Review of health services for Children Looked After and Safeguarding in South Tyneside

Children Looked After and Safeguarding
The role of health services in South Tyneside

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Name(s) of CQC inspector:	Elaine Croll Sue Knight Nikki Holmes Kaye Goodfellow Louise Holland
Provider services included:	South Tyneside and Sunderland NHS Foundation Trust Northumberland, Tyne and Wear NHS Foundation Trust Matrix Humankind Vocare
CCGs included:	NHS South Tyneside CCG
NHS England area:	North East
CQC region:	North East
CQC Deputy Chief Inspector, Primary Medical Services and Integrated Care:	Alison Holbourn

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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 South Tyneside. 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 South Tyneside, 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 2018.
- 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 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 considered the experiences of 149 children and young people.

Context of the review

The 2019 Child and Maternal Health Profile (ChiMat) profile provides a snapshot of child health in South Tyneside.

Children and young people under the age of 20 years make up 21.9% of the population of South Tyneside with 8.4% of school age children being from an ethnic minority group. The level of child poverty is worse than England with 26.4% of children aged under 16 years living in poverty. The rate of family homelessness is better than England.

On the whole, the health and wellbeing of children in South Tyneside generally worse than the England average. South Tyneside was significantly better than the England average for five of the 32 Public Health England indicators (15.6%) but significantly worse for sixteen of the 32 indicators (50.0%).

The teenage pregnancy and infant mortality rate are similar to England but breastfeeding initiation and maintenance at six to eight weeks after birth was worse than the England average.

By age two, the minimum recommended immunisation coverage for MMR and Dtap / IPV / Hib immunisation was achieved and 95.4% of children in care were up to date with their immunisations, which is better than England average.

Dental health of five-year olds and obesity rates in reception are similar to the England average but rates of obesity of children in year six are worse than England average.

Accident and emergency department attendances (0 to four years of age) and hospital admissions for; unintentional and deliberate injuries in children (aged 0-25 years); asthma (under 19 years); mental health conditions; and self-harm (10-24 years) are significantly worse than the England average.

In 2015/16, there were 161 young offenders of which, 39 (24%) were children looked after at some point in their life (Joint Strategic Needs and Assets Assessment (2016).

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

People that received care from the maternity service at South Tyneside Hospital told us:

"The midwife is working well with me and helping me to consider and plan to change my care."

"The staff have been brilliant because they helped me to find ways to enjoy my baby when I was in a lot of pain. I felt listened to and the night staff were absolutely brilliant."

"My treatment has been totally different to others. I feel like I am treated differently by some staff and so I chose not to ring my buzzer."

One parent told us:

“The health visitor made me feel so positive at the beginning and visited regularly but I feel a bit let down as things are not in place.”

A client that received care from Humankind told us:

“I feel listened to by staff.”

Connected carers told us:

“A child in my care was referred for mental health support last year and I’ve got no idea when they will be seen. We’ve called the service twice but no one has called us back. We feel unsupported to meet their emotional and mental health.”

“The crisis system is rubbish, you are better off calling the police. The police are better and more able to help than the crisis team.”

“You can see the children having the same issues as their parents did. There was no help for their parents and there isn’t for them now. They will have children and those children will need care. The cycle needs to stop.”

Adults told us about GP services:

“The GP has been helping me, but it can be hard to get hold of them and to get an appointment.”

“You can wait weeks for appointments.”

Another adult told us:

“It’s been really good to be fair. All staff have been quite respectful of me and considerate of my needs and involved me in decision making.”

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 from South Tyneside and Sunderland NHS Foundation Trust (STSFT) based at South Tyneside District Hospital (STDH) provided pregnant women/expectant parents with important public health information at the earliest point that helped achieve a better start for the unborn baby. The provision of a first 'meet and greet' appointment prior to booking (if not more advanced in pregnancy) helped to facilitate discussion about aspects of lifestyle that, through informed, choice could be improved to benefit all in their care.

