

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

Children Looked After and Safeguarding

The role of health services in Hartlepool

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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 Hartlepool. 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 the North East). NHS England is the commissioner of primary care (co-commissioners of GP services with the CCG) in Hartlepool. This also includes Hartlepool Public Health commissioned services for adult and children substances misuse, contraception and sexual health, school nursing and health visiting service.

Where the findings relate to children and families in local authority areas other than Hartlepool, 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, 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 131 children and young people.

Context of the review

The majority of residents in Hartlepool, 99.6% (95,111) are registered with a GP practice that is a member of NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group (CCG).

Published information from the Child and Maternal Health Observatory (ChiMat) shows that children and young people under the age of 20 years make up 24.4% of the population of Hartlepool with 5.2% of school age children being from a minority ethnic group. The proportion of children under 16 living in poverty is 29.8% (5,300), which is worse than England's average of 19.2%. However, the rate of family homelessness is significantly better than England's average.

The ChiMat data shows that on the whole the health and wellbeing of children in Hartlepool is mixed compared with England's average. For example, in Hartlepool the percentage of children in reception and year 6 classified as being obese or overweight is significantly worse than England's average. Whereas the proportion of children (aged 5 years) in Hartlepool with poor dental health is better than England's average.

The data also shows that Hartlepool is significantly worse than England's average for 12 out of the 32 indicators identified in the Child Health Profile (2015). These include the rate of conceptions in under 18's, hospital admissions caused by injuries to both children and young people, including for substance misuse and the percentage of children killed or seriously injured in road traffic accidents. The rate of hospital admissions for children and young people as a result of self-harm is not significantly different to England's average; however, the rate of hospital admission for mental health conditions is significantly better than England's average.

In 2013, the percentage of 16-18 year olds not in education, employment or training and the number of 10-17 years entering the youth justice system for the first time was significantly worse than England's average.

Breastfeeding initiation in Hartlepool has remained significantly lower than England's average, with only 47.8% mothers initiating breastfeeding in 2013/14, compared with 73.9% nationally. Infant and child mortality rates are similar to England's average.

The Department for Education (DfE) provide annual statistics derived from outcomes for children continuously looked after. As at 31st March 2014, Hartlepool had 140 children who had been continuously looked after for more than 12 months (excluding those children in respite care), 25 of whom were aged five or younger. This is a 21% decrease from the previous year.

The DfE data indicated that 92.9% of looked after children had received an annual health assessment and a dental check-up, which is better than the average for England at 87.1% and 84.4% respectively. Data available from 2014 highlights that 96.6% of looked after children in Hartlepool had their annual health assessments completed. This is greater than England's average of 88.4%.

Commissioning and planning of most health services for children are carried out by NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group (HaST).

Commissioning arrangements for looked-after children's health are the responsibility of HaST CCG which also has the Designated Professional roles. The looked-after children's health team and operational looked-after children's nurse/s, are provided by North Tees and Hartlepool NHS Foundation Trust.

Acute hospital services are provided by North Tees and Hartlepool NHS Foundation Trust, commissioned by HaST CCG.

Health visitor services are commissioned by Hartlepool Public Health and provided by North Tees and Hartlepool NHS Foundation Trust.

School nurse services are commissioned by Hartlepool Public Health and provided by North Tees and Hartlepool NHS Foundation Trust.

Contraception and sexual health services (CASH) are commissioned by Hartlepool Public Health and provided by Virgin Care.

Child substance misuse services are commissioned by Hartlepool Public Health and provided by Hartlepool Recovery Action Team – Lifeline Project.

Adult substance misuse services are commissioned by Hartlepool Public Health and provided by Addaction Hartlepool.

Child and Adolescent Mental Health Services (CAMHS) are provided by Tees, Esk and Wear Valley NHS Foundation Trust, commissioned by HaST CCG.

Specialist facilities are provided by Barnardo's Hartlepool and Sexual Abuse Referral Centre.

Adult mental health services are provided by Tees, Esk and Wear Valley NHS Foundation Trust, commissioned by HaST CCG.

The last inspection of safeguarding and looked after children's services for Hartlepool took place in June 2010. This was a joint inspection, with Ofsted. At that time, the effectiveness of both the arrangements for safeguarding children and the services for looked after children were judged to be 'good'. Recommendations from that inspection are covered in this review.

The report

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

What people told us

We heard from a new parent with her first baby whilst on the maternity ward.

She told us: *"The midwives have been lovely, I was given loads of information and leaflets, my appointments were always handy and close to where I live."*

A new birth father went on to tell us: *"The staff have been really helpful, 'knockout' they treat you as individuals and that's nice."*

Another parent with her fourth baby told us: *"The service has been fantastic, apart from we weren't told that we had to bring our own formula milk in with us."*

We heard from a number of foster carers about their experience of the looked-after children's service.

One carer said: *"The LAC nurse, we know where she is but we don't see her now because she has a little team."*

Another foster carer told us: *"Medicals (health assessments for LAC) always take place at the hospital to start with then at home - there never has been any choice offered. With older children they are often a bit sheepish about medicals but if they don't want me in the room I will go to another."*

And another said: *"I've always had regular contact with the LAC nurse – she comes and measures and weighs the children in my care. She talks directly to the children (dependent on their age) and is always age appropriate. She talks to them in a lovely manner and is lovely with the children."*

She continued to us: *"I had a young girl with a baby in my care and the LAC nurse was great with her. She encouraged her to get the implant and gave her all the support and information that she needed to make a decision."*

Foster carers also told us about their experience of the health visiting service.

One said: *"The health visitor that I have at present is very good in involving parents for the baby I am caring for – they are important and came along to the medical, that's good because they could tell us about the family history, but not all parents do that."*

Another told us: *"The health visitor for my youngest child has been very supportive. She helped me get a diagnosis and I would say she was absolutely marvellous. I've always been able to get an appointment with the health visitor. We have a sure start centre and I can ring my health visitor there if I need her – if she is not there she will call me back straight away when she is next in the office."*

We spoke with a looked-after young person and she told us about her experience with the health visiting service.

She told us: *“The support that I was given with my son has been good. I gained more confidence to speak to the health visitor and be open with her. The health visitor was private in her own role and she could be trusted”*.

A foster carer also told us about their involvement with health plans for looked-after children in her care.

She said: *“I have always received a copy of the care plan and feel involved throughout the entire process”*.

She also told us: *“The health assessments for the children in my care have always been split – sometimes they are at home but it depends if the birth parents are allowed to know my address. Most of the times they are at the children’s centre, especially for the younger ones. We’ve also had health assessment in school for the older children”*.

We heard about experience of the CAMHS service.

A foster carer told us: *“It has been very hard to get an appointment with CAMHS”*.

Another foster carer told us: *“CAMHS are absolutely fine. I’ve always felt supported by them – they have even given me training on ADHD, which I think was great. They have lots of training events that I can access if I want too”*.

We heard about experiences with primary care services.

A young person told us: *“I never have a problem getting seen”*.

A foster carer said: *“The GP practices that my children are registered at are great. I can drop-in and take the children whenever I need to – they even have emergency appointments for after 6pm”*.

We also heard from a young care leaver who said: *“The LAC nurse is really friendly. Whenever I needed anything she would always come and help me. I never felt pressured into doing anything that I didn’t want too – if I had any problems or concerns about my help I would be supported by her in any way that she could”*.

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 Most expectant mothers have good access to maternity services at the University Hospital of Hartlepool. The maternity patient held records include detailed documentation, which helps keep expectant mothers fully informed and enables them to make choices about their individual care plan.

1.2 During the initial booking process an antenatal social assessment is undertaken. The documentation includes prompt questions for midwives to ask if social workers or other agencies are involved. This ensures identification of key agencies at the earliest opportunity and helps strengthen information sharing between partner agencies.

1.3 Most expectant women in Hartlepool who book their pregnancy early are offered an 'early bird' appointment. This allows for early discussion about what to expect at the booking appointment, as well as providing information about health promotion during pregnancy. This enables mothers-to-be to make informed choices early in their pregnancy, thus promoting the opportunity for the best possible outcomes for them and their unborn baby.

1.4 Midwives do not routinely attend vulnerability meetings with GPs. We were advised that midwives are reliant upon health visitors to relay important information to them. However, we were also informed by health visitors that they have no formal arrangements in place to meet on a regular basis with their allocated GP. This is a gap as professionals do not have the opportunity to ensure that vulnerable families or those with more complex needs receive a co-ordinated approach to their care. ***(Recommendation 1.1) This issue has been drawn to the attention of Public Health, as the commissioners of health visiting and school nursing services.***

1.5 The Family Nurse Partnership (FNP) programme in Hartlepool is well established. The service has been commissioned to provide 75 places and we were informed that the team's caseload is nearly at full capacity. The FNP service is an evidence-based, preventative service that is intended to help reduce inequalities and transform lives of vulnerable young people. In one case reviewed, positive outcomes for the young person and their infant were clearly evident. This was as a result of providing early help and offering good parental support. We further saw evidence of the Vulnerable, Exploited, Missing, Trafficked (VEMT) referral form being completed and appropriate action being taken by the FNP practitioner to provide early help for the parent at risk by engaging with other professionals and safeguarding the vulnerable infant.

1.6 Families and children under the age of five benefit from good delivery of the 'Healthy Child Programme' (HCP) provided by the health visiting service. All families are offered an antenatal visit, which enables professionals to identify and assess needs, as well as intervene and provide early help to families that require it. In addition, families receive a new birth and a six week visit, a development review between three and four months, a further review at nine to twelve months, and again at two to two-and-a-half years. We heard of plans to pilot the new integrated two to two-and-a-half year development reviews working in partnership with the children's centre team. It is envisaged that the pilot will commence in April 2016. This is a positive development, as it is a key time when specific issues may begin to become a problem for families.

1.7 All families and children under the age of five that move into Hartlepool receive a transfer-in visit by a health visitor. A notification is received on the electronic patient record used in the service (SystemOne) and allocated to the health visitors aligned to the registered GP practice. If the family has not yet registered with a GP, the record is still allocated to a health visitor in order to ensure the family receive a transfer-in visit. This practice supports health visitors in the early assessment of emerging need and creates an opportunity to encourage families to engage with services.

1.8 A good range of additional support is available to families through the health visiting service in Hartlepool. In records reviewed, we saw evidence of good multi-disciplinary working with family support workers and the adult mental health team, in order to improve outcomes for children.

1.9 Health visitors use the Common Assessment Framework (CAF) in order to ensure that early help is available to vulnerable families. In one CAF seen, the health visitor had clearly identified specific goals based on the child and family's needs and made onward referrals to targeted services, which helped to improve outcomes for the child.

1.10 Community nursery nurses who are part of the health visiting team are given delegated responsibilities to offer packages of support for families and children requiring additional interventions, such as behaviour management, sleep training and other identified needs. In addition, nursery nurses offer baby massage and run weaning groups for parents. This helps to engage vulnerable families and facilitates early help and support.

