

Review of health services for Children Looked After and Safeguarding in County Durham

Children Looked After and Safeguarding The role of health services in County Durham

Date of review:	14 th November – 18 th November 2016
Date of publication:	6 th April 2017
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Provider services included:	County Durham and Darlington NHS Foundation Trust (CDDFT) Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) Harrogate and District NHS Foundation Trust (HDFT). Lifeline – third sector provider for adult and child substance misuse
CCGs included:	Durham Dales, Easington and Sedgefield CCG North Durham CCG
NHS England area:	North
CQC region:	North
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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 County Durham. It focuses on the experiences and outcomes for children within the geographical boundaries of the local authority area and reports on the performance of health providers serving the area including Clinical Commissioning Groups (CCGs) and Local Area Teams (LATs).

Where the findings relate to children and families in local authority areas other than County Durham, 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 121 children and young people.

Context of the review

Most of County Durham residents are registered with a GP practice that is a member of NHS Durham Dales, Easington and Sedgefield Clinical Commissioning Group population 281,249 (53.2%) which covers a huge geographical area and includes some of the most deprived communities in England and some of the most rural areas of the country. There are significant challenges to delivering healthcare in the more rural areas. The population also faces higher than average unemployment rates, severe deprivation, poor housing and isolation in many of the rural communities, all of which contribute to the significant health inequalities across the CCG and a complex health profile. At least 50% of the population in this CCG area has at least one long term condition.

NHS North Durham CCG with 239,155 population (45.2%) operates in the North of the county and includes the conurbation of the City of Durham plus Chester-le-Street, Consett, Lanchester. This CCG hosts the safeguarding service for both CCGs.

Durham Dales, Easington and Sedgefield CCG (DDES CCG) commissions County Durham and Darlington NHS Foundation Trust (CDDFT) to provide acute based services and midwifery (North Durham Clinical Commissioning Group, NDCCG, also holds a contract as an associate commissioner).

DDES CCG also commissions acute and midwifery services from North Tees and Hartlepool NHS Foundation Trust (NTHFT) for residents of East Durham.

DDES CCG and NDCCG commission speech and language therapy (SALT) and paediatric occupational therapy services from North Tees and Hartlepool NHS Foundation Trust for the whole of County Durham.

DDES CCG commissions acute services from City Hospitals Sunderland (CHS) for residents in the Easington locality this includes a community midwifery team in Seaham (not visited as part of this review).

NDCCG commissions mental health and learning disability services for children and adults from Tees, Esk and Wear Valleys NHS Foundation Trust. (DDES CCG has a contract with the same provider as an associate commissioner).

DDES CCG as lead commissioner commissions the looked after children's health team and medical advisor provision to fostering and adoption processes. These staff are employed by CDDFT.

The public health department of Durham County Council (Local Authority) commissions health visiting and school nursing to undertake review health assessments for looked-after children. The public health department of Durham County Council also commissions the 0-19 health child pathway which is provided by Harrogate and District NHS Foundation Trust.

Durham County Council commissions the Full Circle service to provide therapeutic input in respect of emotional support and attachment issues. Some of the staff in Full Circle are employees of TEWV.

The public health department of Durham County Council commissions the contraception and sexual health services. These services are provided by CDDFT.

Substance and alcohol misuse services for adults and young people are commissioned by the public health department of Durham County Council and provided by Lifeline - a registered charity.

The adult sexual assault referral centre (SARC) is commissioned by NHS England and is provided by Durham Constabulary. Durham County Council public health contributes to the costs of commissioning of the SARC. Children's acute sexual assault service is provided by the Northern Paediatric Forensic Network based at the Great North Children's Hospital in Newcastle Hospitals NHS FT and the historic child sexual abuse service is provided by CDDFT. (These services were not visited as part of this CLAS review).

NDCCG host the 3 x 0.6 designated nurses for safeguarding and looked after children on behalf of three local CCGs (ND CCG, DDES CCG and Darlington CCG). One nurse is aligned to each CCG but they cover in each other's absence.

The designated doctors for safeguarding children, looked after children and child death are commissioned by ND CCG from CDDFT (3 different consultants).

Both NDCCG and DDES CCG employ named GPs for 3 sessions each.

The County Durham joint Ofsted/CQC inspection of safeguarding and services for looked after children (SLAC) took place in November - December 2011 (published in January 2012). The inspection findings for health were as follows: The contribution of health agencies to keeping children and young people safe – Good and Being Healthy – Good.

Recommendations from that inspection were encompassed by the lines of enquiry for this CLAS 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 foster carers;

One carer said she felt exceptionally lucky to have a good health visitor in the Seaham area, who has been there a long time and is very thorough.

“We are so lucky to have her; she is thorough and understands the needs of the children in our care as well as our needs as carers”. “Initial health assessments are good, timely and most importantly there is continuity in the paediatrician. She can offer flexibility in time slots at a close-by clinic. She is open and encourages regular and direct contact anytime we want to speak with her, and we have always had a prompt response from her across all the age ranges we have fostered”.

“We receive the looked-after child’s health plans within 3-4 weeks of health assessment appointments; we’ve never not had a copy of health paperwork.”

“Unfortunately, for more specialist appointments such as heart scans etc. at the hospital, the waiting times are getting longer and longer”

“We have had good experiences of the IHA and RHA process, with RHAs completed by a LAC specialist nurse as this is an out of area placement. The care and support we get from health is excellent, we’ve always been happy with the content of assessments and follow up when it is needed, the written reports we get always reflect exactly what has been discussed”.

“The LAC paediatrician will “go the extra mile” and expedites the tests which asylum seeking children need to have, often continuously checking if the GP paperwork has come through to try and mitigate process based delays”.

A parent whose child was supported by CAMHS told us;

“The Crisis CAMHS team are heavily involved in my daughter’s care. They are absolutely fantastic, I cannot fault them. I cannot recommend them highly enough. I felt listened to and helped by my psychologist to know the best way to work with my daughter”

“It is nice to know they will be there for her when she gets discharged. They have shown empathy and understanding and have found ways to engage with her and encourage her to communicate”

“Her younger sibling is able to get support from CAMHS too and talk about any concerns she may have. That’s very helpful”

A parent of a young person awaiting an autism diagnosis who has been out of school for some time said;

“It’s just hard, it feels you are shouting but no one is listening- hard, but frustrating too when it’s your kid”

“The help from CAMHS is not frequent enough – every 3 weeks and it is now a month since we have seen anyone. The 30 minute slot is not long enough to build trust. Her worker does not work school holidays which further delayed progress”

Grandparents who are carers of young person who experienced severe depression told us;

“We were initially disgusted with the lack of help available, but after we made a fuss things changed and we got the level of support our grandchild needed. The team we now have is excellent and she is making good progress”

“A teacher also visits 4 times a week. The consultant psychiatrist has been wonderful- I cannot praise her enough. She helped us get others on board”

A parent waiting in the emergency department for their child to be treated said;

“We did not have to wait long to be initially seen, but it is a shame there are no toys available to help my child pass the time”.

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 Midwives in County Durham and Darlington NHS Foundation Trust (CDDFT) undertook an antenatal home assessment of every pregnant woman and were alert to relationship issues. Families whose first language is not English were well supported with interpreting support to ensure their engagement and understanding at all stages from booking in to postnatal care.
- 1.2 Handovers to health visitors from midwifery worked well and the early introduction of the *Baby Buddy* app by midwives and which was continued into health visiting also supported this pathway for the mother. There was written handover of most vulnerabilities and concerns through the antenatal risk assessment form which included consideration of mental health and substance misuse. Midwives make routine enquiry about domestic abuse and share this information in their liaison with health visitors.
- 1.3 CDDFT had strengthened its offer to teenage parents and the service benefited from having a teenage pregnancy champion in each of its community teams with teenage clinics available to promote greater levels of choice and support. This targeted support was important given that the local family nurse partnership (FNP) service which had previously supported young first-time parents had been decommissioned.
- 1.4 There was positive use of a caseload weighting tool in the health visitor service which was effective in keeping practitioners' caseloads within parameters recommended in national guidelines. Thematic leads among the health visitor locality managers helped to support frontline specialist practitioners in working with vulnerable cohorts whilst ensuring that all health visitors develop skills, knowledge and experience of a range of vulnerabilities.

- 1.5 There were strong joint working arrangements between GPs, midwives, health visitors and school nurses facilitating the early identification of vulnerable unborn children and families through GP safeguarding meetings. These were well established in all practices across the county. Midwives also held a monthly meeting with health visitors to share information and keep each other up to date about progress and areas of concern surrounding individual pregnancies. Practitioners and managers felt that this forum had been an important way of maintaining cohesive multi-disciplinary working following the community health staff's transfer to a new provider, Harrogate and District NHS Foundation Trust (HDFT).
- 1.6 Health visitors and school nurses were well engaged with multi-agency early help support service arrangements; co-location with other disciplines in the One Point hubs facilitated sound co-operative working and joint visiting. Team around the family (TAF) was well established to support vulnerable families with 0-19 practitioners participating fully; either as TAF members or as the lead professionals co-ordinating the TAF. This ensured that children and young people whose health needs were prevalent had their support co-ordinated by the most appropriate person. We saw that school nurses had a good understanding of the thresholds and made reasoned judgments about the levels of need. 0-19 practitioners were also fully engaged in the stronger families work for those meeting the national Troubled Families criteria.

Case Example:

A young mother who had previously been subject to a child protection plan herself had two small children and was struggling to cope. She was getting little support from her partner. Case was managed at a team around the child level (TAF) with close involvement of the family support worker and the health visitor. There were significant financial and housing issues adding to pressures within the family

As a result of an effective TAF approach;

- The family was rehoused and were supported to start clearing their debts.*
- Mum became more engaged with services and developed a greater level of confidence*
- Both children's' immunisations were brought up to date*
- The older child is now hitting developmental milestones*
- Children moved to universal services*

- 1.7 There was good collaboration between the local authority and school nursing for children educated at home to ensure that the offer of health support was made to those families unable to access the service through the usual school route. This provided an opportunity for school nurses to identify any additional support needs for this group of children who may have additional vulnerabilities and who have been the subjects of national serious case reviews (SCR) in the past.