1.2 There was good information sharing between midwifery teams and other practitioners when women had booked their pregnancy. Community midwives were visible and accessible to pregnant women living in the local area through their good links with GPs. Midwives could access the GP electronic patient record (EMIS) and input their direct clinical contacts with women. This helped to keep the primary record up to date and strengthened joint working to meet women's needs.

There were strong links between community midwives and the health visiting team that was helped by the co-location of both services. Health visitors received daily antenatal notifications from midwives when women had booked their pregnancies. These were screened by health visiting which helped to identify any previous concerns. That information was shared promptly with midwives to inform their ongoing assessment, planning and care of women and unborn babies.

1.3 Assurance that pregnant women benefitted from continuity of carer as outlined in Better Births (2018) was weak. When we spoke with leaders they informed us that data submitted by STSFT showed zero percent of women at STDH had benefitted from continuity of carer. This would impact on vulnerable women's access to support from the same midwife. Plans to address this key model of maternity care were yet to be formalised by leaders. ***(Recommendation: 5.13)***

1.4 The absence of a universal home visit antenatally limited the opportunity to identify early on any risk linked to the home that could be hazardous to a new baby. While home circumstances were enquired about at booking with expectant parent/s, in one case examined this check lacked thoroughness. The midwife identified appropriately on the risk assessment that there had been a fire at the home, but the 'booking in' document did not illustrate if this continued to be the woman's place of residence and recorded 'no concern' about the home environment. This conflicted with what was known and lacked clarity about whether the recorded address was in fact a safe environment. This limited assurance that the existing assessment arrangements safeguarded those in their care. ***(Recommendation: 5.10)***

Good practice example

We examined one case of a pregnant woman that had not reported domestic abuse to the midwife when she had booked for that pregnancy. The maternity service informed health visiting of the pregnancy by sharing an antenatal notification.

Checks completed by the health visitor identified that the mother had previously been a victim of domestic abuse and that concern was so great that it had been discussed at the Multi-Agency Assessment Risk Assessment Conference (MARAC).

Further checks confirmed that the current partner and recorded father of the unborn baby had been previously violent and therefore may have posed a potential risk. The health visitor shared this information with the community midwife and made a referral to children's social care.

This level of professional curiosity and completion of rigorous checks ensured that agencies were able to better safeguard the mother and unborn baby.

1.5 Transfers of care between health visiting and school nursing worked well. The transfer process ensured that children's ongoing needs were met as they moved between disciplines. This consisted of a face-to-face handover and/or joint visits for children that had additional health needs or required targeted support and safeguarding. This helped provide a seamless approach to meeting children's ongoing needs at a key point as they moved into school.

1.6 School nurses showed tenacity in their care of children and had a positive impact on children's health and wellbeing. Children referred to the service were seen within two weeks which helped to identify and meet their needs quickly to achieve a better outcome. School nurses worked effectively with schools to support children and young people's emotional wellbeing while they waited for more specialist help. School nurses communicated key public health messages in line with children and young people's stages of development in settings through themed campaigns and via the delivery of personal, social, health and economic education (PSHE) sessions.

1.7 Information sharing between the Paediatric Emergency Department (PED) at STDH and school nursing was effective which ensured children's ongoing needs could be met. Written and verbal notifications of children's attendance were checked by school nurses and follow up was provided where additional needs had been identified.

1.8 Good central open access was available to young people that needed the integrated Contraception and Sexual Health Service (CASH). While there was no dedicated universal under 18 years of age provision, they had access to drop in services six days of the week. Targeted support was provided when additional vulnerabilities had been identified. Links from the outreach service were well established with pharmacists; Matrix (young people's substance misuse service); the looked after children's nursing team; colleges and workplaces that increased awareness of reproductive and sexual health needs of young people.

1.9 Assessments completed by Matrix considered the holistic needs of young people in their care. Assessments addressed not only young people's use of substances but where appropriate staff were able to provide contraceptive and sexual health advice, condom distribution and chlamydia screening. This approach worked towards making every contact count to improving young people's health outcomes and reduced the burden of attending additional health appointments.