1.11 Health visitors record all emergency department (ED) attendances through the SystmOne records and manage these within the significant events process. We were informed that health visitors are supported by a standard operating procedure and use their professional judgements and assessment skills to decide on what action needs to be taken on receipt of ED discharge summaries. However, there are currently no formal care pathways that would guide them to provide a consistent and co-ordinated response. This means that children and young people may not receive the most effective early help and support or be referred on to the most appropriate agency to meet their needs. ***This issue has been drawn to the attention of Public Health, as the commissioners of the health visiting service.***

1.12 Health visitors advised us that maternal mental health and domestic abuse is assessed at each key contact. However, in records seen these questions are not routinely being asked and recorded on patient records. This means that changes in maternal mental health between contacts and the potential impact of domestic abuse upon caring responsibilities could not be properly assessed. As a result, support needs could not easily be identified. ***This issue has been drawn to the attention of Public Health, as the commissioners of the health visiting service.***

1.13 Information from the MARAC (multi agency risk assessment conference) is currently sent to school nurses through the SystmOne records, by the safeguarding children's team. In Hartlepool, 'Operation Encompass', which is an initiative between the police and schools designed to provide early reporting on any domestic abuse incident that may have an impact on a child in school, was launched in March 2015. However, despite the introduction of the Encompass pathway for domestic abuse notifications, school nurses report that they have not yet seen a rise in notifications coming through to them from education settings. This means that victims of domestic abuse may not be easily identified and therefore reduces the opportunity to provide early support. ***This issue has been drawn to the attention of Public Health, as the commissioners of the school nursing service.***

1.14 School nursing cases reviewed highlight good use of standardised documentation to assist with record keeping across the service. However, the current service delivery model is task focussed and dependant on other professionals to re-refer children to the service if further needs are identified, rather than school nurses maintaining continued oversight on cases. In one case reviewed there was evidence of lack of follow-up by the school nurse and so emerging or escalating needs could not easily be identified by the service.

1.15 In school nursing, chronologies are not routinely being used; therefore, the opportunity to identify drift in cases is limited. However, peer supervision is triggered by the receipt of four significant event forms, including ED discharge summaries. This local arrangement means that school nurses have a good overview of the most recent health activity in a family.

1.16 The current early help offer provided by the school nursing service is limited by capacity pressures. As a result, the drop-in session at all secondary schools is now commissioned as monthly whereas previously it had been weekly. In some secondary schools, young people have access to contraception and sexual health (CASH) services, for example c-card and sexually transmitted infection (STI) screening. However, at present not all school nurses have received training in this. The current capacity issues affecting the school nursing teams are having an impact on their ability to provide a highly visible presence and ongoing early intervention work in schools. ***This issue has been drawn to the attention of Public Health, as the commissioners of the school nursing service.***

1.17 Young people have good access to integrated CASH and genitourinary medicine (GUM) services in Hartlepool. CASH services are available in both generic and school-based clinics from Monday to Friday until 8pm. Additional support such as emergency contraception, c-card and chlamydia treatment is available seven days-a-week from pharmacists and also in local GP practices contracted by the CASH service. We heard of plans to link CASH services into school nursing and FNP teams, which will further strengthen the CASH service offer in Hartlepool. This is important as young people are more likely to access support from services if they are provided with choice and are delivered by professionals with whom they have regular contact.

1.18 Practitioners in the CASH service adopt a holistic approach to meet service users wider health needs. For example, in one case reviewed a young person highlighted to a CASH practitioner that she had previously been under the care of the child and adolescent mental health service (CAMHS) but that her support had stopped when she moved into the local area. The CASH practitioner acted on this information rapidly by making enquiries and referring the young person back into local CAMHS, with a follow-up to check that an appointment had been allocated. This case demonstrated good, early identification of support and improved outcomes for this young person.

1.19 During our visit to CAMHS, provided by Tees, Esk and Wear Valley NHS Foundation Trust (TEWV), we saw that comprehensive initial assessments are carried out for each new patient referred into the service. This takes account of the young person's personal circumstances, their lifestyle, their physical and medical needs, their physical ability or disability, their cultural and religious needs and the relationships with other people in their family or social group. In addition, each child or young person coming into the service has a further assessment, which enables practitioners to identify any risks and from this develop a risk management plan that forms part of the overall care plan. We saw that care plans are meaningful and relevant and are set with time-bound actions. In this way, CAMHS employ a targeted approach to protecting young people from potential harm.

1.20 The child's journey throughout CAMHS is clearly demonstrated in records reviewed. This further includes the voice of the young person and the involvement of other relevant services. In this way, the young person's holistic needs are met in a timely and appropriate way. For example, CAMHS use a robust pathway for children with autistic spectrum disorder (ASD). The pathway ensures that such children are assessed and treated under tier three of the CAMHS strategic framework and that the service shows clear ownership of these cases rather than deferring the management to other community or tier two services. We saw that the ASD pathway calls for the involvement of the child, the family and other health services in a multi-disciplinary assessment to enable the service to reach a diagnosis of ASD and plan appropriate treatment. This helps to keep children and families engaged in the process and other services have ownership of various parts of a holistic treatment plan.

1.21 Children and young people up to 16 years are able to access emergency care at the purpose built paediatric ED at the University Hospital of North Tees. The age range was increased to 16 following the findings of a previous CQC review and there is now a discrete area where older children can wait. Families waiting in the area are well sighted by ED practitioners and this ensures that any deterioration in a child's medical condition or concerns about personal interactions can be observed. Children and young people who attend the ED are usually seen quickly.

1.22 In cases reviewed of children who attended ED with head injuries, we saw that their care was compliant with National Institute for Health and Care Excellence (NICE) guidance. However, the Paediatric Early Warning Score (PEWS) is being used intermittently and practitioners were unable to explain clearly when PEWS assessments should be used. If any child is taken from the ED before accessing treatment or discussion with nursing or medical staff, then practitioners make every effort to locate the parents and speak to them. However, there is no formal policy to guide staff in what action to take. This was acknowledged by staff during the review. (**Recommendation 2.1**).

1.23 The treatment environment at the minor injuries unit (MIU) at One Life Centre Hartlepool is not child friendly. Although there is a dedicated children's waiting area it is not in sight of staff; therefore, there is limited observation opportunity either by administration or clinical staff. This means that any additional observations pertinent to safeguarding cannot be fully assessed.

1.24 Comprehensive demographic details are obtained by reception staff for all children and young people attending the ED. Recording of ethnicity and language are mandatory fields; however, this important information is not being pulled through onto the paper casualty record. Therefore, it is not readily available to ED staff to inform their initial assessment of the patient. This is important as the information can help ensure that the children and young people have access to culturally sensitive care as required and it can also inform how best health care support can be delivered. (**Recommendation 2.2**).

1.25 The roll out of the new 'trakcare' e-record in ED is complicated by technical difficulties. This includes, but is not limited to, the availability of information that could previously be accessed quickly by ED staff and which formerly provided management with oversight of attendances. Other missing information on paper records includes names of schools that children attend. We were informed that the trust are aware of the problems and are working hard to resolve this issue.

1.26 In both ED and MIU paperwork, the majority of children and young people seen benefit from safeguarding triage questions known locally as 'ACHILD'. In most cases we saw that this was completed. However, in ED they were not always signed. This makes it difficult to identify which practitioner had asked the questions, which is not considered as good or accountable record keeping practice. (**Recommendation 2.3**).

1.27 The MIU undertake regular audits to monitor compliance with the safeguarding triage questions. The triage questions include who accompanied the child and previous attendances and meets fully the requirement of the NICE guidance.

1.28 Older children and young people attending the ED do not routinely have their vulnerability considered alongside their clinical presentation. We saw cases where young people would have benefited from a VEMT assessment and onward referral to partner agencies to provide a package of support. (**Recommendation 2.4**).

1.29 In ED, there is an integrated care pathway for adults which is a comprehensive care record used to risk assess and inform care planning for adults who attend following self-harm. This assessment guides practitioners to identify if the patient has access to any children and if so, what their details are. This part of the form was routinely completed; however, the remainder of the care record was often incomplete and we saw no record where the mental capacity tool had been used. This is important as it can help ensure that vulnerable families have access to specialist services, as well as promote good holistic care, in order to effectively safeguarding children and young people. (**Recommendation 2.3**).

1.30 Records of children and young people who attend the ED and MIU are not reviewed by any practitioner carrying out a formal paediatric liaison function. This role is not a mandatory requirement; however, it is recognised as a highly valuable safety mechanism for minimising the risk of harm to vulnerable children and young people when it is effectively utilised in an acute setting. In ED, there is a review by a consultant of attendances overnight, although there is no second check to identify any opportunities that may have been missed to identify and intervene early to protect a vulnerable child or young person. We saw cases that would have benefitted from review and these were brought to the attention of the safeguarding team during our inspection. However, in the MIU there is no opportunity to review all under 18 attendances to ensure all vulnerabilities and safeguarding risks have been identified. Strong local relationships and a stable workforce mean that often this liaison with community health teams is via telephone calls from MIU practitioners. Although attendance slips are automatically generated to inform the young person's GP, school nurse or health visitor of any attendance to the department, there is a lack of assured follow-up in the community to ensure children's needs are fully met. (**Recommendation 2.5**).

1.31 A perinatal mental health specialist pathway is used in the adult mental health service. Combined with close links with GPs, this helps to ensure mothers-to-be with mental health needs are well supported throughout their pregnancy.

1.32 In cases reviewed we found that adult mental health practitioners were proactive and assertive in seeking out liaison with partner agencies working with the service user, which was also well reflected within individual care plans seen. In this way, they are ensuring that service users and their children receive early help and support. This is not just confined to children and families who are part of the formal child protection (CP) process but also applies to other levels of risk or need.

Case Example:

An adult mental health practitioner picked up information following attendance at a multi-disciplinary meeting that a service user known to them had become pregnant.

The service user also disclosed the pregnancy to the adult mental health practitioner who initiated contact with children's social care to ensure that early support was available to the vulnerable adult. Further contact was made with the GP to share information and ensure that the woman had made an appointment to book her pregnancy.

The adult mental health practitioner appropriately made a referral to the perinatal mental health service in order to ensure timely and appropriate treatment for the service user, which will help improve maternal and infant outcomes.

This case demonstrates high intensity input and integrated working between the adult mental health team and perinatal mental health nurse. The services complemented each other and work was not being duplicated by practitioners. The adult mental health practitioner remained involved throughout the pathway and package of care, so that the key professional involved with the service user remained consistent. At the same time, this ensured that care was jointly managed. The adult mental health practitioner developed a clear mental health birth plan and completed regular joint visits with the perinatal and health visiting team to ensure that mother's mental health needs were not deteriorating.

Mother remained supported throughout her pregnancy. For example, the adult mental health practitioner attended midwifery appointments with the mother and visited her on the maternity ward post-delivery. This helped ensure that the woman and her family were supported, received co-ordinated multi-agency care and all professionals involved worked together to support the best possible outcome for this family.