- 1.8 Emergency department (ED) facilities for children at University Hospital Durham were extremely limited. There was no separate waiting area for children, no toys to help occupy children although we were advised that infection control issues prevented the provision of toys. We were advised that there is a plan for separate ED paediatric facilities in the locality, but the details in relation to development and timescale were unclear.
- 1.9 The small area designated off the main waiting room was not in direct sight of the nursing or reception staff. This risks potentially critical delay in the identification of a child with a rapidly deteriorating condition. There have been a number of SCRs nationally concerning children whose deteriorating condition had not been identified sufficiently quickly while in the ED of acute hospitals due to staff being unable to directly observe the child. We were also concerned that there was an extremely low provision of paediatric trained nurses in the ED and which was about to reduce further due to staff leaving. This deficit had been raised previously in the 2015 CQC inspection of the trust (**Recommendations 1.1 and 1.2**).
- 1.10 CDDFT's ED paediatric assessment tool CWILTED did not provide a sufficient focus on risks to/or the vulnerability of children and young people, including those with mental health needs. CWILTED provided a limited picture of Condition, Witness, Incident, Time and who escorted. Cases seen demonstrated basic information only being recorded which did not effectively capture key information in relation to children's vulnerability. Routine questioning of whether the child has a social worker for example, was not undertaken, and key detail about adults accompanying the child were not sufficiently clear in terms of their full name and parental or carer responsibilities.
- 1.11 We noted that remedial action was taken by the trust to address this deficit when it was identified during the review. It was not clear from some case records in the ED that planned actions had been followed through or that advice and guidance was always being sought from the trust safeguarding team, midwives or children's social care when the need or benefit of this was clearly indicated (**Recommendation 1.3**).

Case Example:

A woman in the early stages of pregnancy attended County Durham and Darlington NHS Foundation Trust's University Hospital Durham ED for treatment following self-harm. She then attended again two months later at 22 weeks gestation. Risks were identified in relation to substance misuse and that there was a social worker involved. The woman was seen by the mental health crisis team before discharge.

Emergency department notes indicated there was a plan for the clinician who treated her to discuss the case with the social worker the next day but there was no recorded evidence that this was followed up with children's social care, discussed with the safeguarding lead or that further discussion has been had with midwives regarding risks to the unborn child.

- 1.12 CDDFT ED and paediatric assessment documentation did not include a mental health risk assessment tool. The ED used the SAD tool for adults. It was recognised that this was not appropriate for use with children and had been withdrawn (but not replaced/adapted) in the review of the self-harm pathway. Risk assessment documentation lacked prompts and trigger questions; was reliant on the professional understanding and curiosity of the examining clinician in identifying child safeguarding concerns. Cases we reviewed demonstrated that professional curiosity was lacking on a number of occasions resulting in less than comprehensive risk assessment and identification. Recording of clinicians' actions and voice of the child was weak in ED and the urgent care centre (UCC) which we visited and there was limited evidence to demonstrate that young people were routinely seen alone to enable them to express their views and disclose any sensitive information within consultations or examinations (**Recommendation 1.3**).
- 1.13 Focus on the identification of the hidden child in the adult ED at University Hospital and at the UCC was lacking. Adults who presented at ED were not routinely asked if they have parenting responsibilities or have a social worker. This gap in basic information seeking was clearly illustrated by one of the cases we tracked across services: given the question of parental responsibility or social work involvement was not asked, ED staff were unaware of a long-standing history of concerns about the family undermining the robustness of their safeguarding risk assessment. The approach to identifying children at potential risk of hidden harm from adults who present as a result of risky behaviours, mental ill health or domestic violence was also underdeveloped. This means that some children who may be exposed to significant risk might not be identified by acute health staff and their health and wellbeing may not be protected as a result (**Recommendation 1.4**).

- 1.14 Discharge documentation for the paediatric ward included reference to safeguarding however, the ward manager and named nurse identified this was an area to strengthen as auditing indicated a relatively low level of compliance with its completion among ward practitioners. There was no effective system in place for supervisory staff to review documentation at the point of discharge as part of their practice monitoring responsibilities to ensure all potential risks had been considered (**Recommendation 1.5**).
- 1.15 There was variation in the standards of information contained in notifications sent to GPs and community health teams when a child had attended the acute setting for emergency treatment and how useful this was in helping those practitioners make decisions about clinical or safeguarding follow-up. A range of health practitioners told us that notifications from the UCCs through the shared electronic patient records system were generally of a good standard, but that this was not the case for the ED at Durham University Hospital where notifications for the most part contained minimal information which was not helpful in community health services and primary care making decisions about follow-up (**Recommendation 1.6**).
- 1.16 The integrated substance misuse service in Durham was provided through a collaborative arrangement where Lifeline, a charity, provided the recovery service with clinical support from nursing staff from Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV). Part of the service offer was the children and young people and families' team; integral to the service's capacity to deliver early help opportunities. This provided a good range of early help opportunities aimed both at young people and at adults whose behaviour has an impact on children. One example being the time-bound education and recovery programme 'Community Reinforcement and Family Training' (CRAFT). The children and young people and families' team had a presence in each of the ten 'One Point' early help hubs, in the MASH single point of access and in each of the Lifeline recovery centres. As such, the team represented a wrap-around support service for adults who misuse substances, for children and families who are affected by an adult's drug and alcohol misuse and for young people who themselves misuse substances. This was particularly beneficial for young service users who were approaching adulthood where their transition into an adult service was facilitated by the team.
- 1.17 Lifeline had also begun to operate a programme known as 'I see, I hear' designed to educate adults about the impact of their substance misuse on children they have access to and we saw examples of both of these initiatives. The service employed a dedicated practitioner working with the local police to engage young people in a harm reduction pathway when they were brought to the police station as a result of their alcohol consumption although we did not see any examples of this during our visit. Nonetheless, through these initiatives, the service was proactive in supporting young people to stay safe and enabling adults to modify and lessen the impact of their behaviour on their families.

- 1.18 In the child and adolescent mental health service (CAMHS) provided by Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV), progress on transforming services in line with *Future in Mind*¹ was beginning to be made. Action taken to streamline the referral pathway through the single point of access (SPA) and strengthen capacity in the eating disorder and crisis teams was leading to a more timely response at the initial point of need although performance was not yet where it should be. Effective follow up support to help the young person's recovery as they moved through to the care of specialist teams was being put in place. However, significant concerns remained regarding the lengthy waiting time for autistic spectrum disorder (ASD) assessments of between 18-24 months at the time of this inspection and this was of concern to parents we spoke with. TEWV was working to streamline the processes and had advertised for extra ASD co-ordinators. Gaps also remained in services provided through the local authority's education psychology, and North Tees and Hartlepool NHS Foundation Trust's SALT and OT capacity, which inhibited progress on achieving good access to these specialisms.
- 1.19 CAMHS had provided support to mental health leads in schools and in primary health care and this was helping to strengthen identification and support for young people who are at risk of self-harm. We found examples of CAMHS practitioners promoting equality and human rights in their practice and across health services there was generally good attention to recording the ethnicity and religion of children, young people and parents. This knowledge and understanding of the implications for healthcare can be instrumental in how medical treatment and care can best be delivered and was therefore, important good practice.
- 1.20 The MEND programme for young children who are overweight provided good support to children and young people. In one case example of a young boy who was overweight, his parent told us that she had valued him being able to join in activities on this programme throughout school holidays. This had helped address his weight issues and build his confidence.

¹ Future in Mind, promoting, protecting and improving our children and young people's mental health and wellbeing (2015)

- 1.21 The home environment assessment (HEA) tool was an important new development initiated from learning from the 2014 Darlington CQC CLAS and a serious case review. Its implementation across multi-disciplinary and multi-agency services is innovative however; being routinely used by midwives and health visitors, and being introduced in wider services such as housing. This is an evolving tool and we note it had been strengthened with the inclusion of learning from a local SCR as to whether there are locks or bolts on bedroom doors. There was scope to develop the HEA further. There was no prompt for final risk analysis by the practitioner or guidance about what action might or should result from the risk assessment and subsequent analysis. Inclusion of these would strengthen this tool and potentially enhance its impact on multi-agency risk assessment significantly (**Recommendations 1.7 and 3.1**).
- 1.22 Young people had good access to a range of contraception and sexual health services across the county and these were appropriately targeted at areas of higher need and communities with limited access to public transport. The health improvement practitioners' (HIPs) role provided effective and targeted support leading to good outcomes for young people through their improved health and wellbeing. Taking more of a risk assessment based approach to whether the three contacts offered by the HIPs are home visits or telephone contact would strengthen this offer. The Optimum and Primetime programmes for small cohorts of teenage or young mothers operated by the local authority had proved effective in promoting young people's continuous engagement with education.
- 1.23 The sexual health service was well engaged with the missing and exploited group (MEG) arrangements and with the child sexual exploitation team, ERASE. We found some examples of good recording of clinicians' observations of young people's body language and demeanour where this gave the practitioner cause for concern; although this was not prompted as part of the assessment tool within the electronic system so that it becomes routine embedded practice (**Recommendation 4.1**). *This has been drawn to the attention of Durham County Council Public Health as the commissioner of the sexual health service.*
- 1.24 The school nursing service maintained an effective relationship with the ERASE team and had an active presence at case discussion meetings where they contributed to assessment and re-assessment of young people at risk of CSE. This enabled them to undertake actions arising from the case discussions so that young people, and in some cases their families, had opportunities to benefit from preventative and supportive health interventions. This included receiving sexual health and contraceptive advice and being supported with work to improve their self-esteem and emotional wellbeing.

- 1.25 The adult mental health service had a 'liaison and diversion' team. This was an all-age service aimed at both young people and adults who come into contact with the criminal justice system, either because they are in police custody or going through the courts or youth offending system. The team took an early intervention approach to assess and provide advice about people to help the police and Crown Prosecution Service or the courts to make decisions about offenders. The team also signposted or referred clients to relevant services. This initiative should offer diversionary alternatives to a route through the criminal justice system but it had been operating for little over a year and so its impact had not been measured.