1.10 Children that attended the PED benefitted from good assessment and identification of risk. In cases examined, staff completed comprehensive initial assessments on children that attended which helped the early identification of safeguarding risks. This included consideration of previous attendances and the circumstances of their current attendance which provided opportunity to consider other factors which may have triggered safeguarding concerns. The completion of such checks helped staff to safeguard children in their care.

1.11 The PED shared information effectively with public health nurses and primary care through the completion of good quality discharge summaries of children's attendances. This was enhanced by contact from the paediatric liaison nurse should children and young people's presenting condition be more complex or required safeguarding. This facilitated joint working to meet the ongoing needs of children in the community.

1.12 Staff in the PED demonstrated good awareness of findings from a neighbouring areas serious case review and described their management of people and in particular children that had dog bites. The dissemination of this learning provided enhanced opportunities to safeguard those in their care.

1.13 Safeguarding checks of young people aged 16 and 17 years that attended the Adult Emergency Department (AED) at STDH lacked rigour. Staff did not always complete the safeguarding prompts despite their access to paediatric documentation. The Trust were aware and introduced retrospective oversight of attendances by the safeguarding team which helped to lessen the risk until standards improved. However, this risked the under-identification of safeguarding for young people in their care that could have resulted in an unsafe discharge from the unit. ***(Recommendation: 12.1)***

1.14 Good arrangements were in place to support children and families with emerging vulnerabilities. Multi Agency Allocation Team (MAAT) meetings were held fortnightly with attendance from a range of health professionals to include health visitors, CASH and Matrix. The presence of key health services was positive and provided a focus on the health needs of those identified. Professionals were able to share information and plan how to meet the needs of children and families, so they could be met.

However, midwives were less involved in early help arrangements for unborn babies. Following an audit, local area leaders found early help arrangements needed to be strengthened for unborn babies because it was underutilised. An action plan was developed in February 2019, but this was yet to be fully implemented at the time of the review. ***(Recommendation: 5.12)***

2. Children in need

2.1 Overall, good consideration of safeguarding risk was made by midwives when women booked their pregnancy. In all cases examined, the details of partners/fathers of the unborn were recorded along with all other children of expectant parents whether in their care or not. This included contact arrangements and who had parental responsibility for linked children. Routine enquiry into domestic abuse was consistently completed at booking and at other points of care such as when a scan was being performed. In one case we examined, the midwife had responded quickly to a disclosure of domestic abuse and made a prompt referral to children's social care, MARAC and domestic abuse services. Nationally research had evidenced that domestic abuse began or increased during pregnancy hence midwives have an important safeguarding role throughout women's care.

2.2 Young pregnant women aged under 18 years were well supported by midwives and CASH staff through the Young Women's Pregnancy Service. Midwives and CASH services worked together and provided effective midwifery and sexual health care through joint clinics. This helped prepare young expectant parents for their new baby and engaged them early on with contraceptive choices. This ensured that between 2017-2018 85% of young mothers had a contraceptive plan that helped prevent an unplanned pregnancy. Furthermore, data from Public Health England in 2017 showed that the conception rate for those aged under 18 years of age in South Tyneside was the lowest in the region.

2.3 Cases examined demonstrated effective joint working between midwives and Humankind (adult substance misuse service). While there were no joint clinics provided to women there were strong links between both services. In one case, Humankind provided good in-reach and assessed a woman on the antenatal ward. They updated the woman's care plan in the hospital notes which ensured their substance misuse could be cared for while in the hospital.