1.33 Adult mental health and adult substance misuse practitioners work in close partnership, including joint appointments to help facilitate service user engagement. Both services offer routine home visits to all service users who have children or access to children at home. This is a good opportunity to complete parenting assessments and assess the home environment and any additional vulnerability, particularly when children and young people are concerned.

1.34 An initial assessment is completed for all service users under the care of the adult substance misuse team, which includes assessing for children and young people to whom they have access. This is important information to help ensure that children living in the homes of risk taking adults are identified and better safeguarded and protected from risks. However, currently this important information is not easy to locate or visible within the assessment paperwork, and is not readily available for practitioners. We were informed that a new IT system, which was scheduled to be launched on the 1st February 2016, will flag all service user records that have children in their care.

1.35 Transition into adult substance misuse services starts at the age of seventeen and a half years of age. The transition usually last for six months to the age of 18 and includes joint working between the young person's service and adult services in order to promote the transition process. In addition, a specialist family service is provided by the adult substance misuse service, where children and young people may be affected by an adult with risk taking behaviour or if a child or young person is affected likewise. This is important and demonstrates that the service has embedded the 'Think Family' model.

1.36 Adult substance misuse practitioners regularly visit GP practices in order to update service user records and to share important information with them. An update letter is also sent to all GP practices every six months, which updates them on care and treatment provided by the team. However, adult substance misuse practitioners currently have no direct or regular contact with health visitors or school nurses other than at formal CP meetings. Good routine information sharing by services working with adults with risk taking behaviour would help support the early identification of vulnerable children and young people in households. This would further facilitate early support for children and young person by the health visiting and school nursing service. ***This issue has been drawn to the attention of Public Health, as the commissioners of the adult substance misuse service.***

2. Children in need

2.1 In Hartlepool, there is a perinatal mental health pathway in place for women with an identified high level of need and long term or complex mental health conditions. Support for women with low to moderate mental health issues is provided by GPs. This means that all women with both complex and low level mental health problems are provided with targeted support throughout their pregnancy. Vulnerabilities and changes in circumstances is reassessed and documented as part of the on-going care pathway.

2.2 There is a specialist midwife post for drug and alcohol use in pregnancy that includes links with the addictive behaviour services, with a clinic running from their base. This ensures that women who have problems with addictions during pregnancy are offered targeted support and monitoring with specialist antenatal care that will monitor the needs of and risks to the unborn baby.

2.3 Vulnerable families or children and young people do not always receive a co-ordinated approach to their care involving primary care and community health practitioners. All GPs in Hartlepool have a linked named health visitor attached to their service. However, work needs to be done to ensure that all health visitors have an opportunity to meet with their allocated GP practice to ensure safeguarding cases and families of concern can be discussed. We were informed by management and health visitors that the current arrangements are variable and that not all GPs hold regular vulnerabilities liaison meetings. We were also informed that there are no GP liaison meetings with school nurses; however, school nurses liaise with GPs on an individual basis. GPs hold essential information about patients' current and historical health and social issues which may impact on parenting capacity, so accessing this information is an essential part of risk assessing potential harm to children and young people. Not holding regular liaison meetings is a missed opportunity to ensure that vulnerable and more complex families receive a co-ordinated approach to their care. ***(Recommendation 1.1). This issue has been drawn to the attention of Public Health, as the commissioners of the health visiting and school nursing services.***

2.4 There are currently no specialist roles within the health visiting service, except for a care of next infant (CONI) health visitor. This specialist role is added on to an existing role. Although this supports practice it means that the service provision is practitioner dependent and therefore liable to change in the event of the practitioner leaving the organisation. Health visitors in Hartlepool are supported by a pathway for accessing advice and support from a liaison health visitor for asylum seeking families; however this is on a needs led basis. The lack of specialist health visitor roles has not been identified as a gap locally or by the trust. However, specialist health visitors can effectively help reduce health inequalities of vulnerable children due to the expert knowledge they have relating to specialist areas, such as domestic violence, perinatal mental health, travelling families or substance misuse. They can further help ensure that children have a positive start to their life.

2.5 Transfer of care between health visitors and school nurses in the school health service works well. Joint visits are usually scheduled or face-to-face handover is arranged for children on CP plans or those who have complex health needs. Robust handover of children and young people with additional vulnerabilities ensures information exchange on important safeguarding issues resulting in children and young people being adequately supported and kept safe at this transition point. The current arrangement further means that families and children are more likely to receive support in a timely manner by the time the child starts school.

2.6 School nurses are not well linked in with other health partners; for example with CAMHS. This is recognised as a significant gap for sharing of information between services. Given that school nurses provide drop-in services to secondary schools and may see vulnerable young people with emotional health needs, they are often not fully aware of CAMHS involvement and are therefore unable to best support young people and school staff. **(Recommendation 3.1). This issue has been drawn to the attention of Public Health, as the commissioners of school nursing services.**

2.7 CAMHS practitioners effectively apply escalation processes to ensure safe outcomes for children and young people. For example, in one case reviewed we noted that there had been dialogue between the CAMHS clinician and the social worker about the support that would be offered to a young person who was subject of a child in need (CiN) plan. The young person was experiencing emotional difficulties in their relationship with their parents, which had resulted in self-harming behaviour. We saw that the CAMHS practitioner had effectively initiated the escalation procedure to ensure that the differences of professional opinion were addressed. As a result, the young patient experienced positive outcomes as they were able to access regular CAMHS appointments at the right time and were kept safe.

2.8 CAMHS deliver a crisis response service that helps to protect young people with acute mental ill-health throughout the day and night. Currently the CAMHS crisis team guarantee that they will respond to young people admitted to ED, for example, within one hour, 24 hours-a-day, albeit that the service is on an 'on-call' basis between midnight and 8am.

2.9 We were encouraged to see that the CAMHS crisis team extend their remit to young people up to the age of 18 with a guaranteed response time within an hour. This means that young people between the ages of 16 and 18 who are particularly vulnerable receive an age appropriate service where they can be assured that their needs would be met by appropriately skilled clinicians.

2.10 In ED records reviewed, we saw evidence of the effectiveness of CAMHS provisions for children and young people attending with self-harm or other mental health needs. Young people were seen and assessed quickly by the CAMHS team and as soon as possible once cleared as medically fit for assessment. We saw evidence of prompt discharges home with follow-up appointments made and parents and carers provided with telephone numbers should they need additional support. This means that those children and young people with low to medium risk are not being kept in the hospital inappropriately.

Case Example:

T is a young female who was brought to ED by her foster carers following an incident of self-harm. T had suffered an adoption placement breakdown and had previous involvement with CAMHS.

On reviewing the records we found that CAMHS attended the ED promptly and assessed T as soon as possible. T was discharged from the unit and given a follow-up appointment at her home address. In addition, T and her foster carers were provided with a telephone number for the crisis team if she felt her mental health deteriorating at any point.

ED did not complete a VEMT form though they did complete an information sharing form for children's social care.

This case demonstrates that young people requiring CAMHS input are not being kept inappropriately in hospital for long periods of time; therefore, having a positive impact upon the emotional and psychological wellbeing of vulnerable young people.

2.11 When young people with mental health needs are transferred to the paediatric ward at University Hospital of Hartlepool and University Hospital of North Tees for further medical intervention or to wait for assessment, they are not assessed for the risk that they pose to themselves or to others and their physical environment is also not assessed to ensure it is safe and appropriate for their needs. The current process needs to be changed to ensure that all children and young people who are admitted for CAMHS assessment are better safeguarded. This lack of risk assessment is potentially unsafe. (**Recommendation 2.6**).

2.12 Considerable efforts have been made to identify the "hidden child" of adults who attend the ED with risk taking behaviours including overdose, abuse of alcohol, those with mental health needs and victims of domestic violence. However, the 'Think Family' principles are not fully embedded within the adult ED and MIU assessment pro-forma where there are currently no questions included to prompt practitioners to ascertain if there are children at home for all adults who present with risk taking behaviours. The current arrangements are too variable and there is an over-reliance on the knowledge, experience and professional curiosity of individual practitioners to ask the right questions. (**Recommendation 2.7**).

2.13 MIU practitioners have good links with the young person's substance misuse service, Lifeline. Lifeline provide a "ten-a-day" slot, which is a ten minute teaching and learning session on young people's substance misuse issues. Although this is currently only delivered at the ED, it is accessible by MIU practitioners on an *ad hoc* basis, during their rotational shifts. MIU practitioners informed us that the sessions have been valuable in helping raise awareness on when and how to make appropriate referrals to the specialist service.

2.14 A clear and robust transition policy and pathway exists for young people moving from the CAMHS to the adult mental health teams. The transition process starts when the young person is seventeen years and six months old, continuing for up to six months. During the transition period, there is joint working between the services, which also involves the young person. Appointments are usually held in familiar CAMHS settings in order to ensure that the transition process runs smoothly for the young people. It further means that young people have stability and are not lost in the system during this critical time, thereby helping to improve their mental health outcomes. Despite very different service models, we saw evidence of flexibility in adult mental health appointments to fit round usual routine and to avoid any impact on college attendance for the young person. For example, in one case reviewed there was evidence of consideration of the young person's needs around appointment days and times and the ability to offer flexibility to assist engagement.

2.15 The adult mental health team employ a strong 'Think Family' approach and are fully engaged with all aspects of the CiN and CP process. A risk assessment tool is available on the electronic patient records system (known as PARIS), with an additional risk assessment for service users who have dependent children and young people. However, practitioners are not currently prompted to ask adult patients questions during their initial or routine risk assessments that will enable them to collect important information about any caring responsibilities, for example, service users who may have regular contact with their grandchildren or their partners children. This is a gap as key information might be missed, which may affect treatment and care planning in the context of the impact of the adult's illness on the child. (**Recommendation 4.1**).

3. Child protection

3.1 At the University Hospital of Hartlepool, midwives are not routinely notified about domestic abuse incidents which involve police attendance, or any attendances at ED involving pregnant women. This is important because research shows there is an increased risk of first time incidence of domestic abuse during pregnancy. This is a missed opportunity to gather important information in order to safeguard the unborn baby. (**Recommendation 2.8**).

3.2 In midwifery, there is an expectation that questions relating to domestic abuse will be asked at the early bird and first booking appointments. However, if partners are present the questions are not routinely asked unless there is disclosure or an opportunity is created at a later date to ask these questions. This means that if partners are always present there may not be the opportunity to fully explore domestic abuse or exploitation issues experienced by some women. Good practice would be to give women and their partners information at their initial antenatal booking appointment that on at least one visit the women will be asked to be seen on her own as part of her care plan. This would reduce the reliance on professional confidence in asking an accompanying adult to leave a consultation and the potential for variable practice. (**Recommendation 2.9**).

3.3 There is an expectation from the trust that midwives will prioritise attendance at initial CP conferences as well as provide reports. In cases that we reviewed, the midwifery service was well represented at CP conferences and reports provided were detailed and relevant, clearly articulating any risk to the unborn baby. In addition, the midwifery records seen were detailed and comprehensive. Where appropriate they included copies of medical and social assessments, CP conference reports, minutes, as well as copies of safeguarding supervision. This ensures there is a complete set of medical records which supports ongoing decision making about risk.

