. NHS South Tees CCG and South Tees Foundation Trust should:

3.1 Consider increasing the number of paediatric trained nurses within ED.

4. NHS South Tees CCG and TEWV NHS FT should:

4.1 Ensure that early help services for children who require access to tier one and two services for emotional health and well-being are strengthened.

Next steps

An action plan addressing the recommendations above is required from NHS South Tees 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.