However, pregnant women that experienced mental ill health were cared for by midwives that had not been well trained in the management of mental wellbeing. This did not comply with National Institute for Health and Care Excellence (NICE) guidance. This placed midwives in the difficult position of supporting women with insufficient training. The absence of a dedicated specialist midwife for mental health was recognised as a gap by the named midwife which meant at that time there was a lack of enhanced knowledge in the team. While there was an intent to provide women with more dedicated mental health midwifery support, at the time of the review progress was at an early stage of development. ***(Recommendation: 5.1)***

2.4 The recent addition of specialist peri-natal mental health provision to South Tyneside (April 2019) was positive but was a fragile arrangement. In one case study, the specialist help that the service provided to a mother and infant showed better safeguarding outcomes had started to be achieved. However, in maternity we could not analyse more broadly the joint working arrangements and impact of the peri-natal mental health service because cases could not be found. Named professionals at STSFT acknowledged in March 2019 that maternity and health visiting would need to develop their interface with the peri-natal mental health service. We noted that Northumberland Tyne and Wear NHS Foundation Trust (NTWT) were working to secure more capacity in their 2019 priorities to deliver the CCG commissioned service. The devastating impact of mental ill health for some expectant women and new mothers was well evidenced, hence the importance of continued and well-resourced provision. ***(Recommendation: 6.6)***

2.5 The health visiting service provided effective support to families that sought asylum and where children had additional needs. There was a dedicated specialist health visitor that delivered targeted support to families or provided consultation to the wider health visiting team. This ensured that harder to reach children and families received help that was tailored to meet their individual needs.

2.6 The health visiting service 'Think Family' model aided the identification of hidden harm in young children. Proactive screening for domestic abuse, substance misuse and mental health increased the identification of changing needs to people in their care. The good use of genograms captured complex family compositions and facilitated exploration of the appropriateness of adult-child relationships. This practice ensured that risks to children from linked adults could be considered and acted upon to safeguard children.

2.7 The school nursing service did not always use tools effectively to aid their assessment of children and families. In the case of complex family structures, the use of genograms would have enhanced professional consideration of the appropriateness of adult-child relationships. Chronologies of significant events were not used consistently which limited the oversight and tracking of changed risk for example, when children were not brought to health appointments. ***(Recommendation: 3.1*** *and* ***12.1)***. *Public Health commissioners will also be notified of this finding.*

2.8 The profile of home educated children was strong in school nursing. Established links between school nursing service and the local authority helped identify home educated children or those accessing alternative provision such as the pupil referral centre. This ensured that children continued to have access to public health services despite not being in mainstream education.

2.9 Children and young people experienced unacceptable delays to access mental health services and specialist assessments. Data provided about the Lifecycle service indicated that 76.9% of children had waited over 12 weeks for treatment with some children waiting up to 10 months. In the Children and Young People's specialist mental health service (CYPS) between November 2018 to March 2019 data indicated that between four and 25 children had waited over 30 weeks for treatment. Waiting times for neurodevelopmental assessment were reported to be long. The data lacked specificity to show what treatment or assessment children were waiting for, which would reduce leaders understanding of the demand for certain services. Children and young people incurred additional waits when they moved between both Lifecycle and CYPS that caused further delayed achievement of better mental health outcomes. ***(Recommendation: 6.1)***

2.10 Lifecycle had weak oversight of children and young people that were waiting for mental health support or intervention. This prevented the early identification of changed risk and needs in children because they waited too long for help. Whilst there was effective risk assessment at triage to prioritise children's access to services, those with non-urgent needs placed on the waiting list had not benefitted from proactive monitoring to identify changed risk. The provision of telephone contact numbers to parents and carers following referral was not a robust way to lessen that risk. ***(Recommendation: 5.2)***

2.11 Lifecycle had established good assessment and transition arrangements for 16- and 17-year olds in their care. Staff considered well the maturity and competency of young people referred for low to moderate mental health needs. That thoughtful practice helped to engage the young person with the most appropriate practitioner to meet their needs. Transition worked well because Lifecycle was an 'all age' service. Young people had the choice of whether they remained in the care of the children's team or moved to adult practitioners. The specialist practitioners supported those aged between 14 and 25 years which ensured continuity of care at a key stage when a young person was preparing for adulthood.