3.4 Health visitors in Hartlepool have access to a generic 'failed access' policy, which is used trust-wide. We heard that the policy stipulates that two appointments should be offered before a patient is discharged from the service. However, in cases seen health visiting teams offer many more appointments to ensure that families and children are receiving the support which they require. In cases where parents repeatedly fail to attend appointments with the health visitor, appropriate liaison takes place between professionals in order to ensure safety of the child. This includes liaison with the GP, safeguarding named nurse team and, where necessary, children's social care. This practice demonstrates that health visitors in Hartlepool are proactively working to ensure that children are safeguarded and protected from harm.

3.5 In records reviewed, we saw that health visitors are consistently being notified and invited to safeguarding meetings, including CP conferences, core groups and CiN meetings. Where required, health visitors are producing reports and presenting them at core group meetings, in order for them to be incorporated into a joint multidisciplinary report in preparation for the CP conference meeting. The reports reviewed were detailed and clearly articulated any concerns that the health visitors had.

3.6 Health visitors are aware of the process to following when referring families to children's social care. In records reviewed, we saw that the quality of SAFER (Situation, Assessment, Family-detail, Expected-response, Recording) referrals varied in terms of articulating risk. However, in one record reviewed the referral was exemplary and illustrated clear articulation of risk and the impact that the mother's behaviour was having on the child. Good quality referrals are important to facilitate optimum decision making in children's social care about what intervention or support may achieve the best outcome for the child.

Case Example:

We reviewed a SAFER referral made by a health visitor due to professional concerns relating to mother's eating disorder, mental health and general well-being. The health visitor also had concerns about mother's ability to care for her baby in a physical and emotional capacity.

The health visitor had comprehensively completed all boxes and articulated the reason for the referral. In addition, the impact of mother's lifestyle choices on the baby was clearly documented, including citation of research studies and department of health guidance to articulate risk. This detailed referral helped facilitate a prompt response and effective decision making from children social care.

Outcome: *Mother continues to engage with professionals and baby is reported to be making good progress.*

3.7 Health visitors are making good use of the electronic patient records by routinely adding flags for all vulnerable children or those subject to a CP or CiN plan. This information is also clearly visible on the homepage of the patient record, which means that practitioners are immediately alerted to vulnerable cases that they need to be aware of when opening a patient's record.

3.8 In records reviewed we saw evidence of health visitors using the significant events tab on SystmOne, for example to record attendance at safeguarding and multi-agency meetings, ED attendances and failed access appointments. However, we were informed that the effective use of the significant events tab is reliant on individual practitioners. It is vital that all health visitors are effectively using the functionalities of SystmOne and recording chronologies of significant events, as it allows practitioners to review patient records at a quick glance, as well as identify any potential drift in the case. ***This issue has been drawn to the attention of Public Health, as the commissioners of the health visiting service.***

3.9 The effectiveness of liaison between the health visiting and midwifery service requires strengthening. We heard that health visitors are contacting the midwifery service by telephone prior to completing an antenatal visit. However, we were informed by the health visitors that there is currently no formal health visitor and midwifery liaison meeting. This is important as it helps facilitate information sharing and enable families needing additional support to be identified and engaged with promptly by the health visiting service. An antenatal care pathway was launched in October 2015, and compliance on its use is due to be audited by the end of March 2016. **(Recommendation 2.10). This issue has been drawn to the attention of Public Health, as the commissioners of health visiting and school nursing services.**

3.10 In school nursing, we saw inconsistencies in cases reviewed with reference to attendance at CP meetings. Some practitioners attend all meetings, others attend on a needs only basis and if they have ongoing input with a young person. Despite the introduction of a local safeguarding children's board (LSCB) protocol, which means that school nurses are no longer expected to attend all CP meetings, it currently excludes CP cases in the category of neglect meaning it has not yet had an impact on the numbers of meetings attended by the service. Some school nurses that we spoke with during our inspection were not clear about when they should attend and when it was appropriate to step back. **This issue has been drawn to the attention of Public Health, as the commissioners of school nursing service.**

3.11 School nurses have access to a basic child sexual exploitation (CSE) risk assessment screening tool on SystmOne; however, there is more to do to ensure that the service fully understands their important role in risk assessment, identification and follow-up of potential CSE cases. In cases reviewed, the CSE risk assessment tool was not fully completed. This is a missed opportunity to identify potentially vulnerable young people. This is particularly relevant given that there are plans to introduce some CASH services at secondary school drop-ins. **This issue has been drawn to the attention of Public Health, as the commissioners of school nursing service.**

3.12 In MIU, there is an over-reliance on practitioners to identify young people at risk of CSE, as they do not have access to a risk assessment tool. Without a formal risk assessment, the opportunities to identify young people at risk of exploitation could be missed. It is important that practitioners working closely with children and young people in the MIU have access to appropriate tools, which they will require to help them identify and assess additional vulnerabilities in order to effectively safeguard them. **(Recommendation 2.11).**

3.13 The use of a single IT system across all unplanned care settings ensures practitioners can undertake a full risk assessment utilising information from any previous and multiple attendances. Easy access to previous attendance information on the front screen of the system also assists with flagging vulnerabilities in addition to children on a CP plan. This ensures that practitioners are fully aware of children and young people's vulnerabilities at the time of attendance.

3.14 Record keeping practice at the MIU is good. Records that we reviewed were written clearly, gave good detail of examinations and treatments, including the use of body maps to indicate locations of injuries sustained by children. The voice of the child was reflected and captured well by MIU practitioners and there was good observational documentation on the interaction between the child and adult.

3.15 The current arrangement for risk assessing young people under the age of 18 in CASH services across Hartlepool is good. We were informed that double appointment times are now allocated for all under 18s to help ensure adequate time is allocated to explore risk and potential vulnerabilities. A comprehensive risk assessment tool is in place for all under 18s based on the Brook 'Spotting the Signs' national template. This template also incorporates thorough questioning, analysis of risks around CSE and coercive relationships, and guidance on onward referrals as appropriate. This is repeated each time a young person presents as the team have an awareness that new information may come to light, especially when different practitioners are seeing young people. Therefore, CASH practitioners are fully assessing potential vulnerabilities during their contact. It further provides the opportunity for an in-depth discussion with the young person around their social circumstances and also their emotional health and wellbeing.

3.16 The CASH team are well linked into the VEMT forum for CSE. The introduction of a VEMT template and a pop-up alert onto the client electronic records system in use in the service (known as Lillie) helps ensure that all practitioners are fully aware of vulnerabilities. It further means that the most up-to-date information from VEMT intelligence can be considered in order to effectively safeguard young people. This alert system also includes perpetrators information in case they access the CASH service.

3.17 The 'Think Family' approach is well embedded with the CASH service. In one case reviewed, the CASH practitioners liaised and shared information appropriately with the health visiting team to ensure the service users and their families had their needs met and were safeguarded on an ongoing basis.

Case Example:

X is a 21 year old female who attended the CASH service with her 13 week old baby. A comprehensive service assessment tool was completed, which highlighted mother's cocaine uses. The CASH practitioner appropriately raised a SAFER referral form. Contact was also made with the health visiting team to share information and discuss safeguarding concerns. The case was discussed at safeguarding supervision, with outcomes clearly recorded on the service user notes.

Outcome: *The case was held as a team around family (TAF) to ensure that the needs of the child and family were met through a multiagency approach.*

3.18 SAFER referrals made to children's social care by CASH practitioners clearly articulate risk. Operational management oversight of this is robust as risk articulation forms part of monthly audit process. However, understanding of the importance of CASH services being represented at CP meetings is currently under developed. ***This issue has been drawn to the attention of Public Health, as the commissioners of the CASH service.***

3.19 We examined SAFER referrals made to children's social care by the adult mental health team and found that they clearly analysed and articulated risk, as well as what the expected outcome of the referral was. We found that care plans and reference to children was evident in records reviewed, including clear actions for the care co-ordinators to link with social workers fortnightly to ensure they had the most recent updates about families.

3.20 In adult mental health, departmental systems help ensure that children and young people are safeguarded well. For example, detailed discussions at the daily team meeting of all appointments scheduled for the day helps ensure that all team members, as well as the team manager, is fully sighted on the most recent safeguarding issues or information related to service users and their families. This allows for peer oversight and can also act as cover arrangements if a care co-ordinator is absent from work.

3.21 In adult mental health, practitioners are effectively utilising the alert functionality on the PARIS IT system to highlight CP cases and those discussed at MARAC meetings. This means that adult mental health practitioners are immediately alerted to vulnerable children and young people when accessing case records.

3.22 GP practices that we visited informed us that a report for CP meetings is always provided when it has been requested. However, GPs are not being provided with detailed outcome information following CP meetings. We saw no copies of CP plans or conference minutes, despite this information being requested. In one case reviewed, there had been a CP conference held in August 2015 and a further review in November 2015. The only information that the GP had as an outcome was a notification document that informed the GP that the child was subject of a plan under the category of emotional abuse. GPs told us that this was usual practice. This is not acceptable, as it means that vital information in respect of the on-going protection of children is not being shared appropriately and therefore, primary care records are incomplete. (***Recommendation 6.1***).

3.23 GP practices across Hartlepool use a variety of electronic primary care systems. Although some GP practices are using the same electronic patient database as used in the health visiting and school nursing teams. However, we were informed that GP practices set their primary records on the system so that they cannot be shared with other providers by default, unless the patient had overtly consented. This was also the case for children who were subject of a CP plan, which means that health visiting and school nursing teams cannot see information from the GP about vulnerable children they might encounter. For example, in one case that we reviewed, a 10-week old baby on a CP plan had been to the GP for a six week check and the GP had made a record of the examination on the system. This information was not available for the health visitor to view unless there was some other means of overtly sharing this information. This means that the health visitor would not have access to complete information about the child. As highlighted under the Early Help section in this report, multi-disciplinary work, including information sharing with other health providers is underdeveloped in GP practices; the under use of the sharing facility on the electronic system exacerbates this problem and means that the needs of vulnerable children are being assessed without the benefit of complete information. (**Recommendation 1.1**).

3.24 In the GP practices that we visited, we saw that any cause for concerns resulting in referrals to children's social care were not generally made using the correct communication tools; that is, a telephone call to the children's hub followed up by a multi-agency SAFER referral form. In some cases, where a telephone call had been made to discuss concerns, it was not followed up by the GP to find out the outcome and this meant that there was no way of tracking decisions that had been made about particular cases originating from primary care.

3.25 The use of alerts on the GP records to flag children who were subject of a CP plan or where there are other concerns was inconsistent across the GPs that we visited. In some cases an alert was prominent on the child's record and in others there was no alert. In addition, there was nothing on the record to indicate parental history or any information from the health visitor or children's social care. This means there is a risk that staff seeing vulnerable children presenting for treatment may be unaware of concerns that would inform the conduct of their encounter with the child. (**Recommendation 6.2**).