2. Children in need

- 2.1 Women and their babies who are vulnerable to harm were supported by a clear and well-developed safeguarding pathway and the transitional care work undertaken by CDDFT had received a national award. We saw a case example of the effectiveness of this care pathway, enabling a vulnerable baby to be safely cared for when discharged home. Although there were no specialist midwifery roles for vulnerable cohorts of women, midwives were encouraged to develop areas of expertise in specific areas of vulnerability where they had special interest.
- 2.2 Midwives were appropriately engaged in a range of team around the family (TAF) and child protection activity. The CDDFT named nurse ensured midwives were kept informed about young people at high risk of sexual exploitation and who may be pregnant and midwives were familiar with the signs of exploitation.
- 2.3 The twelve month appointment of a midwife to offer enhanced support to women in local prisons was a positive recent development ensuring vulnerabilities; including mental health or substance misuse concerns, were effectively recognised and addressed.
- 2.4 The substance misuse service operated by TEWV and Lifeline worked well with midwives to support pregnant women engaged with the substance misuse service through a pregnancy pathway although there were no joint clinics. Good practice examples we saw included contingency and relapse plans put in place by the substance misuse service being shared with midwives thus facilitating the safeguarding of the unborn child.
- 2.5 There was no specialist perinatal mental health pathway in place in County Durham compliant with national guidance. While we noted that national wave two funding was being applied for to support the development of this pathway, at the time of this inspection this was an area for development (**Recommendation 2.1**).
- 2.6 The school nursing service was sufficiently well resourced to enable safeguarding work to continue through the school holidays. This ensured that key health activity to support children and young people was not delayed or overlooked. Where safeguarding processes, such as child protection conferences or core group work, were due to occur during the school holidays, practitioners prepared for this in advance undertaking a one-to-one handover of the work to another practitioner. This ensured continuity of support to children and young people who might be vulnerable or at risk during these periods.

Case Example:

A young person subject to Child in Need (CIN) and being supported by a school nurse and other professionals.

Outcomes from a CIN meeting were fully described in the child's electronic patient record in the school nurse service, including a summary of the progress against previous planned health interventions.

Through her ongoing engagement with the child and the family, the school nurse had observed deteriorating home conditions and subtle, but increased risk factors in relation to potential neglect. These evolving concerns had been recorded by the nurse in a chronology which enabled her to present her analysis to the child's key social worker.

At the time of our review this was in the process of being escalated into child protection procedures.

- 2.7 In midwifery, health visiting and the school nurse service we saw detailed observational recording by practitioners when they were undertaking home visits or examining infants and children. What we found consistently lacking however, was a clear focus on the evaluation of these observations resulting in a robust analysis of risk; gauging of whether the level of risk was changing and whether progress against CIN or child protection plan objectives was being made. Regular risk analysis and evaluation of progress in cases by practitioners helps to ensure effective safeguarding of vulnerable children and its absence can raise the risk of drift (**Recommendations 1.8 and 3.2**).
- 2.8 Along with other service providers across the Durham County Council footprint, school nurses had begun to routinely carry out home environment assessments for every home contact with children and families. We saw examples of this in the cases we looked at and the impact of this practice had been significant. For example in two of the cases, we noted that the assessment of the child's home environment had enabled the practitioner to fully understand the risks to the children, one of which had led to a child protection referral being made for neglect.
- 2.9 At the CDDFT urgent care centre (UCC) we visited, the use of a body mapping template within the electronic patient record to chart any physical injuries to children supported effective risk assessment by practitioners. This helped staff involved in the examination of a child to assess the child's presentation and supported staff who might see that child at any future consultation with strong visual information to make judgments about risks to the child. The absence of any formal protocol for when it should be used however, such as for bruising in non-mobile infants, meant that its use relied solely on staff's professional curiosity and its benefits were therefore potentially limited as a result (**Recommendation 1.9**).

- 2.10 The identification of and response to risks of child sexual exploitation (CSE) was also underdeveloped in the urgent care centre. There was no formal assessment of risks to young people who might fall within certain risk groups and we saw no risk assessment tool in use that might facilitate this. This meant that some young people at risk, particularly those who attend for sexual health advice or contraception may not be properly identified. Following the inspection we were advised that there is a risk assessment tool for CSE endorsed by the LSCB and for use by all professionals across the multi-agency network. However, we did not see evidence of its use at the UCC (**Recommendation 1.10**).
- 2.11 The number of repeat attendances at UHND's ED of young people in mental health crisis was relatively high (see context section) and was identified as an area for development from a local serious case review (SCR) on Child K. We noted the plans that were in place to address this issue and the actions being taken across the partnership, including a review of high attender cases by CAMHS. We noted that a delay in data analysis within CDDFT had slowed progress of the achievement of improved outcomes for this cohort of vulnerable children. However, a new self-harm pathway which had been put in place supported stronger partnership working between CDDFT and TEWV, with timely assessment of children and prompt follow up by the CAMHS team. This had significantly reduced the need for most children and young people having to be admitted to the paediatric ward.
- 2.12 When young people with mental health needs were placed on the paediatric ward, CAMHS support for children was valued by the paediatric team. The voice of the child was clearly and well reflected in ward records. Ward staff had good access to the mental health assessments undertaken to inform the wider delivery of care, with good evidence of effective multi-disciplinary team work to recognise and meet individual children's needs. This was helping to facilitate appropriate and timely discharge home. However, there was no provision of a systematic assessment tool that took account of environmental and personal safety/peer safety risks to ensure that risk of serious self-harm or detriment to others was minimised while the young person was an in-patient (**Recommendation 1.11 and 2.2**).

Case example:

Female aged 15 years was taken to ED having overdosed. An alert on the hospital patient record system immediately highlighted to staff that the young person was vulnerable with a history of self-harm, suicidal ideation and self-neglect.

Paediatric practitioners undertook a comprehensive assessment of risk including the risk of child sexual exploitation (CSE). A harm minimisation plan was put in place while she was on the ward and there was evidence of this being regularly reviewed.

The young person's discharge home was well planned for and followed up promptly with CAMHS intensive home support with daily/more frequent contact as required, with practitioners checking in to ensure the young person felt safe. The eating disorders service meal support texts prompted and encouraged the young person to comply with their treatment plan.

Records clearly denoted the young person's views about the effectiveness of their treatment, with recognition of the value from the young person's perspective of the 1:1 support provided by the eating disorder service.

This is one of a number of cases seen that demonstrated prompt and person-centred responses to young people in mental health crisis presenting at ED with comprehensive risk assessment and care planning by paediatric services and the specialist eating disorder service supporting their return home.

- 2.13 While paediatric ward discharge documentation included reference to safeguarding, practitioner compliance with the completion of the documentation was low. This may be impacting on the minimising of risk as the young person returns home and potentially be a factor in the level of repeat attendances (**Recommendation 1.5**).

Good Practice Example:

The Harrogate and District NHS Foundation Trust were innovative in their approach to meet the emotional health needs of young people across Durham and two examples illustrate this approach;

The school nursing service had recruited five wellbeing and resilience nurses, one in each locality, through a collaborative arrangement with the Tees, Esk and Wear Valley NHS Foundation Trust, the providers of the CAMHS. These practitioners would directly support individual children but would also provide advice and guidance to school nurses for individual children school nurses are supporting. This was further enhanced by the designation of a school nurse in each locality as an emotional health champion, and the provision of extra training for those nurses in supporting young people with their emotional wellbeing.

The school nursing service had also collaborated with Durham County Council to develop a project known as 'Youth Awareness of Mental Health' (YAM); one of only two such initiatives in the UK. This project involves the training of four members of the council's educational psychology team and 11 identified members of the school nursing workforce to deliver five classroom sessions to year nine students (ages 13 and 14) over the course of an academic year. The classroom sessions are designed to build confidence and self-esteem in young people to help them manage their own feelings and anxieties.

Delivery of the programme was due to start in January 2017 and its impact will be evaluated by Teesside University.

- 2.14 While we saw some positive CAMHS case work with beneficial outcomes for the child from the therapeutic intervention, there was too much variation in the standard of practice across cases. We saw one case where safeguarding and clinical practice in CAMHS was not robust; there were also gaps in relation to this case in adult mental health (**Recommendation 2.3**).
- 2.15 TEWV had identified transitions from CAMHS to adult mental health as an area for further improvement within the service benchmarking against *Not Seen: Not Heard (CQC 2016)*. However, joint assessment between Durham and Darlington crisis and liaison teams was enabling more young person-centred and holistic recognition of risks within individual pathways. A CQUIN target in place for the last three years had helped to support seamless transition and generally the target had been met, although we noted that performance had fallen in the last quarter before this inspection.

- 2.16 Adult mental health practitioners demonstrated good insight into the impact of adult mental ill-health on children and the need to consider this when engaging with clients. The daily 'huddle' meetings held within each team to discuss every new case or cases of concern and other regular team forums helped to keep the profile of children high in day-to-day practice. Practitioners were supported to 'think family' through the use of mandatory child safeguarding questions as part of the assessment tool embedded within the electronic case management system. We saw case examples of adult mental health practitioners working co-operatively and in direct liaison with other disciplines and professionals and practitioners were active members of TAFs which were well embedded. Practitioners were prompted to consider if the mental health of the client had an impact on their parenting, if the family had an impact on their mental health and if there were any safeguarding children issues. Although we heard about a PAMIC tool (potentiality for the adult's mental ill health to impact on the child) embedded into the system to support practitioners in making judgements about this, we were unable to locate it electronically and saw no case examples where it had been used (**Recommendation 2.4**).
- 2.17 The substance misuse service's children and young people and families practitioners worked effectively and in co-operation with ERASE, to support young people who misuse substances and who are at risk of child sexual exploitation (CSE). Reports for the ERASE meetings we looked at were of a good standard; setting out the risks of CSE as they were affected by a young person's substance misuse well. This supports good decision making and contributes to the achievement of good outcomes for young people.