2.12 Access to 24-hour specialist child and adolescent mental health service provision was underdeveloped. Minutes from the Health and Wellbeing Board earlier this year showed that NTWT had prioritised enhancement of their services which included crisis care. Out of hours children and young people that attended the PED with self-harm or suicidal thoughts were cared for in the department until CYPS assessed their needs. Good links between the PED and CYPS ensured children and young people's mental health concerns were addressed which achieved a safe discharge or transfer of care. ***(Recommendation: 11.3)***

2.13 Children's mental health services managed risk well when children and young people were not brought or did not attend for their appointments. Clinicians in both services undertook a risk assessment and another appointment was offered with neither service closing the case until they had discussed this with the referrer and the child's GP. This joint approach helped ensure children did not get missed because they had not accessed their appointment.

2.14 Young people who attended CASH services benefitted from effective assessments of risk. Cases examined demonstrated that staff completed an assessment of vulnerabilities, risk of abuse and exploitation and domestic abuse at each attendance. This provided a comprehensive picture and useful intelligence that could be appropriately shared with relevant partners to provide an up to date picture of levels of engagement and risk. This joined up working helped to safeguard children and young people.

Good practice example

There were good links between the young women's pregnancy service and CASH at STDH. This provided expectant young parents with easy access to the outreach sexual health nurse practitioner who provided them with effective support about their reproductive and sexual health.

The young expectant parents were involved in their contraceptive planning during the antenatal period. Post-delivery, the outreach sexual health nurse practitioner provided their chosen contraceptive method either at their home or in the clinic at Palmer Community Hospital. Young mothers remained on their case-load until they were set up on their chosen method of contraception and able to access mainstream services for repeat supplies. The provision of this proactive support helped reduce the risk of an unplanned pregnancy which further helped achieve better outcomes for all in their care.

2.15 Matrix did not use genograms to aid their assessment of children and young people which could enhance staff understanding of linked relationships and complex family compositions. While practitioners considered family dynamics and peer relationships as part of their assessment, this could be strengthened further to include the use of genograms. *Public Health commissioners will be notified of this finding.*

2.16 Good arrangements between Matrix and Humankind ensured that transition was managed effectively. Both services worked jointly to prepare young people to move between services. There was a formalised transition pathway and managers from both services would meet to discuss cases to co-ordinate and plan ongoing care. Young people with additional needs and vulnerabilities such as those with a learning difficulty, benefitted from transition tailored to their pace which supported their onward engagement with services into adulthood.

2.17 The ‘Think Family’ approach was not embedded in STSFT and NTWT adult mental health services. There were weaknesses in the effective identification and assessment of children linked to adults that received care from both services. Assessment prompts did not support staff to record the details of children linked to clients but did not have parental responsibility for. Assessments often lacked analysis of adult and child interaction and children’s lived experience of the impact of the adult’s mental ill health. This inhibited the early identification of risks to children and young people due to the impact of adult behaviours. ***(Recommendation: 3.1)***

2.18 Humankind could not provide assurance that their existing management of clients treated with opiate substitution replacement therapy effectively safeguarded any child or young person in the household. Clients were expected to store harmful medication in a locked cabinet to prevent access by children or other vulnerable people. Managers had placed too great a reliance on the relationship between the worker and client to determine compliance rather than having procedures in place. Historic written agreements the previous provider held with clients about the safe storage of medication had not been retained when records were migrated in April 2018. We were aware that Humankind were developing arrangements to address this, but the pace to implement robust procedures was too slow and we were not assured that this protected children from harm. ***(Recommendation: 7.1)***. *Public Health commissioners will also be notified of this finding.*

2.19 Joint working between adult health services and the health visiting and school nursing service were underdeveloped. While this was more effective for children and families at a child protection level this was less established when needs were not at that threshold. This was a missed opportunity to increase the vigilance and awareness of universal children’s health services to the changed needs of adults linked to children they cared for and that they could be visiting at home. This was particularly key as Humankind did not routinely visit adults they provided treatment to at home or complete enhanced checks. ***(Recommendation: 4.6)***