3.26 In the adult substance misuse service, records are not routinely flagged to alert practitioners to consider any safeguarding vulnerabilities, including whether clients have children on a CP or CiN plan. This means that practitioners are not being well alerted of the need to consider any additional risks to children, which will in turn help ensure that their assessments and recommended care plans to support and protect the whole family, are robust. ***This issue has been drawn to the attention of Public Health, as the commissioners of the adult substance misuse service.***

3.27 Adult substance misuse practitioners engage well with formal CP processes, including attendance and contribution at CP and core group meetings. However, reports provided for CP conference meetings are not consistently being filed in service user paper records. In addition, CP plans are not routinely being received. Therefore, health records reviewed were often incomplete. As a result, it was difficult to identify whether adult substance misuse practitioners were fully taking into consideration decisions made at safeguarding meetings to better inform their individual plan of care, in order to effectively meet the needs of vulnerable children of risk taking adults. ***This issue has been drawn to the attention of Public Health, as the commissioners of the adult substance misuse service.***

3.28 When adult substance misuse practitioners have any safeguarding concerns, they appropriately complete a referral to children's social care via the SAFER referral form, which prompts them to provide as much information as possible regarding their reasons for making a referral. However, we saw variation in the quality of referrals to children's social care, where some practitioners were clearly articulating risk to children and young people whilst others were providing a description of the parents' substance misuse but no information about any risk that their behaviour has on the children and young people under their care. We were informed that all referrals to children's social care are overseen by the team leader or a senior practitioner. This is a good way of ensuring that referrals are detailed and clearly describes such risk; however, from the referrals seen we could not be assured that the current arrangements are effective. ***This issue has been drawn to the attention of Public Health, as the commissioners of the adult substance misuse service.***

3.29 We were informed that an adult substance misuse care co-ordinator attends the bi-monthly VEMT meetings and will then provide feedback to the rest of the team through the service manager. We were also informed that the adult substance misuse service is represented at monthly MARAC and multi-agency public protection arrangements (MAPPA) meetings when invited, which facilitates information sharing across teams.

3.30 Adult substance misuse services hold monthly multi-disciplinary team meetings to discuss high risk cases. This meeting is attended by social care, police, housing, practice managers and health services if they are involved in care. Multi-disciplinary working means that practitioners are in a better position to address the needs of all family members, which can result in improved outcomes, in particular for children and young people. This also means that professionals are working together to inform joint decision making and co-ordination of care for families.

4. Looked after children

4.1 The current arrangements for looked-after children in Hartlepool are under-developed. The LAC nurse is a committed practitioner; however, the role is untenable at present given the level of resource, support and oversight into the service. The present post holder is due to retire at the end of April 2016 and as of the date of our visit a replacement has not yet been advertised. This requires urgent clarification in order to ensure continuity of service for looked-after children in Hartlepool. (**Recommendation 2.12**).

4.2 During our inspection we found that most initial and review health assessments are completed within recommended time scales and by appropriately qualified practitioners. Initial health assessments are undertaken by the community paediatricians or associate specialists. Review health assessments are undertaken by health visitors for children under five years old and school nurses for children over five and up to 16 years of age. The specialist looked-after children's nurse usually undertakes health assessments for those young people over 16, the majority of children placed out of area or family groups.

4.3 Health information is collated in preparation for the initial health assessment by the community paediatric administrator, on behalf of the looked after service. This is in order to ensure that the paediatrician who carries out the initial health assessment has access to all important information that they need to make an accurate and meaningful assessment of the child or young person's health needs. However, we found little evidence that any information gathered in this way had been used by the assessing doctor. We are aware that the community paediatric administrator's time is not dedicated for looked-after children and therefore their capacity to gather information from the wider health community is limited. In addition, information from GPs, CAMHS or the midwifery service is not gathered as part of the preparation for the initial health assessment. This means that important information in relation to the child's health and wellbeing is not available for the assessment. Gathering essential information as part of the child's care pathway is important and demonstrates compliance with the statutory guidance for looked-after children (promoting the health and wellbeing of looked-after children, 2015). The current system means there is the risk that the resulting care plan would not meet the needs of the child. (**Recommendation 2.13**).

4.4 The looked-after children's health team informed us that after every health assessment a retrospective request for information, is sent to the GP, with a copy of the care plan and immunisation sheet. However, this is not compliant with the statutory guidance which states that to ensure that health care plans are of a high quality, the health assessments should use relevant information which is drawn together beforehand. This includes obtaining information from GP held records prior to the assessment taking place and not in retrospect. GPs that we visited at the time of our inspection informed us that they are not routinely given the opportunity to contribute to the initial and review health assessments of children looked after. They also told us that they were not aware of the processes and requirements for their contribution to these assessments. As the primary record holder, GPs have key information in relation to children and their families and are therefore in a strong position to contribute to health care assessments in accordance with the statutory guidance. (**Recommendation 6.3**).

4.5 In records that we reviewed, we saw evidence that GPs are not always being update on the status of looked-after children. This means that their records are incomplete and not up-to-date. Therefore, there is a risk that children may be lost in systems or details coded wrongly as is highlighted in the case example below. (**Recommendation 6.4**).

Case Example:

In one case that we looked at in primary care, an 11 year old was flagged as being looked after on the GP records; however, the child had not been seen at the surgery since 2012. The last correspondence noted on the GP records in respect of looked-after children status is a 'did not attend' (DNA) letter for not attending a review health assessment.

We could not be assured by the GP that the looked after status of the child recorded on the patient record was up-to-date. During our inspection, a telephone call was made to the specialist looked-after children's nurse who confirmed that the child was no longer in care; however, they could not provide information or details on the whereabouts of the child. A further telephone call was made to the children's social care team, who provided an update for the GP and advised that the child had been a former CiN but that the case was no longer active to them.

In order to determine the safety and whereabouts of the child, a telephone call was also made to the school nurse who confirmed the details of the school that the child was recorded as presently attending. The school nurse further contacted the school on behalf of the GP to confirm that the family had moved address but was still living in the locality and the child remained at the same school.

4.6 Our review of records of health assessments for looked-after children showed that certain key information was consistently missing from files. This information included the reason why the child was looked after, whether there were any legal proceedings, the child's ethnicity, language and religion. Furthermore, the recorded information about the parents of the subject child was scant. In particular, information about parental health history was missing or superficial. We could not be assured that these questions had been asked during the assessments and so a clear picture of the child's background could not be seen and any potential risk arising from the parent's histories did not feature. The absence of this information can have a lifelong impact upon the child's journey throughout placement and into adulthood. (**Recommendation 2.14**).

4.7 In most cases reviewed, the records contained just the health assessment documents and did not contain records of health service interventions experienced by the child, such as attendances at ED. Therefore, we could not be assured that such important information had been considered when assessing the child's precise health needs and appropriate health interventions. The use of chronologies or key actions lists would help to track key points and interventions in looked-after children files.

4.8 The practice of recording consent for the health assessments of looked-after children were found to be inconsistent, with consent to medical examinations not being on files or signatories cross referenced to the original looked-after children documentation. In records reviewed, the section that required consent from a person with parental responsibility was often left blank, so it was not clear if such a person had received information about the health assessment and therefore had provided informed consent for it to go ahead. In addition, the prompts that required the practitioner to consider a child's competence to provide consent in their own right was not completed, even though some of the children were of an age where this was likely to be important. We could not be assured, therefore, that consent of the child or the child's competence to consent to the assessment had been properly considered. As a result it was also not clear whether the child had been given enough information about the assessment and understood what was to happen. (**Recommendation 2.15**).

4.9 We saw little evidence of the 'voice of the child' being heard during assessments. Not obtaining and recording the voice of children and young people in the initial health assessment process means opportunity to engage them in the process and 'set the scene' for future interventions is limited. Plans seen were not always SMART (specific, measurable, achievable, realistic and time-bound) with clear timeframes and areas of responsibility. (**Recommendation 2.16**).

4.10 Additional screening or assessment tools are not being used effectively by the looked-after children's service, in particular, to determine the risk of CSE. In one case that we reviewed, there were clear indicators of the risk of CSE, including risk taking behaviour, the use of contraception and an unknown sexual partner alongside other vulnerability factors. However, a screening tool was not being used by the looked-after children's service. This means that opportunity to formally identify vulnerabilities was missed and the young person was not referred to the multi-agency forum set up to examine this risk in more detail. (**Recommendation 2.17**).

4.11 We were informed that care leavers are offered a health passport as part of their final health assessment, but few take up this offer. However, we could not be assured this was routinely being offered, as in two cases that we reviewed no information about whether the young person had been offered a health passport or other summary record of their health history was evident. This is not compliant with the statutory guidance for promoting the health and wellbeing of looked-after children (2015). We were told that a health passport has been developed in conjunction with the children in care council, although we did not see any examples of this. Good practice would be to prepare and present the passport as part of a wider delivery of preventative approaches and in preparation for independence and transition to adulthood with explanation, thereby enabling young people to make informed choice. If they then decline to accept the document it could be placed on file to be available at a later date. The absence of the provision of health passport means that the information is not being provided in a format appropriate for the care leaver to access in a timely way. (**Recommendation 2.18**).

4.12 Children and young people are not offered a choice of venue for their health care assessments with the majority of initial health assessments completed at the hospital site and review health assessments undertaken in the family or foster home. We were informed that this does not usually cause any difficulties. However, we often hear from older young people that being given a choice of venue is important for them and that they do not like being subject to health assessments in family homes because of lack of privacy. This is particularly the case when asked to talk about personal, sensitive information.

4.13 A therapeutic support service is provided to looked-after children. Referrals are accepted, usually from social workers in respect of children and young people who are experiencing emotional or mental health difficulties. The team consists of staff employed by social care and an allocated CAMHS looked-after children's practitioner. The specialist nurse for looked-after children is part of the team that screens referrals. We were told that the service is due for review and therefore are unable to comment on the effectiveness of the service.

4.14 In CASH services, looked-after children and those subject to a CP plan are not routinely flagged on the Lillie IT system, unless they have been discussed at a VEMT meeting. However, once CASH practitioners have identified young people as looked after, extensive liaison with social workers was evident in records reviewed. We noted thorough and diligent follow-up in cases where there were additional vulnerabilities unrelated to sexual health.

Case Example:

S is a 17 year old looked-after young person from out of area, who presented at the CASH service in Hartlepool. The CASH practitioner contacted the social worker to check information that had been provided by the young person was correct. The social worker informed the CASH practitioner that they had not seen S for some time, however, through investigation it transpires that S was now living with her father in Hartlepool.

The CASH practitioner completed the safeguarding template with thorough information, and advice being sought from the local children's social care team. A follow-up appointment was scheduled for S with the CASH service; however she did not attend.

The CASH practitioner diligently followed up the case by making contact with S and also with her last known social worker. The CASH practitioner also asked a colleague who provides an outreach CASH service in school to follow-up on the whereabouts of S and passed this information on to the social worker.

This case demonstrates that CASH practitioners are proactively safeguarding vulnerable young people attending the service, as well as working in partnership to improve outcomes for young people.