3. Child protection

- 3.1 We saw a number of case examples where pre-birth planning meetings were convened late in pregnancy. This had recently been addressed and the cross-agency protocol strengthened with children's social care now accepting earlier referrals where the midwife identified concerns about the parenting capacity of the mother or other risk factors likely to impact on the health and wellbeing of the unborn child. This was a welcome strengthening of the pre-birth safeguarding pathway but was too recent for us to determine the full impact of changes through case examples.
- 3.2 Midwives in Co Durham had not had much experience of female genital mutilation (FGM) among expectant mothers. However; learning events, policy and guidance were in place in line with expected standards of practice. Obstetrician leads for this area of work had been identified.
- 3.3 Although we had understood that the pathway for making referral by UCC staff was generally clear with operational managers ensuring that the referrals were copied to the trust's safeguarding team and that an entry was made in the trust's internal incident reporting system ('safeguard'). Thus providing the trust with assurance that appropriate action required by the referral pathway had been taken. Following the inspection however, we were advised that not all referrals are entered onto Safeguard. In CDDFT, management oversight and quality assurance of safeguarding referrals made by practitioners had been recently strengthened. However, we found considerable inconsistency in the level of referral detail provided including key demographic detail regarding children's faith, language and ethnicity and the analysis and articulation of risk by both ED and UCC staff. This was not always best informing a timely and appropriate response to concerns about a child in First Contact or the MASH. There was no formal process for following up on referrals and ensuring that the outcomes of referrals were noted in the patient record and operational governance should be strengthened to ensure that practitioners are systematic in their assessments, recordings and in stating expected outcomes when making referrals into children's social care (**Recommendation 1.12**).

- 3.4 In most services including; ED and the UCC, midwifery, health visiting, CAMHs and sexual health we found a common theme of variation in the quality of referrals made by health practitioners to First Contact. Overall, this was an area for development of which senior managers in commissioning and provider organisations were well aware. MASH reported that GPs in particular, submitted poor quality referrals. In some cases, poor quality referrals had led to delays in the engagement of children's social care or resulted in invocation of the escalation policy which may well have been avoidable. Across health services, there was a lack of quality assurance of referrals by operational managers or supervisory staff in frontline services prior to the referral being submitted. While there was a general expectation that copies of referrals were sent to safeguarding teams to facilitate quality monitoring and we saw and heard about safeguarding leads providing feedback to practitioners to support the improvement of practice; this was retrospective and likely to be less effective in driving up and sustaining improved practice. The service manager for the sexual health service had recognised a need to strengthen her oversight of referrals made by the service and was in the process of developing a tool to facilitate this (**Recommendations 1.12, 2.5 and 5.1**).
- 3.5 In line with the established referral pathway, school nurses made referrals into 'First Contact' using the multi-agency referral form (MARF). As with reports for child protection conferences, written referrals were detailed and set out risk in a clear and unambiguous way. In one record we saw that the school nurse had obtained information about a child's dental hygiene from the family dentist and this, together with the nurse's observations of the home had led to her establishing that the child was experiencing significant neglect. The nurse made the referral and the child was protected through multi-agency work directed by a child protection plan.

- 3.6 CAMHs and adult mental health services staff were expected to attend child protection conferences and prepare reports submitted in advance in line with best practice. In adult mental health, we were unable to see any written reports to determine their quality. In CAMHS, case examples showed that consultant psychiatrist reports to child protection case conferences were generally in the form of a letter rather than using the trust child protection report template and were of variable standard. Reports seen, particularly those from psychiatrists, were often focused largely on clinical activity undertaken without sufficient consideration of the child protection context and the impact for the child. Whilst the information provided was relevant and focused on risks of harm, it did not provide to conference a professional recommendation about whether the child should be placed on, remain or be removed from a plan. This therefore, may not be fully contributing to conference decision making, particularly if the psychiatrist is not able to attend. The named nurse confirmed this was the approach usually taken by medical staff. Inclusion of an evaluation of risk and professional opinion as to a recommended response in order to safeguard the child or children can be a valuable contribution to the multi-agency forum. In another report to child protection conference, the practitioner did not clearly outline the impact of domestic abuse on a young person living with domestic abuse. There were insufficient linkages to the objectives of the child protection plan and analysis of progress (**Recommendation 2.6**).
- 3.7 We understand that the Durham LSCB arrangements do not require health and other practitioners to make such a recommendation. However, in areas where this is established practice, this can facilitate the multi-agency decision making in an initial child protection case conference and sharpen professional's subsequent monitoring and reporting of compliance/non-compliance and progress being made as a result of the provision of a child protection plan. It may therefore, be helpful for the Durham LSCB to re-consider this.
- 3.8 In adult mental health, while referrals were made appropriately when concerns were identified, copies of referrals were held in the e-mail system and not secured within the electronic client record. This was very poor practice. The copy of the referral could not be viewed operationally by anyone other than the practitioner who created it. This frustrated practitioners and, dangerously, could lead to the loss of key information. It also undermined effective oversight and governance of safeguarding activity by operational managers (**Recommendation 2.7**).
- 3.9 We were advised by the adult mental health service that the service's annual audit of child protection referrals had demonstrated that the standard of information contained within referrals had improved significantly since the introduction of the structured multi-agency early help referral form. However, since we were only able to see one referral, which was of an acceptable standard, we were unable to make an assertion about the general quality of referrals made by the service.

Good practice example:

The safeguarding questions in the Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) adult mental health initial assessment are followed by data fields that capture the full details of the children in the case including the name of their GP and school and whether or not they are subject of a child protection plan.

In the cases we looked at, and during interviews with practitioners we saw that this had prompted them to gather information from and share information with other agencies.

For example; in one case we noted that the practitioner had contacted the social worker, the GP and the health visitor to gather and share information and that these contacts were logged in the patient record. This enables other agencies involved in a child's care or life to be aware of parental mental ill-health that might have an impact on the child.

- 3.10 In one of the GP practices we visited we found that there had been no recent referrals made to First Contact, which is the single point of access for all referrals for early help as well as safeguarding and in another there had been only one. The one referral we saw had been made to request early help support. This had been handwritten on the referral form and contained scant information about the need for the referral or about the child, parents and environment. The standard of the form's completion was very poor and had been returned to the practice for further information causing a delay to the early help response (**Recommendation 5.1**).

Case Example:

A school nurse had attended a team around the family (TAF) meeting where additional information about the family became available. As a result of this information the school nurse, together with a practitioner from the One Point service, attended the family home to find the young child at home without any adult supervision.

This resulted in the child being removed into police protection and a child protection referral being made. We noted that the child's record in relation to this activity contained a very detailed account of the circumstances of the finding of this child but in particular, the analysis of the information that led to the joint visit being carried out.

The school nurse attended the subsequent strategy meeting and the initial child protection conference (ICPC). Information for the conference was submitted in advance by the school nurse using a structured format. This also contained key information for each of the assessment framework domains, including a summary of the practitioner's analysis of the risks and a recommendation the child should be subject of a child protection plan for neglect. The conference decision was to place the child on a child protection plan.

The case outlined here illustrates the generally very high standard of written contributions to conference by the school nursing service, including detailed chronologies. In all of the cases we looked at we found that risk factors and evidence were clearly described, the analysis of which led to unambiguous assertions as to the risks. This is good practice as it supports good decision making within any safeguarding process.

- 3.11 School nurses routinely attended all strategy meetings and initial child protection case conferences (ICPCs) and supported these with written information. Thereafter, having completed the health needs assessment for the child, only where there was an active school nurse role, did the practitioner continue to participate in child protection procedures for that child. This pragmatic approach facilitated the service in effectively targeting resources at priority work.

- 3.12 In the substance misuse service, case evidence demonstrated good identification of risk when a service user with a known significant history of domestic abuse and child sexual abuse began a relationship with a new partner who had children. A prompt and good quality referral to First Contact resulted in immediate action being taken by a social worker to ensure the woman and her children were protected. Substance misuse staff routinely attended child protection conferences for both children and young people who were clients and for children affected by the substance misuse of adult clients. Substance misuse staff were routinely members of core groups. Child protection conference minutes and child protection plans were well secured into the client record ensuring that practitioners and managers were well informed when accessing individual client records. Staff submitted reports for child protection conferences to support a practitioner's attendance. However, one report we reviewed was superficially completed using a non-standard format and did not provide a clear picture about risks. This was addressed by managers with the practitioner concerned but did highlight that quality assurance of practitioners' submissions to case conferences was not routinely undertaken by operational managers (**Recommendation 6.1**). *This was drawn to the attention of Durham County Council Public Health as the commissioner of Lifeline substance misuse services.*
- 3.13 In one of the GP practices we visited, attendance at child protection conferences was occasional whereas at the other practice GPs were unable to attend. One of our common findings in CLAS reviews is that many GPs are unaware that the records of child protection conferences set the date of the next review conference six months hence, giving good opportunity for GPs to plan ahead and set time aside to either attend or more realistically, participate by dialling in to teleconference. This was the case in one of the practices we visited and this meant that opportunities for the practice's participation in conference discussion and decision making were being lost (**Recommendation 5.2**).
- 3.14 In both GP practices visited, reports were produced for child protection conferences and submitted in lieu of attendance by the GP. In one practice the level of detail in the structured form was satisfactory but did not provide an analysis of the information to determine risk. In the other practice, there was a great deal of detail in chronological form but this too did not show an analysis of risk or the GP's opinion of the parent's capacity to parent effectively. The named GP group had revised the template for GP reports to child protection case conferences. This now included a risk gauge and prompted the GP to include their professional opinion of the need for the child to be subject to child protection which facilitated a strengthening of GPs' participation in the conference decision-making process. However, both practices we visited were using the old form and their input to conferences was not benefiting from the improved proforma.

- 3.15 Effective and pragmatic partnership arrangements between CDDFT and HDFT were in place to ensure that community health practitioners and acute trust practitioners were well engaged with multi-agency public protection arrangements (MAPPA) and multi-agency risk assessment conference (MARAC) arrangements. CDDFT attended MARAC and MAPPA on behalf of HDFT, taking information gathered from health visitors and school nurses to inform meetings and disseminating information back into appropriate services.
- 3.16 Health services were well engaged with ERASE and the Missing and Exploited Group (MEG) arrangements, however, with the exception of the sexual health service, we saw no use of CSE risk assessment tools in acute, community or primary care services. Following the inspection we were advised that CSE risk assessment tools have been disseminated in CAMHS via team managers, operational MEG attendees, training and link professionals and that the trust is looking to embed them in PARIS. The identification of and response to risks of CSE was underdeveloped in the urgent care centre we visited. There was no formal assessment of risks to young people who might fall within certain risk groups and no risk assessment tool in use that might facilitate this. Similarly, in the substance misuse service although there was good engagement with the ERASE team, the service did not use a formal CSE risk assessment tool to support practitioners in identifying young people who may be at risk of exploitation. This did give rise to the potential that some young people at risk may not be properly identified (**Recommendations 1.13, 2.8, 5.3 and 6.2**).
- 3.17 The term “child protection list” was used frequently across the health economy and we understood it to be part of the local vernacular. Its continued use however, does give rise to the potential for ambiguity and confusion about the legal status of children subject to plan; can undermine other professionals’ or external agencies’ confidence in the practitioner’s knowledge of current national procedures and we would encourage managers to promote accuracy of terminology (**Recommendation 5.4**).