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 absence of strong strategic leadership in the looked-after children's service is hindering effective progress of the looked after agenda for children and young people in Hartlepool. We are aware that the CCG has recently appointed people to some leadership posts in safeguarding. Therefore, in some areas it is too early to see the impact of changes related to these roles in respect of safeguarding and looked-after children.

5.1.2 The CCG are supporting the implementation of the 'Better Childhood' Programme to promote early help and intervention and in addition to support more vulnerable families in Hartlepool. The programme is aimed at streamlining services offered by a range of providers, including school nursing and health visiting. It is anticipated that over the next twelve months there will be a transformation of services and in order to achieve this partners will be working closely to integrate services by sharing pockets of excellence.

5.1.3 The role of the named GP was underdeveloped at the time of our review. The impact of new initiatives introduced by the recently appointed named GP was not yet evident. For example, we saw the named GP had begun to issue monthly bulletins to GPs on topical matters and emerging themes, such as female genital mutilation (FGM) which is a simple but encouraging development. The effectiveness of this as an awareness raising tool had not yet been measured although we understand there were plans to assess its value through the use of a survey.

5.1.4 We learned of future planned initiatives to enable primary care providers to become more integrated with the rest of the health care economy on matters of children's safeguarding. For example, GPs will be offered support and guidance on generating a clear picture of vulnerable children on the patient lists so they can better monitor and manage their needs. A 'children do not DNA' campaign is to be launched in 2016, aimed at raising awareness of the importance of proactively monitoring children where this is a frequent occurrence. In addition, we heard of an initiative to heighten GPs understanding of the impact of domestic abuse on children and young people. These are encouraging initiatives that will require support from the CCG and NHS England, in order to maintain the impetus towards improved safeguarding performance.

5.1.5 All GP practices in Hartlepool have identified a safeguarding lead GP. In September 2015, the designated doctor for safeguarding facilitated safeguarding children lead GP engagement sessions, following identification of training needs. The sessions are planned to continue and will be available to all lead GP's on a quarterly basis. This is a useful forum for peer review and complex case discussions. It further gives GPs an opportunity to keep up-to-date on safeguarding changing practice, which can be shared with their practice staff. Evaluation of the impact of the engagements sessions is yet to be undertaken; however, we were informed that the primary session was well received by those who attended.

5.1.6 None of the GP practices we visited are managing the needs of vulnerable children and young people by way of structured, formalised dialogue with other community health teams. The absence of a multi-disciplinary process for sharing up-to-date information about particular children and families between midwifery, school nursing and health visiting means that the needs of those children were being considered by those teams in isolation and from a single disciplinary perspective. As primary providers and record holders for children's health care, GPs are in a unique position to facilitate such dialogue to ensure children's needs are met more effectively. As a minimum, GPs should regularly monitor the records of vulnerable children on their patient list to ensure they are in possession of the most up-to-date information to help them make accurate assessments of their needs when the child next visits them or to proactively consider other services that would benefit the child. (**Recommendation 1.1**).

5.1.7 In all of the GP practices we visited we saw that information streams about vulnerable children between the local authority and the GPs are poor. Information about children subject of CP plans is often not received and where it is, it is usually no more than an outcome sheet stating that a child is subject of a plan with no supporting information to enable the GPs to consider or plan the child's health care. In the case of CiN this information is not known to the GPs at all. For example, one of the practices had been compiling a list of children subject of a CP plan based on historical requests for information they had received from the social care team and where no update had been sent. They discovered that eleven children who were initially subject of a CP plan were no longer subject of such a plan having been stepped down during 2015. The GP practice did not have a system for chasing requests for information and so this was undiscovered until recently. This inconsistent quality of information streams about vulnerable children means that GPs are not in possession of the most up-to-date information and there is a significant risk that the needs of the most vulnerable children are not being met effectively. This should be addressed as a matter of urgency to ensure that no vulnerable children are missed. (**Recommendation 6.1**).

5.1.8 Community midwives hold daily meetings which allows for discussion and information sharing in respect of new referrals and on-going casework, including arrangements for joint visiting or post-natal transfers. For more complex cases, joint visits are arranged between health visitors and midwives where possible. This is good practice as it ensures that information is shared between professionals and facilitates continuity of service. Midwives and health visitors are co-located in some of the children's centres and run concurrent clinics. This enables new parents with other young children to attend both clinics if required and for midwives and health visitors to liaise with each other in regard to post-natal transfers.

5.1.9 The school nursing team in Hartlepool is commissioned to deliver the Healthy Child Programme (HCP) for children and young people aged five to 19. However, the team acknowledge limited input with 16 to 19 year olds as support is provided only on task based intervention. Once a package of care has been provided to this age group, input is withdrawn and the school nursing team await re-referral if further needs or intervention are identified. Therefore, additional vulnerabilities of this age group are not routinely being addressed by the school nursing service. ***This issue has been drawn to the attention of Public Health, as the commissioners of the school nursing service.***

5.1.10 In school nursing, the clinical team leader monitors caseloads and CP cases regularly. Cases are allocated corporately across the team by the team leader, rather than in specific schools to ensure balanced workload. However, caseload holders are kept stable throughout interventions of care. Similarly, in health visiting, the team leader monitors individual health visitor caseloads on a monthly basis to ensure they remain manageable for individual practitioners.

5.1.11 CAMHS practitioners have good safeguarding practice embedded in their working culture. This was demonstrated in their diligent approach to record keeping, their child focused care planning, involvement of young people in the design of the service and their use of escalation processes to ensure safe outcomes for young people. In particular, the records we reviewed showed chronological log entries that were completed with exceptional detail, clearly articulating the rationale for decisions made in respect of young people and leaving the reader assured that the service operated with the child's needs as paramount. Coupled with the process for analysing current or ongoing risk through meaningful supervision, we considered this to be reflective of a strong safeguarding vision and good leadership throughout the service.

5.1.12 The CAMHS service have recently reinvigorated their service user participation group, made up of young people using or discharged from the CAMHS service. We learned that the group is facilitated by one of the clinical leads and monthly meetings are held to discuss how the service can be improved. We heard that the group has been responsible for the redesign of the art therapy room in the CAMHS unit to ensure it was more suitable for young people. We were advised that funding had been arranged to redecorate the room according to the group's specifications. We also learned that the TEWV intended to involve this group in consultations about the configuration of the service, although this had not happened yet.

5.1.13 As part of learning achieved from the recent reviews of looked-after children services and safeguarding arrangements in Stockton and Middlesbrough, CASH services in Hartlepool have actioned a number of service developments in order to improve service delivery for young people. Practitioners reported a significant cultural shift in embedding safeguarding practice across the service from this learning, with clear emphasis on holistic rather than purely clinical assessment.

5.1.14 NT&H NHS FT have invested in a team of safeguarding professionals to promote safe practice across the trust. Although the named nurse at the trust is currently on a secondment we heard of imminent plans to advertise the role as a substantive post. The named nurse currently heads a team of four whole time equivalent senior nurses, with one vacancy that is being converted to specialist safeguarding midwife. The team is further supplemented by two part-time safeguarding children's trainers.

5.1.15 A network of safeguarding champions help to promote safeguarding practice across NT&H NHS FT; however, attendance at recent network meetings has not been representative of the whole organisation. This is a missed opportunity to engage those departments in an acute trust who are often less exposed or knowledgeable in working with vulnerable families and children who may be at risk.

5.1.16 Adult substance misuse practitioners informed us that they were not aware of a formal escalation policy in relation to resolving professional's disagreements with social care. However, practitioners reassured us that any concerns they had would be escalated through their line managers.

5.2 Governance

5.2.1 The designated nurse for safeguarding children and looked-after children, and the designated doctor for safeguarding children are both active members of the safeguarding children's board in Hartlepool and associated sub-groups including the performance and quality assurance group. They also attend a designated professionals meeting, which is a good opportunity to discuss areas of improvement in regard to safeguarding and looked-after children.

5.2.2 There is currently no multi-agency safeguarding hub (MASH) in Hartlepool; however, discussions are ongoing with partner agencies and plans are in place to launch a multi-agency children's hub (MACH) by June 2016. The MACH is to be known as 'the children's hub' locally. The partner vision is for a MACH, which will be an integrated single point of access across north Tees. It will provide multi-professional triage and assessment to improve intelligence sharing, risk assessment and decision making for vulnerable children, young people and their families, ensuring they get access to the right early help and specialist support. The CCG designated nurse for safeguarding and looked-after children sit on the MACH strategic management board and project implementation group.

5.2.3 The local authority in Hartlepool undertook a partner survey, in which practitioners identified the CAF process as a barrier for accessing appropriate support. As a result of this, the local authority are currently in the process of rebranding the CAF in order to ensure effective intervention for children, young people and their families. We were informed that the language used when referring to the CAF will be changing. It is envisaged that this will better support the children's workforce in utilising the tool to promote effective early intervention and improve outcomes for vulnerable children and families.

5.2.4 The CCG has identified the currently vacant post of a designated doctor for looked-after children as a priority. Designated doctors can assist service planning and advise CCGs in fulfilling their responsibility as commissioners of services to improve the health of looked-after children in accordance with the intercollegiate guidance, 2015. Although support and guidance is available and provided by the designated doctor for safeguarding, the current arrangements are not sufficient in meetings the needs of the service, as identified during our inspection.
(Recommendation 5.1).

5.2.5 There is further work for the CCG and providers to do to ensure the provision of health for looked-after children is fully and effectively co-ordinated and quality assured. There is no audit or quality assurance of the looked-after children's service and this is a significant gap. We were informed that the last audit was in 2015 and was in relation to initial and review health assessments. This audit found that the voice of the child was not evident, and views of children and young people were not being recorded within records. At the time of our inspection we found that this still remains an issue for the service; one which requires attention as we have reported above under 'Looked after children'. The CCG acknowledge that a re-audit of the service is due. (**Recommendation 2.19**).

5.2.6 The health visiting skill mix team in Hartlepool is split into two teams, the north and south. The north team is based at University Hospital of Hartlepool and the south team at a children's centre. Health visitors report that they have clear roles and responsibilities, and are able to appropriately delegate work to the skill mix team, as well as supervise their practice accordingly.

5.2.7 Following the wake of the 'Health visitor implementation plan, a call to action', the health visiting team in Hartlepool has reached its full complement following a successful recruitment drive. Health visitor caseload sizes are around 240 and are reported to be manageable by practitioners that we spoke with. This is below the minimum floor standard of 300 as outlined by the institute of health visiting guidance (IHV, 2015). All families in Hartlepool now have a named health visitor allocated to them until their child is aged five and this supports the identification of and response to any risk.

5.2.8 Senior management from the health visiting service regularly monitor delivery of the HCP. Data is collected monthly and presented to the CCG and public health in order to demonstrate whether targets are being achieved. In addition, health visiting clinical leads have access to a dashboard tool, which they access regularly for exception reporting. We were informed that health visitors have recently attended a half-day 'time-out' session to discuss and explore compliance of performance.

5.2.9 In health visiting records reviewed, we saw detailed documentation by health visitors on SystemOne records. However, outcomes following visits are not always clear and were found to be hidden within the assessment template, which makes identifying plans of care difficult. It also does not facilitate effective managerial oversight of progress of a practitioners practice through the case record. Where plans were being identified they were not always SMART. ***This issue have been drawn to the attention of Public Health, as the commissioners of the health visiting service.***

5.2.10 There is a lack of operational oversight in school nursing to ensure the quality of information contained in CP conference reports is of a high standard. Cases sampled highlight variation in quality of information submitted via the standard template used for CP conference reports. Once completed they are copied to the safeguarding team. However, we did not see evidence that these were checked by the safeguarding team prior to submission to children's social care. ***This issue have been drawn to the attention of Public Health, as the commissioners of the school nursing service.***

5.2.11 The safeguarding team monitor all CP conference invitations for school nursing and health visiting. This helps maintain robust oversight of safeguarding performance and ensure there is representation of key health professionals who can contribute to decision making at safeguarding meetings in order to help achieve the best outcome for the children and young people.

5.2.12 Each CASH team in Hartlepool has a safeguarding champion who meets with the regional safeguarding lead every month. The service undertakes significant levels of audit on a monthly basis in order to ensure practice is consistently maintained across teams. For example, five VEMT cases and any referrals made to children's social care are audited. In addition, five random cases are audited to check that the under 18s risk assessment template has been completed, and that any identified risks are actioned with follow-up by CASH team as necessary. The lead safeguarding doctor at Virgin Care presents the "safeguarding log" every month at a clinical governance meeting, which helps provide assurance of the safeguarding practice embedded within this service.

5.2.13 The University Hospital of Hartlepool use a programme of audit to demonstrate compliance and improve safeguarding practice, including the LSCB Section 11 audit. Regular case audits have demonstrated the need for more rigorous analysis of risk by health professionals when making referrals to children's social care and in reports submitted for CP conferences. The audits have also identified the need for more robust recording of ethnicity, language and father or partner details of vulnerable families. These findings were reflected in the cases seen by inspectors during the visit to ED.

5.2.14 A significant challenge faced by not only NT&H NHS FT, but other acute trusts is to identify and safeguard children of adults who repeatedly cancel and rearrange their child's medical appointments. This is opposed to the more easily identifiable families who just fail to attend an appointment. The named nurse is working with the Teeswide network to help find a solution to this problem.

5.2.15 At the University Hospital of Hartlepool safeguarding governance arrangements are appropriate and provide assurance to the trust board, primarily through the safeguarding steering group. This group is chaired by a non-executive member of the trust board and is attended by the designated nurse as well as service managers.

5.2.16 SAFER referrals completed by the MIU are copied to the trust safeguarding team to allow for quality assurance and management oversight. However, referrals are not held on MIU records; therefore, we are unable to comment on overall quality.

5.2.17 In most cases seen, adult mental health practitioners are recording details of children in patient records; however, there is currently no operational management oversight on safeguarding practice. Although there is an annual casefile audit, no audits have been instigated by the adult mental health team around safeguarding practice particularly for families who are not on a CP plan. **(Recommendation 4.2).**

5.2.18 SAFER referrals made by the adult substance misuse service are overseen by the team leader or a senior practitioner. This is a good way of ensuring that referrals are detailed and clearly articulate risk. However, the referrals reviewed at the time of our inspection were variable in their quality. Therefore, we could not be assured that the current arrangements are effective in improving practice. ***This issue has been drawn to the attention of Public Health, as the commissioners of the adult substance misuse service.***

5.2.19 GP practices in Hartlepool are contractually obliged to review ED discharge summaries within three days of their patient being discharged from the department. However, GPs reported that the lack of timely and comprehensive summaries means that GPs are not always able to comply with their contractual obligation and therefore respond in a timely way to identified need. **(Recommendation 2.20).**

5.2.20 One GP practice that we visited cross-populated the codes on the electronic patient record for all members of the household. This means that the GP had access to important information during consultation. GPs also had good arrangements for ensuring that all documentation received is scanned onto the system by a senior administrator and reviewed by the safeguarding lead GP. We were shown how documentation was appropriately scanned, coded and stored on the electronic patient record. However, in records seen, not all scanned documents were legible, particularly initial and review health assessments for looked-after children. The receipt of the scanned document had not been quality assured and returned to the sender for clarification. There is a risk that vital information will be missed. **(Recommendation 6.5).**

5.2.21 Adult substance misuse practitioners are currently using both paper and electronic patient records. All risk assessments are currently being filed in paper records. Therefore patient records are fragmented and as such, practitioners do not always have access to a full set of records. This has been recognised as a gap by management and we are aware of a new IT system which will be launched from 1st February 2016 to help address this problem. This means that all patient related information will be held on one electronic IT system.

5.3 Training and supervision

5.3.1 Access to safeguarding training ensures continuous professional development and that practice has a strong evidence base. Compliance with training attendance for safeguarding level one, two, three and four stands in excess of 95% at NT&H NHS FT. We were advised the training has been approved by the LSCB and that it is in line with the requirements of the intercollegiate guidelines.

5.3.2 The arrangement for training and supervision within the looked-after children's service is limited. The looked-after children's team have regular contact with vulnerable children and young people; therefore, it is vital that practitioners have access to additional training in respect of CSE, FGM, radicalisation or any other training in relation to contemporary CP matters. We were informed that safeguarding supervision is available from the safeguarding team on an *ad hoc* basis if required; however, rarely used. There have been several findings from serious case reviews which cite how the role of supervision in relation to the development of skills and judgement is strongly advocated. Good reflective supervision is therefore the cornerstone to effective professional practice for those working with complex cases. Practitioners working with looked-after children in delivering health services should make sure that their systems and processes track and focus on meeting the needs of each child's physical, emotional and mental health needs and therefore receive training, supervision, guidance and support accordingly. (**Recommendation 2.21**).

5.3.3 All midwives undertake level three multi-agency safeguarding training. In addition there is an expectation that all midwives will attend level three plus training, which includes at least one multi agency session every three years'. A range of topics are on offer, including training sessions on VEMT, CSE, FGM, neglect and addictive behaviours. Safeguarding training to the appropriate level helps ensure that all staff have competence to assess, plan, intervene and evaluate the needs of new born babies and parenting capacity where there are safeguarding or CP concerns.

5.3.4 In both midwifery and health visiting there is an expectation that one-to-one safeguarding supervision with the safeguarding named nurse team at the trust will be accessed as a minimum four times throughout the year. However, it is currently the duty of the practitioner to decide which cases to take to supervision. This current arrangement could restrict supervisory oversight and the opportunity for a degree of professional challenge. (**Recommendation 2.22**). ***This issue has been drawn to the attention of Public Health, as the commissioners of the health visiting service.***

5.3.5 The safeguarding named nurse administrative team regularly monitor the number of safeguarding CP cases, and which practitioner has attended and accessed safeguarding supervision within the recommended timeframe. However, there is currently no monitoring of CiN cases, which means that performance cannot be effectively monitored. (**Recommendation 2.23**).

5.3.6 All newly qualified health visitors are allocated a mentor based in the same office as them, as well as a preceptor from a different team. Regular meetings are facilitated in order to ensure ongoing support is provided in terms of managing caseload commitments. In addition one-to-one and group preceptorship meetings are scheduled, which is important as this creates the opportunity to share learning and their experience with peer groups. The twelve-month preceptorship programme also incorporates assessment and validation of safeguarding competencies. This is good as it helps ensure that practitioners understand and demonstrate their knowledge and awareness of safeguarding practice. In addition, where identified, more experienced practitioners or mentors support newly qualified health visitors at CP conferences, in making SAFER referrals or when producing reports for conference to ensure a good standard of practice.

5.3.7 We were informed that school nurses are compliant with level three safeguarding training. School nurses reported feeling well supported by the trust safeguarding team. The trust safeguarding team supports school nurses at initial CP conferences and or strategy meetings if identified. School nurses also have good access to both scheduled and *ad hoc* one-to-one safeguarding supervision. Supervision notes are reportedly kept on the child's records; however, we did not see evidence of this in cases sampled. ***This issue has been drawn to the attention of Public Health, as the commissioners of the school nursing service.***

5.3.8 The CASH service access level three safeguarding training from NT&H NHS FT. However, the perceived lack of open access to additional multi-agency training is a gap. Accessing multi-agency training is vital in order to share knowledge and experience so that practitioners are better informed and able to tackle a range of risk factors in vulnerable young people. Virgin Care has additional topic specific e-learning packages, therefore ensuring that CASH practitioners' knowledge remains up-to-date with important safeguarding matters. ***This issue has been drawn to the attention of Public Health, as the commissioners of the CASH service.***

5.3.9 Formal safeguarding supervision arrangements are in place within the CASH service with very robust management oversight of vulnerable service users. Practitioners reported that they have good access to *ad hoc* advice and support on request from the safeguarding champions and we saw evidence of one champion being asked to jointly see a young person for assessment when risks and vulnerabilities were identified.

5.3.10 CAMHS practitioners receive regular, scheduled safeguarding supervision, which is meaningful and relevant. There are three practitioners from CAMHS who have had specific training in safeguarding supervision and who carry out all of the safeguarding supervision for the service, thus developing a certain level of expertise. The TEWV trust is committed to increasing the number of practitioners who are trained to provide such supervision. During the week of our inspection for example, the safeguarding team were running an additional two-day course to increase the number of authorised managerial staff who could provide safeguarding supervision to practitioners in a variety of roles.

5.3.11 The CAMHS team maintain a bespoke database set up specifically to monitor safeguarding supervision. Each team member is required to undergo safeguarding supervision on each of the cases they hold for children subject of a CP plan every three months or more frequently if required. Each child who is either subject of a CP plan on entering the service or who becomes subject of a CP plan whilst in service is entered on to the database, allocated a care coordinator and a designated supervisor. The supervisor then tracks safeguarding supervision sessions as well as attendance at core group meetings and CP conferences. In this way the trust can be assured that the protection of children subject of a CP plan are properly considered through a robust system of supervision. As a corollary, however, case workers for children who are categorised as 'in need' or for whom there are concerns where a CP plan is not in existence do not have the same level of supervision. This means that not all children who are vulnerable are subject to the same level of scrutiny. (**Recommendation 4.3**).

5.3.12 In CAMHS we looked at two records of children where the case worker had received safeguarding supervision routinely according to the trust's approach. We found that the level of detail of the record of the discussion and the articulation of the current or ongoing risks was exemplary. We saw, for example, that the stated aims of a supervision session were to enable the practitioner to reflect on their practice and their involvement and to ensure they completed all relevant documentation. The outcome of the supervision sessions was a time-bound action plan focused on the child's needs. All such sessions were recorded in a structured format on the child's record and this is considered to be best practice.

5.3.13 Arrangements for the training and supervision of the named nurse at the University Hospital of Hartlepool reflect intercollegiate guidance. The acting named nurse has access to one-to-one supervision with the designated nurse and continues to attend a programme of level four safeguarding training.