4. Looked after children

- 4.1 Although most recent initial health assessments (IHA's) and review health assessments (RHA's) that we reviewed were completed in a timely fashion within expected timescales, this area of performance was a recognised area for development for the partnership. Work had begun between the local authority and the looked-after children's health team to align data and improve efficiency in processes which will support improvement, although this was from a low base.
- 4.2 Initial health assessments were undertaken by a small team of paediatricians with oversight from the designated doctor. We saw good attention paid by paediatricians to recording ethnicity and gathering as much parental and birth history as possible in the IHA. Particularly good was the clinicians' analysis of what the future potential implication of this history might be on the child or young person's health and wellbeing. This was being used well to identify the needs of children and inform the development of teach child's health plan. Voice of the child was less well developed however and in most IHAs and RHAs we did not see the child, sometimes described as chatty, actually quoted which was a pity (**Recommendation 4.2**).
- 4.3 For IHA's and RHA's in children aged over 10 years, we saw a good demonstration of young people being given comprehensive information about their health assessments, and encouraged to sign consent forms. This is positive in ensuring young people have a good understanding and ownership of the process; helping them to engage with managing their own health and wellbeing.
- 4.4 As with all IHA's sampled, those pertaining to unaccompanied asylum seeking children (UASC) were of a high quality with good sensitivity to the current and potential health needs of the young person. For example; the potential impact of travel and history of torture on the young person's mental health in later years. However, practitioners undertaking IHAs and RHAs for this highly vulnerable cohort which is increasing in County Durham would benefit from specific training on the unaccompanied asylum seeking child's experience (**Recommendation 4.3**)

- 4.5 Recent changes in local commissioning meant that the Harrogate and District NHS Foundation Trust 0-19 service undertakes all RHA's, regardless of complexity and residence, including children's homes. However, in some cases we sampled, where the young person had declined their RHA, this had been undertaken by the specialist looked-after children's (LAC) nurse who knew the young person well. This flexibility and person-centred approach was a credit to the LAC team, although this would need to be fully handed over to the 0-19 service to ensure the new arrangements become embedded. For USAC, the first RHA is undertaken by the LAC nurse, primarily due to the young person having no relationship with a school nurse and possible complexity of screening etc. arising from the young person's IHA. If the young person is over 16, future RHAs are undertaken by the LAC nurse as the young person will not be going into school. The specialist LAC nurses undertake RHAs for children placed out of area within a 20 mile radius.
- 4.6 Children and young people were being given choices on where and when their RHA takes place and practitioners were flexible in meeting requests whenever possible. We found effective use of local bespoke documentation for RHAs, developed following learning from the Darlington CLAS review. The newly designed paperwork supported the voice of the child and the proforma were detailed and facilitative of comprehensive assessment.
- 4.7 There was a positive and clear expectation that GP's would input to IHAs and RHA's and, increasingly, requests for primary care information were being sent to GPs. The named GPs closely monitored the responses of GPs to these requests and were therefore able to target their work with individual GPs to encourage their engagement. As a result, response rates were growing albeit slowly, and this was very positive. In the most recent quarter reports indicated 61% of the relevant GPs were contacted with 44% returning information. Where GP information had been received in cases we reviewed however, it was difficult to see on the case record how this had informed the looked-after child's health assessment.
- 4.8 The facility to include strengths and difficulties questionnaire (SDQ) scores and evaluative information had been built into the bespoke RHA proforma which was a positive initiative. At the time of the inspection, only the SDQ score was supplied by the local authority. Limiting the information being shared in this way created a missed opportunity to use the SDQ to inform the health review more meaningfully. For example, enabling the older young person to reflect on their own personal and emotional development over their time in care, tracked by a series of RHAs, encourages their engagement with their own health and wellbeing. The SDQ score was also not routinely received by the health reviewer in line with the RHA timeframe and therefore these were not yet informing health assessments and plans to best effect (**Recommendation 4.4**).

- 4.9 Arrangements were in place for the lead looked-after children's nurse to quality assure a small percentage of RHA's each quarter. In the most recent quarter to the inspection 15% of the RHAs undertaken had been subject to quality assurance and in the previous quarter all RHA's completed had been quality assured. The RHA's we reviewed which had been undertaken by school nurses were very variable in quality. Whilst new paperwork was clearly helping to strengthen the voice or sense of the child as an individual personality, there was more to do to ensure that all 0-19 practitioners were undertaking the same quality of RHA in order that all young people had their health needs reviewed to the same high standard. One carer with whom we spoke reported experiencing a difference in quality of practice across health visitor teams when children moved into their care from other areas of Durham. The foster carer told us that they found that often the original health visitor had not have filled in the red book or completed the review health assessment (RHA) as comprehensively as their own health visitor does. This experience helps to highlight the looked-after children's nursing team's aim for effective quality assurance to help drive consistency. The delivery of training for the 0-19 practitioners in undertaking the new approach to RHAs was at an early stage and roll-out of this training would ensure all practitioners understood the standard of assessment expected (**Recommendations 3.3 and 4.5**).
- 4.10 The quality of IHA and RHA health plans was also variable. We saw some good practice examples, particularly from health visitors but some seen, including some that were undertaken by paediatricians, were incomplete or generic in nature; lacking clear goals and some timescales were loose.
- 4.11 We found a lack of awareness of the heightened vulnerability of looked-after children and young people among ED, UCC and MIU staff. In common with other cases seen in the ED and described in paragraph 1.8 above, the voice of the looked-after child was weak and appropriate consent for treatment was not clearly or routinely recorded. There was limited assurance from the acute service provider on how the LAC team were informed of ED attendances at UHND or the UCC and that any health actions following these were being followed up. This was a significant gap (**Recommendation 1.14**).
- 4.12 Specialist service pathways were in place for looked-after children to access the local authority commissioned Full Circle service for mental health support. LAC practitioners valued the ability to refer to this service and the level of expertise, particularly related to attachment disorder, highly.
- 4.13 The substance misuse service had begun a pilot for looked after children known as 'supporting looked-after children in decreasing drugs and alcohol' (SOLID). Although we saw evidence of the programme being offered to young people it was too early in the implementation to see whether expected outcomes were being achieved.

- 4.14 Young people were being engaged in the development of the looked-after child health service to a greater degree than in the past; having influence over the way nurses undertook assessments and in how questions about sensitive subjects were being asked. This was likely to increase the engagement of hard to engage older young people in the assessment and management of their health and wellbeing.
- 4.15 Health passports for care leavers were in the early stage of development following scoping and piloting in April 2016. Plans involved a staged roll-out starting at age 15 ½ in line with pathways planning at year 11. However the final RHA's we saw for young people who were beyond that point were very poor in quality, giving no indication to the young person that this would be their last RHA. As the plan for the implementation of health passports involved the school nurse undertaking the RHA, then the LAC nurse meeting the young person for health passport development, there was some risk that this approach may lead to either duplication or fragmentation of information and might be challenging in gaining multiple engagements with the young person (**Recommendation 4.6**).

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 While County Durham strategic leaders acknowledged that there had been challenges to overcome across the multi-agency partnership, organisational leaders were able to engage in mature dialogue to resolve these; seek solutions and jointly identify ways of moving the partnership and new service configurations forward. We saw some pragmatic and efficient arrangements to ensure good cross-organisational information sharing; examples being the MARAC and MAPPA representational arrangements.

5.1.2 The local child safeguarding board's (LSCB) governance of safeguarding arrangements through section 11 audits was working well and the chair of the LSCB described good engagement of all health partners and a healthy ethos of professional challenge between partners. We saw evidence of appropriate professional challenge between services being encouraged in all agencies and at all levels of service. This was constructive, helping practitioners to develop professional confidence balanced with a capacity for reflection and practice improvement. The TUPE transfer of practitioners in health visiting and school nursing into HDFT 0-19 service was well managed. Practitioners and managers in these services were well engaged with new service developments and well-motivated in taking the services forward. New service initiatives such as Crisis CAMHS were evaluating well with parents and young people and were leading to positive outcomes with reduced need for inpatient care.

Leadership and Management Good Practice:

'Investing in Children' in County Durham has made a significant difference to enabling a range of health and social care agencies to value, recognise and learn from the experiences and expertise of children and young people living in the area. This is a great example of children and young people in County Durham being seen and heard. Examples of the impact of children and young peoples' voice in supporting improvements in the work of local health providers included:

- *Influencing the way personal questions are asked about whether the young person is taking drugs or is having sex within LAC annual reviews*
- *Development of health passports for young people leaving care*
- *Reviewed and provided advice to help make the Erase child sexual exploitation team's website more child/young-person friendly*
- *Reviewed GP surgeries in County Durham to help make them more approachable for young people- young people then went back to check what changes had been made as a result of what they said. As a result, 20 GP surgeries were given the Investing in Children award with evidence of young peoples' information boards, including 'You Said-We Did' feedback and more child friendly waiting areas. This is helping young people to know they can bring a friend to appointments, reducing the need for formal chaperoning by surgery staff. Appointments are now offered after school if requested.*
- *Young people also worked with CAMHS to make their waiting areas more welcoming; and helped develop a more young person friendly guide using an Investing In Children member's artwork*
- *Information displayed about childhood type one diabetes on Treetops, the paediatric ward at Durham hospital had also been shaped by the Investing in Children network members.*
- *Network members were also regularly involved in staff interviews and training.*

One young person said;

"I like the fact that we can give our opinion, and that this is respected"

- 5.1.3 Despite the numbers of UASC being low in Durham at the time of the inspection, a clear plan of action was in place for this vulnerable group, including flowcharts on how services will be adapted, revised paperwork to prompt practitioners to consider wider issues specific to the UASC population. Good consideration had been given to the needs of this group which should have a positive impact on maximising outcomes for these highly vulnerable young people. This well reflected the proactive approach to strategic and operational development taken by the designated doctor.

- 5.1.4 The designated doctor and designated nurses provided good leadership across the CCG areas. However, there was limited capacity in the part-time designated nurse roles in the CCGs with post-holders having combined safeguarding and looked-after children responsibilities. With the growing complexity in both these areas, nationally and locally, in recent times and the local performance challenges that were well known to partnership leaders, there was a risk that capacity did not give sufficient flexibility to enable focused designated attention on areas for improvement although having three post-holders is helpful. It is important that the CCGs and partners take account of all these factors and assure themselves that there is sufficient capacity at the designated nurse level and a strategic review of this would be timely (**Recommendation 7.1**).
- 5.1.5 The referral pathway into the First Contact single point of access for triage with appropriate cases then proceeding into the multi-agency safeguarding hub (MASH) was clear and well understood by all stakeholders. We saw and heard a number of case examples where the presence and input of the HDFT practitioner had been instrumental in identifying key information leading to a prompt and effective multi-agency response to safeguard a child or children at risk of harm. The SNSC practitioner in the MASH was enthusiastic and committed and felt well supported although her capacity was limited. Cover arrangements for the health practitioner's absence or to allow her to undertake further training and develop the role within the MASH arrangements was also very limited. We noted that HDFT was reviewing the health presence at the MASH at the time of the inspection and we viewed this as timely. The inclusion of "Beautiful Moments" case examples that demonstrated good outcomes resulting from MASH arrangements in every fortnightly MASH meeting helped partners to celebrate these outcomes.
- 5.1.6 While we understood the rationale for initially having social care professionals have the direct contact with GPs and CDDFT when the MASH was initially set up, this would also benefit from review. Having a health professional rather than social care professional talking directly to other health professionals can ensure that clinical information is more easily and immediately understood and the implications for the health and wellbeing of unborn, children and young people more readily identified (**Recommendation 3.4 and 7.2**).

- 5.1.7 In CDDFT, good attention was paid to ensuring ED staff had an awareness of child development and expected milestones, with improved recording of bruising and promotion of professional curiosity in relation to injuries although documentation did not support consistent best practice well (see paragraph 1.8). Frontline staff reported 75% of the ED staff team had received European paediatric life support training. This was not a high percentage, particularly given that paediatric trained nurse provision in the ED was very limited which meant expertise in the assessment of risk and care of babies and young children was spread very thinly. Usage of bank staff was reported to be high given recent staffing turnover. In total only three paediatric nurses were employed when the inspection took place; one was on maternity leave and another, who took a lead for chasing outcomes from MARFs, was about to take up a new post. Frontline staff highlighted this as a deficit and were concerned about its impact; particularly in relation to the expertise needed in assessing risks to babies and young children. Overall, we were not assured that the trust had taken sufficient or effective action in response to concerns on this issue raised within the CQC inspection in February 2015 and this was a significant concern (**Recommendation 1.2**).
- 5.1.8 The new senior management team in CDDFT's midwifery service was providing strong leadership and support to practitioners; strengthening capacity and driving continuous improvement in the standard of clinical care and safeguarding practice across the service. Safeguarding governance arrangements for midwifery were sound.
- 5.1.9 Midwives were benefiting from a shared electric case management system that supports good information sharing between the hospital and community midwifery teams. Community midwifery caseloads were higher than recommended Nursing & Midwifery Council (NMC) levels and further work is being undertaken to ensure midwifery capacity recognises the additional impact of safeguarding work (**Recommendation 1.15**).
- 5.1.10 The group of named GPs was committed and enthusiastic; providing good safeguarding leadership to primary care services across County Durham. The monthly named GP meetings were well organised and productive; supporting the group well in formulating a shared agenda, often based on lessons learnt or recommendations from SCRs, and in helping to develop their own safeguarding knowledge and expertise. We heard a number of examples of positive developments led by named GPs including the redesign of the safeguarding website on GP Teamnet and the recent development of a primary care MAPPa proforma which was being piloted countywide. This was aimed at helping GPs to provide information to MAPPa and for information from MAPPa regarding individuals who may present risk to be shared effectively with the relevant GP to support the practice's assessment of risk presented by the individual. The named GPs had also worked closely with the LMC to produce a model practice policy on safeguarding children based on the Toolkit for General Practice (2011 revision) produced by the Royal College of General Practitioners and National Society for the Prevention of Cruelty to Children.

- 5.1.11 The County Durham GP safeguarding leads forum was established in line with good practice and attendance from safeguarding lead GPs across the county was increasing. Recognising the need to increase GP awareness, the focus of the next forum was CSE, the work of the ERASE team and the introduction and use of the intelligence sharing form. The venue for this lunchtime forum, held quarterly, was being moved around the county to facilitate attendance by those practices in more remote locations. Named GPs were also facilitating the participation of young people in the training programme for GPs.
- 5.1.12 A lead GP in one of the practices we visited in North Durham had been particularly proactive in safeguarding developmental work which had benefitted GP safeguarding performance across the county developing a bespoke safeguarding case management system. The named GPs were instrumental in the implementation of this system in all GP practices which facilitated the consistent and effective delivery and management of safeguarding activity across County Durham's primary care.
- 5.1.13 Named GPs had been instrumental in the multi-agency work which was underway to give opportunities to GPs to participate in child protection strategy meetings through a range of methods including the use of technology such as teleconferencing. This was a very positive multi-agency initiative. While GP safeguarding practice, participation and engagement with safeguarding arrangements was improving supported by the positive leadership of the named GPs, addressing non- engagement or suboptimal practice through GP appraisal had not been explored in County Durham although we have seen this well established with good outcomes in other areas.
- 5.1.14 The bespoke GP safeguarding case management system, known as the Derwentside Clinical System, provided a highly effective platform for ensuring vulnerable children were identified and their care managed in a timely and meaningful way.
- 5.1.15 The needs and prevalence data set out in the CAMHS Plan 2015-2020 indicated further work was required to reduce the gap in health inequalities as the most deprived local communities were still the most likely to suffer mental health deterioration. Whilst the CAMHS Plan provided an overview of the priority areas to address health inequalities, commissioning levels and expected impact were not yet as clearly mapped as they could be and the plan not sufficiently SMART in relation to planning for improved outcomes. Partners had identified that further work was required in the eating disorder services to ensure first appointments were offered within the target of nine weeks from referral and response timescales to referrals for in North Durham CCG area (22% in Q2 2016-17) was an area for significant improvement. Performance gaps had been identified with work in progress to ensure compliance with NICE guidance.

- 5.1.16 TEWV's establishment of a safeguarding and public protection team had enabled the mental health service review processes, working towards a 'Think Family' way of working across mental health services. The TEWV CAMHS crisis response team was working well and was a very positive recent development. The service was effective in ensuring a timely response to requests for assessment of young person's mental health needs by the ED or paediatric staff teams, with priority being given to supporting young people in the ED and paediatric ward, children living in residential homes and the staff who were working with these young people.
- 5.1.17 The widespread use of an electronic patient record system across UCC, most GP practices, the health visitor and school nurse services was facilitating the effective sharing of information across health services and disciplines. Pragmatic protocols had been put in place in some services; for example in the specialist looked-after child health service to ensure there is a single unified secure e-mail based method of requesting and receiving information from primary care to mitigate risk that practices using a different patient record system may not be communicated with as effectively.
- 5.1.18 The TEWV client information system (PARIS) was not supporting robust safeguarding and child protection practice in CAMHS and adult mental health. The system does not have the capability to upload key documents such as practitioners' reports into child protection case conferences, child protection meeting minutes and child protection plans. As a result, the client record was fragmented with no single and complete client record held centrally and electronically. We were told that paper records and correspondence were filed in case folders in each locality. However, in adult mental health when we accessed these folders, child protection documentation was not there. This was a significant concern as managers and new practitioners accessing the client record may not be effectively informed of their child protection responsibilities and there was risk that key activity would not be carried out. One case we reviewed evidenced exactly this outcome; where a new practitioner was not aware of child protection procedures in the case as there was no flag and child protection documents were not on the record until informed by the client the day before a review case conference. This meant the practitioner arrived at the conference unprepared to provide information which would have helped the conference to properly consider parental mental health as part of its deliberations. This was unacceptable. This system deficit was identified and made subject of a recommendation to the trust in the 2014 CLAS review in Darlington and we were very concerned that this had not been addressed and resolved at the time of the CLAS review in County Durham (**Recommendation 2.7**).

- 5.1.19 The TEWV IT system did have the facility to enter appropriate alerts for children who are on child protection plans, who are looked-after children or where there are MARAC related concerns. However, these were not always put onto case records by practitioners thus increasing risk that managers or practitioners accessing the electronic case record may not be immediately aware that there was a child known to be at risk in the case. Managers in adult mental health were not sufficiently aware of and sighted on the children within the service or the cohorts of CIN and child protection cases in team caseloads (**Recommendation 2.9**).
- 5.1.20 TEWV's appointment of a MARAC advisor along with the fixed term MARAC band six post becoming permanent was effective in strengthening the mental health services' focus on domestic abuse.

5.2 Governance

- 5.2.1 There was a significant challenge to the County Durham partnership in achieving a satisfactory and sustainable level of performance on the timeliness of initial and review health assessments and performance had been poor. The previously valued multi-agency looked-after children (MALAC) strategic group being in abeyance recent to the time of the inspection had created a hiatus at the strategic partnership level. Formal liaison between the LAC health team, 0-19 service and children's social care had been limited hampering joint problem solving between the teams and leading to a slower pace of change with the new initiatives in service delivery. The introduction of the new bimonthly partnership performance group gave agencies a good opportunity to focus on resolving the existing barriers to good performance in which each partner agency has equal ownership and accountability. The group was at an early stage of forming with a strong lead from the designated nurse; ensuring the right level of authority to effect real change were part of this group and developing its agenda of priority actions. While this was a positive step to developing a whole system approach, there was a distance to travel before this is truly established.
- 5.2.2 The national child protection information sharing system (CP-IS) had been introduced in UHND ED and Durham children on child protection plans and those who are looked after were flagged on the electronic patient information system (Symphony). Case sampling identified some gaps in relation to looked-after children which were resolved promptly as a result of this review.
- 5.2.3 Durham's named GPs had worked effectively with GPs to establish multi-agency safeguarding meetings across primary care and attend these at least annually in each practice. Whilst the meetings were common to all GPs, the frequency of convening meetings was variable. In one GP practice the safeguarding meetings were monthly where vulnerable children were scheduled for discussion according to the level of risk or complexity. Oversight of some children was every month where there were heightened needs, ongoing concerns or subject to formal procedures, whereas other children were discussed less frequently.
- 5.2.4 In another practice we visited, safeguarding meetings took place every three months where all vulnerable children on the practice's patient list were discussed. Whilst this ensured information was regularly exchanged on each child there was potential for the extent, depth and outcome of such discussions to be limited due to the number of children and the time allocated for the meeting.