5.3.14 The training needs analysis for ambulatory care and the emergency assessment unit has incorrectly identified that only senior nurses need to access level three safeguarding training. As young people aged 16 and over are admitted to these departments, predominantly following an incident of self-harm or with mental health need, it is important that all staff working with this cohort of young people are trained to the appropriately level. (**Recommendation 2.24**).

5.3.15 Health professionals working on the paediatric wards have not attended any training on working with children and young people with additional emotional health needs. We were told that if a young person needed additional observation, then this would be provided by the existing nursing establishment. (**Recommendation 3.2**).

5.3.16 All ED practitioners are trained to safeguarding level three and adult practitioners who provide nursing support to the paediatric ED have extensive experience of working with children and young people. In addition, they have attended advanced paediatric life support training. The staff skill set is part of the supporting information used when working out rostering and this ensures that the paediatric ED is appropriately staffed by experienced nurses. However, the MIU does not always have a paediatric nurse on duty, although practitioners reported that all nurses have undertaken paediatric competency training and PILS (paediatric intensive life support) training.

5.3.17 No formal scheduled safeguarding supervision is in place at the ED or MIU. Whilst supervision of safeguarding children at the ED has been strengthened to ensure there is good access to it, with practitioners reporting discussing various types of cases, including early help, CiN and CP, it is not mandated as part of the trust safeguarding supervision policy. This needs to be integrated into the policy as effective supervision ensures that practitioners are able to reflect and transfer their learning and apply it to their day to day work. (**Recommendation 2.25**).

5.3.18 Not all GPs visited were compliant with level three safeguarding training. In one practice, the safeguarding lead GP had not accessed any level three training in two years. Most practice nurses are trained to level three, with plans in place to ensure that those who had not yet accessed the appropriate training for their role. (**Recommendation 6.6**).

5.3.19 We were informed there have been a number of local CSE campaigns, including the police attending the GP engagement sessions, to help raise awareness about CSE. However, despite concerted effort, we found that GPs only had a basic awareness of CSE and that the training provided and toolkits available it is not at the forefront of practice. We found this to also be the case for FGM. (**Recommendation 6.7**).

5.3.20 Adult mental health practitioners are trained to level three with access to multi-agency training through the LSCB. They are reported to have good engagement and shared learning with GPs. This includes training for GPs around mental health issues as part of their “lunch and learn” sessions, which has had a good uptake and has impacted on more appropriate referrals being received from GPs.

5.3.21 Formal safeguarding supervision arrangements and access to *ad hoc* advice are in place for adult mental health practitioners. Practitioners reported that evidence of discussion is recorded in notes; however, this was not evident in cases reviewed. (**Recommendation 4.4**).

5.3.22 Not all practitioners in adult mental health and CAMHS are aware of the functionality of the electronic IT system to support the complete storage of documentation related to CP or CiN processes. The filing of paper records is a risk as it means the practitioners are not fully sighted on their contribution in the CP plan. (**Recommendation 4.5**).

5.3.23 There is more work to be done to ensure that safeguarding supervision is embedded in the adult substance misuse services. Practitioners currently have access to general group supervision every six weeks, which incorporates safeguarding supervision. Although group supervision enhances shared learning opportunities, one-to-one safeguarding supervision is an opportunity to address individual emotional needs of staff working with CP cases and to assess and develop compassionate resilience to the impact of their work. This may not be obvious in group sessions and the onus is placed upon the worker to recognise and request one-to-one safeguarding supervision. Cases for discussion are being identified by adult substance misuse practitioners; however, there is currently no management oversight of safeguarding activity or practice in place to ensure that all safeguarding issues have been considered and brought forward for discussion. We were informed that a safeguarding supervision pro-forma is completed; however, this is not currently being held on patient records. Therefore, we could not be assured that any identified outcomes for practitioners following supervision were being actioned. In addition, as practitioners are regularly holding CP cases, they need to have dedicated safeguarding supervision sessions, which can help facilitate best practice for children and young people. ***This issue has been drawn to the attention of Public Health, as the commissioners for adult substance misuse service.***

5.3.24 We were informed that all adult substance misuse practitioners have been appropriately trained to level three provided by the LSCB. There is also an expectation by management that adult substance misuse practitioners access some form of safeguarding training annually, which has included training on the CAF, CSE and domestic abuse.

Recommendations

- 1. NHS England, Hartlepool and Stockton-on-Tees CCG and North Tees and Hartlepool Foundation Trust should:**
 - 1.1 Formalise arrangements for sharing information between GPs, maternity and the community health teams, including health visiting and school nursing, to ensure that multi-disciplinary exchange of information takes place for vulnerable children and young people or those at risk.

- 2. Hartlepool and Stockton-on-Tees CCG and North Tees and Hartlepool NHS Foundation Trust should:**
 - 2.1 Ensure that ED practitioners have access to and adhere to a left before treatment protocol.
 - 2.2 Ensure that important information captured at the booking in process is available for ED practitioners, so they are well supported during the initial assessment of a patient.
 - 2.3 Ensure that record keeping practice in the ED is strengthened, so that practitioners are effectively utilising the tools available to them. This will need to be audited to monitor compliance.
 - 2.4 Formalise the arrangements to ensure that ED practitioners are routinely assessing the vulnerabilities of older young people.
 - 2.5 Develop adequate paediatric liaison arrangements in both ED and MIU, to support best safeguarding practice and to effectively facilitate communication with community and primary care teams. This will help ensure that potentially vulnerable children and young people are appropriately followed-up in the community.
 - 2.6 Ensure all young people admitted to wards at University Hospital of Hartlepool and the University Hospital of North Tees for medical treatment whilst waiting for formal CAMHS assessment are each formally risk assessed to ensure both their safety and that of others on the ward.

- 2.7 Ensure that adult documentation sets out appropriate prompts and trigger questions to best support practitioners assessment of the potential for hidden harm to a child when adults present as a result of risky behaviours in both the ED and MIU.
- 2.8 Develop a robust system to ensure that ED practitioners are notifying the midwifery service of all pregnant women who attend the ED following an incidence of DV. This is to ensure that the midwifery service, caring for the pregnant women have access to all important information in order to effectively offer support to the women in the community and to safeguard the unborn baby.
- 2.9 Ensure women are made aware that they will be seen alone at least once during pregnancy and incorporate this into the antenatal appointment care plan.
- 2.10 Ensure that inter-service liaison meetings between midwifery and health visitor teams are embedded to support consistent effective information sharing and cohesive multi-disciplinary practice.
- 2.11 Ensure that MIU practitioners have access to a CSE risk assessment toolkit to inform their assessments of whether a child or young person is at risk of exploitation.
- 2.12 Ensure that the looked after children's specialist service is adequately resourced to effectively undertake commissioned services, including quality assurance and development work.
- 2.13 Develop robust systems to collate and utilise information from all health services for children and young people new into care to ensure an accurate and meaningful assessment of need.
- 2.14 Ensure that family medical history and the reason for coming into care for looked-after children is recorded and transferred onto the health assessment documentation as part of initial health assessments.
- 2.15 Ensure that consent is recorded properly for both initial and review health assessment. This will need to be subject to audit to monitor compliance.
- 2.16 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.

- 2.17 Ensure that the looked-after children's service have access to and adhere to a formal CSE risk assessment tool and protocol and that practitioners are trained appropriately to identify CSE risk factors when working with vulnerable children and young people.
- 2.18 Ensure that all young people leaving care routinely have access to their health histories or a summary of them.
- 2.19 Develop effective arrangements to quality assure the work of the looked-after service, including initial and review health assessments for looked-after children and those who are placed outside of Hartlepool.
- 2.20 Ensure that GPs are receiving timely discharge summaries of children and young people discharged from ED and implement a system to quality assure the level of detail included so that community teams are better informed.
- 2.21 Ensure that the specialist nurse for looked-after children has access to regular scheduled safeguarding supervision and contemporary training relating to safeguarding matters in order to effectively identify risk and safeguard children and young people.
- 2.22 Strengthen safeguarding supervision arrangements so there is less reliance on individual practitioners to identify cases for discussion.
- 2.23 Develop robust monitoring system for CiN cases in order to effectively monitor performance.
- 2.24 Ensure that level three training for all relevant staff is provided in accordance with the intercollegiate guidance on roles and competences issued by the Royal College of Paediatrics and Child Health.
- 2.25 Ensure that practitioners at the ED and MIU have access to regular safeguarding supervision in order to fully support their safeguarding practice on a day to day basis.

3. Hartlepool and Stockton-on-Tees CCG, Tees & Esk Wear Valley NHS Foundation Trust and North Tees and Hartlepool Foundation Trust should:

- 3.1 Ensure communication channels are strengthened between the CAMHS and school nursing service in order to ensure that school nurses are best able to support children and young people with whom they may have contact.
- 3.2 Ensure that paediatric nursing staff both at the University Hospital of Hartlepool (paediatric day unit) and the University Hospital of North Tees are provided with appropriate training in caring for young people with mental health difficulties and those who self-harm.

4. Hartlepool and Stockton-on-Tees CCG and Tees & Esk Wear Valley NHS Foundation Trust should:

- 4.1 Ensure that adult mental health practitioners are supported by systems which enable them to easily identify all children and young people of adult service user, not just those subject to CP or CiN plans.
- 4.2 Ensure that adult mental health develop a robust auditing system to monitor and check compliance with recording of safeguarding information.
- 4.3 Strengthen safeguarding supervision arrangement to incorporate those cases categorised as CiN, in order to ensure they receive the same level of scrutiny as CP cases.
- 4.4 Ensure patient records are complete within adult mental health service by routinely recording supervision discussions and their outcomes.
- 4.5 Provide refresher training for all staff on how to use PARIS IT system and ensuring all relevant information is readily accessible on patient records.

5. Hartlepool and Stockton-on-Tees CCG should:

- 5.1 Evaluate and monitor the current arrangements for the Designated Doctor for looked-after children's service and continue to prioritise recruitment to the post, in order to support the development of looked-after children provisions in Hartlepool.

6. NHS England and Hartlepool and Stockton-on-Tees CCG should:

- 6.1 Work with the local authority to implement a robust system to ensure that GPs have copies of updated child protection plans, core group and child in need meeting minutes and plans, including those that 'step down' from protection measures are available for practitioners, so that they can be appropriately filed on the patient records.
- 6.2 Implement a robust system to help ensure that GPs are appropriately flagging vulnerable children and young people on their caseload.
- 6.3 Ensure that GPs have a good understanding of their role and responsibilities in the provision of good health care for looked-after children and that they have the opportunity to contribute routinely to initial and review health assessments.
- 6.4 GPs to ensure they are regularly updated on looked-after children status, in order to keep their records up-to-date.
- 6.5 Implement robust quality assurance measures in primary care to ensure information that is scanned onto paper records is legible.
- 6.6 Ensure that all primary care practitioners have access the level three safeguarding training in accordance with the intercollegiate guidance on roles and competences issued by the Royal College of Paediatrics and Child Health.
- 6.7 Ensure that all primary care practitioners are aware of and competent in the use of the CSE toolkit.

Next steps

An action plan addressing the recommendations above is required from NHS Hartlepool and Stockton-on-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.