- 5.2.5 In one GP practice, reports for conference and conference minutes and plans were intentionally kept off the patient record and were held on paper format in a separate filing system. This was not good practice as it resulted in there being no centrally held complete patient record that could be used to inform consultations or clinical interventions. It was also practice contrary to current DH and intercollegiate guidance (**Recommendation 5.5**).
- 5.2.6 A record keeping audit was undertaken on a sample of the work of each school nurse every four to six weeks to assure the quality of records which we found to be of a good standard. This audit included an examination of the way that safeguarding information was obtained and recorded, such as whether information about siblings or fathers had been properly recorded. Feedback from this process helped school nurses to maintain or improve the standard of their practice. Moreover it enabled the safeguarding team to identify trends and to use this to inform their ongoing training programme.
- 5.2.7 Case recording was of a variable standard in health visiting however, while observational recording was highly detailed and clear, some case recording lacked analysis of observations and information and therefore lacked the resultant evaluation of risk to support practitioners in assessing the level and rate of progress. Effective and regular evaluation of risk in cases is also helpful to the multi-disciplinary team in reducing the risk of cases drifting (**Recommendation 3.5**).
- 5.2.8 Operational oversight of under 18 presentations to the UCCs and ED to ensure that all safeguarding vulnerabilities and risks had been identified and appropriate action taken was underdeveloped. Where auditing activity was taking place; for example as we saw in the Bishop Auckland UCC, this was focused on the completeness of recording and was not monitoring or quality assuring safeguarding risk assessment practice. We saw the same gap in the ED and we saw at least one case where clear potential safeguarding concerns were not identified, investigated further through physical examination of the child and notified to appropriate services. There was no review of under 18 presentations by a shift leader or ED safeguarding lead prior to or close to the point of discharge and there was no paediatric liaison in place. While this is not a mandatory role, where we see this established, it can provide a valuable strand of governance, ensuring that notifications of attendance are promptly directed to the appropriate community health services to facilitate effective follow-up in health visiting, school nurse service and primary care. The role is often used to provide a review of under 18 presentations to ED minimising the risk that safeguarding issues may be overlooked. At the time of this inspection, the trust board could not be assured that this was the case (**Recommendation 1.16**).
- 5.2.9 Although information about lessons learnt or recommendations from SCRs was provided to staff in CDDFT UCCS through team and departmental meetings, there was no mechanism for evaluating improvements in practice arising from formal briefings, specific training or procedural developments and ensuring these are embedded (**Recommendation 1.17**).

- 5.2.10 CAMHS operational management oversight of key safeguarding priority work was good. TEWV had also been working to secure continuous improvements in the practice of its frontline staff through ensuring good access to safeguarding supervision and building professional expertise in the management of deliberate self-harm in young people. Recent practice improvements resulting from learning from SCRs, included collaborative care planning and strengthening of approaches to risk management including the interface of child safeguarding arrangements with MAPPA.
- 5.2.11 In adult mental health, formal records from TAF processes were not stored in the case management system and so the only record of this activity was by way of free narrative log entries made by the practitioner. The standard of these log entries was inconsistent. In one case we looked at, it was clear who had been involved at the TAF meeting, what had been discussed and what contribution the adult mental health worker had made. However, in the same case a later entry by another staff member who was temporarily holding the case at that time was of a poor standard. There was no information about the current progress of the work of the TAF or of the contribution made by the adult mental health staff member, other than to state that a new care co-ordinator was to be appointed and would make contact with the client. This lack of information was not helpful to the incoming practitioner who would be unsighted on any current family impact (**Recommendation 2.10**).
- 5.2.12 While some aspects of operational frontline safeguarding governance was underdeveloped as set out above, organisational safeguarding governance arrangements in the Tees, Esk and Wear Valleys NHS Foundation trust were sound, by virtue of a quarterly safeguarding and public protection group which reported directly to the trust board through the trust's safeguarding lead and an executive director. Performance was monitored through bi-annual and exception reports made through the trust's quality assurance committee. Heads of nursing from each of the five localities have inward facing responsibility communicating with operational managers through the locality management and governance boards. In this way, there was an accountable framework for safeguarding performance and the capacity to drive and oversee organisational change for safeguarding performance.

- 5.2.13 TEWV had undertaken a thorough bench-marking of its services against *Not Seen: Not Heard (CQC 2016)*. As a result there had been a number of improvements made. These included CAMHS strengthening its care assessment and planning approach through the development of robust risk assessment and management plans. The review of practice had identified areas of weakness that accord with our inspection findings. These included; the reliability of PARIS recording system, including in areas such as safeguarding alerts and staff being unable to access practice guidance tools for CSE within the PARIS system. The benchmarking also acknowledged joint working between adult mental health and CAMHS was variable. Further action was being taken to ensure relevant family members are aware of and have an up to date care and safety plan. A range of actions were also being taken as a result of the trust having identified the need to more effectively recognise risk of harm in children. This was work in progress.
- 5.2.14 Harrogate and District NHS Foundation Trust's safeguarding children governance group provided good accountability for safeguarding performance. The group was led by the trust's head of safeguarding and reported directly to the operational director and to the trust board. The group also directed activity designed to improve safeguarding practice such as through the record keeping task and finish group aimed at improving, for example, the quality of records and of written statements prepared for court.
- 5.2.15 The HDFT health visitor service was developing parent participation in service development and governance. The TEWV CAMHS service was open to and responsive to feedback from young people and action had been taken to improve waiting areas and encourage learning from Durham's 'Investing in Children' young people's champions. Young people and their families were also routinely invited to be part of staff selection panels. TEWV recognised engagement with younger children as an area to strengthen further.
- 5.2.16 The substance misuse service had recently migrated case records from one electronic system to a newer, more capable electronic case management system. Some initial problems with data transfer between both systems meant that not all attached key documents had fully migrated across and therefore some case records were incomplete. The service managers were aware of this issue and taking steps to ensure that all documents were properly transferred in due course but in the meantime this had resulted in staff having to work with two systems. This was operationally unwieldy and gave rise for the potential for some key safeguarding and child protection information being overlooked.

5.3 Training and supervision

- 5.3.1 Safeguarding training had been strongly promoted by local commissioners and health providers. Work had commenced to promote a strategic approach and ensure training delivered is quality assured and that its impact on strengthening workforce competences is clearly evidenced. It was too early to assess the impact of this recent development work.
- 5.3.2 CDDFT advised us following the inspection that it would be compliant with intercollegiate safeguarding children training by the end of March 2017. We found that training coverage across locations including the UCCs was tightly monitored within the trust; with frontline health professionals also being encouraged to access LSCB multi-agency level 3 training in line with best practice.
- 5.3.3 Midwifery supervision was undertaken in line with trust policy. The supervision tool in use appropriately supported analysis of risk and reflection on practice. Supervision was helping to strengthen midwifery safeguarding practice in key areas such as use of chronologies and quality of information provided within referrals to children's social care, albeit slowly, given the frequency of sessions.
- 5.3.4 All school nursing staff and health visitors received training to the specification as described by the relevant guidance for level three specialist practitioners. This means that they received 16 hours of training in a three year period exclusively about safeguarding. Training took a variety of forms through this period including the trust's rolling full-day 'core and procedural' training as well as 'hot topic' events on particular issues, the most recent of which for school nurses had been FGM, CSE, 'Prevent' (about radicalisation) and neglect. Compliance was monitored through the trust's training database using a risk rated spreadsheet sent to managers. However, due to the migration of electronic staff records as a result of the change of provider trust in April 2016, there was a disparity between the central training figures and those understood by the service managers. HDFT were aware of this and were working to correct the inaccurate data but in the meantime we are unable to assert whether or not practitioners had received sufficient recent safeguarding training.
- 5.3.5 Appropriate safeguarding supervision arrangements were not in place in the ED at UHND with not all staff accessing supervision in line with the trust's revised policy. We heard of plans to introduce six-monthly group supervision but this was an area for development (**Recommendation 1.18**).

- 5.3.6 The TEWV manager and safeguarding lead from the CAMHS Crisis team reported full compliance with intercollegiate level 3 training. All adult mental health service staff received training at level three and this was for both clinical staff employed by the trust and for those employed directly by the county council. This was in line with best practice. Training compliance was monitored by the trust through managers using a risk rated matrix generated by the trust's training department. Therefore, the trust were assured that at any given time all staff will be either up to date with their training or booked on to a scheduled event.
- 5.3.7 Supervision arrangements for TEWV practitioners were sound. The adult mental health operated a multi-layered safeguarding supervision model which incorporated the facility for advice and guidance from the trust safeguarding team whenever it was required. For children subject to a child protection plan, formal safeguarding supervision was carried out every three months for the duration of the plan. For CAMHS practitioners this was mainly delivered by clinical nurse specialists who had been trained to deliver supervision and for adult mental practitioners, was provided by the safeguarding nurses. Child in Need cases, looked after children, and those whose parent/carer was open to MARAC or MAPPA were discussed in clinical supervision delivered by a manager or peer. Supervision was recorded through a safeguarding assessment tool that is part of the client record and which is intended to be 'signed off' by the safeguarding practitioner providing the supervision. During our review of cases we saw that this tool was used in every instance thus providing a good audit trail of supported decision making. However, not all practitioners spoken to were able to confirm that they were having regular safeguarding supervision in line with trust policy. Compliance with policy was not monitored to full effect therefore (**Recommendation 2.11**).
- 5.3.8 TEWV had designated staff members from both CAMHS and adult mental health teams across the Durham locality to act as safeguarding link professionals. For example, we learned that the trust had recently presented the findings of a recent SCR to the link practitioners and this was in the process of being cascaded by them to the team members at local meetings.
- 5.3.9 In the HDFT 0-19 service, in addition to regular, scheduled management supervision, there was a strong, multi-layered approach to safeguarding supervision. This was particularly enhanced by practitioners receiving training in the participation and contribution to the group supervision element and by peer facilitators who had received further training as supervisors. The one-to-one case specific safeguarding supervision by the trust's safeguarding team as a mandatory requirement for all nurses within two weeks of their participation in an initial child protection conference was innovative and effective in helping to support confident child protection multi-agency practice. Records of all supervision or advice sought were made in the electronic patient record in line with best practice using a structured template and this was well evidenced. This supervisory oversight provides nurses with robust support and helps to develop practice

- 5.3.10 Practitioners in the Lifeline substance misuse children, young people and families' team undertook level three safeguarding training in line with guidance and their roles with children. All other recovery service staff working with adults were trained to level one only. We acknowledge that the relevant guidance applies to only health staff, however, since practitioners work with adults who may have access to children then the service's training offer could be strengthened by making level three training also available to them. This would better support Think Family practice and the protection of children from hidden harm (**Recommendation 6.3**). *This has been drawn to the attention of Durham County Council as the commissioner of the Lifeline substance misuse service.*
- 5.3.11 While supervision arrangements for staff in Lifeline were robust, records of individual cases having been discussed in supervision and any decisions or points of action resulting from that discussion were not logged onto the client record. This is not in line with best practice in ensuring the case record is comprehensive and that an effective audit trail exists to support operational oversight and practice monitoring through the case record (**Recommendation 6.4**). *This has been drawn to the attention of Durham County Council as the commissioner of the Lifeline substance misuse service.*

Recommendations

1. **Durham Dales, Easington and Sedgfield CCG, North Durham CCG and County Durham and Darlington NHS Foundation Trust should:**
 - 1.1 Put in place facilities and arrangements at the emergency department to ensure effective observation of children waiting for treatment and the prompt identification of the deteriorating child
 - 1.2 Ensure the provision of at least one paediatric trained nurse on duty at all times in the emergency department in line with RCPCH and CQC requirements
 - 1.3 Ensure that children and young people's safeguarding risk assessment is well informed, comprehensive and rigorous, prompts professional curiosity, captures the voice of the child and is subject to robust quality assurance and governance arrangements at an operational level
 - 1.4 Ensure that risk assessment documentation in use in the urgent care centres and emergency department promotes the consideration of risks to children as a result of hidden harm
 - 1.5 Ensure that paediatric ward staff complete discharge documentation fully to facilitate effective discharge
 - 1.6 Ensure information set out in notifications of attendances at the ED to primary care and the public health 0-19 service is sufficient to support optimum decision making about clinical and safeguarding follow-up
 - 1.7 Include an overall risk evaluation of information gathered on the home environment assessment with guidance to practitioners on the appropriate next steps resulting from the analysis
 - 1.8 Ensure that case recording in midwifery includes routine analysis of casework and evaluation of risk to facilitate effective progress tracking and monitoring of cases where children are known to have vulnerabilities
 - 1.9 Ensure that practitioners' use of the body mapping template at the urgent care centre is well supported by comprehensive guidance to promote consistency of practice
 - 1.10 Ensure a robust approach to identifying and responding to young people at risk of sexual exploitation is in place in the urgent care centres

- 1.11 Ensure that where children and young people have been admitted to the paediatric ward through serious self-harm, individual risk assessment and risk management plans are put in place in order that environmental and personal safety/peer safety risks are fully considered and addressed
- 1.12 Put effective operational governance arrangements in place to ensure that practitioners are systematic in their assessments, recordings, articulation of risks and in stating expected outcomes when making referrals into children's social care
- 1.13 Make effective use of child sexual exploitation risk assessment tools to identify children and young people who may be at risk of exploitation
- 1.14 Ensure that practitioners in the emergency department and the urgent care centre have a good understanding of the raised vulnerability of looked-after children, that appropriate consent to treatment is obtained and appropriate notification of the child's attendance is made to facilitate robust follow-up
- 1.15 Ensure community midwifery caseloads are brought within the guidelines of the Nursing and Midwifery Council
- 1.16 Ensure robust frontline safeguarding governance arrangements are in place in services providing emergency treatment in order that safeguarding concerns are appropriately identified and acted upon
- 1.17 Ensure that mechanisms for evaluating improvements in practice arising from formal briefings, specific training or procedural developments as a result of serious case reviews are embedded
- 1.18 Ensure that clinical and non-clinical staff in services providing emergency treatment are well supported through robust safeguarding supervision arrangements in line with trust policy

2. Durham Dales, Easington and Sedgfield CCG, North Durham CCG and Tees, Esk and Wear Valleys NHS Foundation Trust should:

- 2.1 Develop and establish a perinatal mental health pathway in compliance with NICE Guidance
- 2.2 Ensure that where children and young people have been admitted to the paediatric ward through serious self-harm, individual risk assessment and risk management plans are put in place in order that environmental and personal safety/peer safety risks are fully considered and addressed
- 2.3 Ensure that adult mental health and CAMHs practice is subject to effective governance and operational oversight in order that practice is of a consistently high standard

- 2.4 Ensure that adult mental health practitioners can demonstrate through the case record their active use of the “potentiality for the adult’s mental ill health to impact on the child” (PAMIC) tool in supporting effective Think Family practice
- 2.5 Put effective operational governance arrangements in place to ensure that practitioners are systematic in their assessments, recordings, articulation of risks and in stating expected outcomes when making referrals into children's social care
- 2.6 Ensure that all practitioners make consistent contributions to child protection case conferences through their written reports which should be child focused, demonstrating linkage to the objectives and requirements of the child protection plan, analysis and evaluation of risk. These should be subject to effective operational oversight and quality assurance in order that they best support optimum decision-making at conference.
- 2.7 Ensure that copies of all key safeguarding documentation, including referrals to MASH, CIN and child protection minutes and plans, are promptly and properly secured as part of the individual client record to enable practitioners to access the complete record when working with their client
- 2.8 Make effective use of child sexual exploitation risk assessment tools to identify children and young people who may be at risk of exploitation
- 2.9 Ensure that managers in adult mental health and CAMHS understand the cohort of CIN and child protection cases in their service and that effective use is made of the electronic flagging system to alert staff accessing the record to the presence of a child known to be at risk.
- 2.10 Ensure that adult mental health practitioners are compliant with appropriate standards of case recording and that recording practice is subject to effective frontline operational governance arrangements
- 2.11 Ensure that teams’ compliance with the trust’s supervision policy and safeguarding children supervision procedure is monitored effectively in order that practitioners are well supported in their safeguarding practice

3. Harrogate and District NHS Foundation Trust should:

- 3.1 Include an overall risk evaluation of information gathered on the home environment assessment with guidance to practitioners on the appropriate next steps resulting from the analysis
- 3.2 Ensure that case recording in the 0-19 service includes routine analysis of casework and evaluation of risk to facilitate effective progress tracking and monitoring of cases where children are known to have vulnerabilities

- 3.3 Ensure that quality assurance for health assessments and the resultant health plans for looked-after children is undertaken in the relevant frontline services and that arrangements are effective in driving up quality and consistency
- 3.4 Work with MASH partners to ensure there is sufficient health professional capacity in the MASH and that the role is utilised to best effect within the arrangements
- 3.5 Ensure that health visitor case recording includes regular analysis and evaluation of risk in order to monitor progress in cases effectively and prevent drift

4. Durham Dales, Easington and Sedgefield CCG and County Durham and Darlington NHS Foundation Trust should:

- 4.1 Include consideration of the young people' presentation and demeanour as part of the standard assessment in the sexual health service
- 4.2 Ensure that practitioners hear and record the Voice of The Child when undertaking initial and review health assessments, quoting the child whenever possible in order that the child's voice fully informs the assessment and health plan
- 4.3 Ensure that practitioners undertaking initial and review health assessments of unaccompanied asylum seeking young people have received training on the asylum seeking experience
- 4.4 Work with Durham County Council to further develop the use of strengths and difficulties questionnaires and sharing of information to best inform the health assessments and health planning for looked-after children and young people
- 4.5 Ensure that quality assurance for health assessments and the resultant health plans for looked-after children is undertaken in the relevant frontline services and that arrangements are effective in driving up quality and consistency
- 4.6 Ensure that young people who are looked after are engaged in co-producing the provision of health passports for care leavers; that the final health reviews of care leavers are comprehensive, aligned with the statutory review and subject to effective quality assurance

5. NHS England, Durham Dales, Easington and Sedgefield CCG and North Durham CCG should:

- 5.1 Work with GPs across County Durham to improve the quality and comprehensiveness of referrals to First Contact and MASH

- 5.2 Work with GPs across County Durham to increase their direct participation on child protection case conferences making best use of technology to promote engagement
- 5.3 Work with GPs across County Durham to make effective use of child sexual exploitation risk assessment tools to identify children and young people who may be at risk of exploitation
- 5.4 Work with all health providers to promote accuracy of terminology in relation to child protection procedures
- 5.5 Work together and with GPs to ensure that patient records are complete; inclusive of CIN and child protection, plans, reports and conference minutes to best inform primary care safeguarding practice and in line with DH and intercollegiate guidance

6. Lifeline should:

- 6.1 Ensure that practitioners' reports to child protection case conferences are subject to appropriate operational management oversight and quality assurance
- 6.2 Make effective use of child sexual exploitation risk assessment tools to identify children and young people who may be at risk of exploitation
- 6.3 Ensure that practitioners undertake child safeguarding training at a level commensurate with their roles and responsibilities in safeguarding children from hidden harm
- 6.4 Ensure that a note is made on case records of discussions of the case in supervision and any resultant decisions or actions

7. Durham Dales, Easington and Sedgefield CCG and North Durham CCG should:

- 7.1 Ensure there is sufficient capacity in the designated roles for safeguarding and looked-after children to meet national and local priorities for strategic development and effective governance
- 7.2 Work with MASH partners to ensure there is sufficient health professional capacity in the MASH and that the role is utilised to best effect within the arrangements

Next steps

An action plan addressing the recommendations above is required from North Durham CCG and Durham Dales, Easington and Sedgefield 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.