2.20 In Humankind, ‘Think Family’ practice was not embedded. In cases examined, risk assessments were not always thorough and did not include enquiry about domestic abuse. The details of linked children were not always recorded in the dedicated fields on the patient record which reduced the visibility of children linked to adults in their care. This prevented the early identification of changed risk and delayed any necessary safeguarding response. ***(Recommendation: 3.1*** *and* ***7.2)***. *Public Health commissioners will also be notified of this finding.*

2.21 Children with additional vulnerability had their needs assessed effectively by PED staff. In cases examined staff consistently used a nationally recognised safeguarding psychological tool (HEADSSS) to assess under 16-year olds that presented following self-harm, risk taking behaviour, substance misuse or with other potential vulnerabilities. With consent and where appropriate, this resulted in referral to other services such as Matrix or the CYPS. This enhanced approach to assessment helped the identification of children’s needs and facilitated timely access to help and improved outcomes.

2.22 It was of concern that AED staff did not use tools effectively to assess the needs of 16- and 17-year olds they cared for. Therefore, this placed too great a reliance on individual staff professional curiosity to identify and respond to young people's needs. Whilst there was some oversight provided by the safeguarding team, this was retrospective and delayed the identification of needs and would not prevent potentially an unsafe discharge from the unit. ***(Recommendation: 12.1)***

2.23 Staff in the AED had not ensured that unborn babies and children at risk of hidden harm were identified effectively when adults attended. Cases examined illustrated that staff did not always completed the required adult safeguarding checks. Some assessments seen lacked professional curiosity and omitted to check for linked children which was a concern should adults attend with behaviours that caused concern. Assessments prompted staff to enquire about social work involvement, but this was not always used effectively to inform decision making and ensure a safe discharge. Measures implemented by the Trust such as ongoing audit and management oversight were yet to improve standards of safeguarding practice. ***(Recommendation: 3.1** and **12.1)***

2.24 Record keeping systems at STDH were fragmented which restricted access to a complete record of people's care. This prevented frontline staff from having good access to information that could be used to inform more robust assessment of people's care and needs to include safeguarding. An example of this was that existing maternity safeguarding information was not visible to AED staff that if known could have informed their risk assessment of expectant women that attended. This limited the opportunity to complete more thorough assessments of need to avoid an unsafe discharge. ***(Recommendation: 4.2)***

2.25 Information shared between the AED and children's social care staff was limited which weakened joint working to safeguard children. AED staff shared information about concerning adult attendances when children's social care involvement was known, but staff did not always check if a social worker was involved. This reduced the robustness of assessment and impeded effective multi-agency planning in response to changing risk linked to the AED presenting condition. ***(Recommendation: 6.2)***

2.26 Joint working was strengthened at GP practices that hosted monthly vulnerable persons meetings with midwives and health visitors. In practices visited we could see clear planning in children's records which could help to safeguard children. We heard that it could be challenging for the health visiting and school nursing service to attend consistently due to other competing priorities. *Public Health commissioners will be notified of this finding.*

2.27 Safeguarding practice in primary care was underdeveloped. Opportunities to proactively identify domestic abuse in the primary care setting were not well established. The two GP practices we visited did not search for or enquire about domestic abuse in people they cared for despite its prevalence in the local area. This was a missed opportunity to safeguard adults, hidden children and unborn babies. ***(Recommendation: 8.1)***

2.28 There were weaknesses in GP and UCC use of tools that limited the robustness of safeguarding assessments. In the two GP practices visited use of the Missing, Sexually Exploited and Trafficked (MSET) tool and Fraser guidance to check competence to consent was poor when young people presented for their sexual and reproductive health. This placed too great a reliance on individual practitioners' professional curiosity to identify safeguarding risks and competence, rather than embedding the use of tools and guidance to underpin their assessment. This was not effective safeguarding practice and may have delayed the identification of changed risk to children and issues about competency to consent to sexual activity. ***(Recommendation: 12.1)***

3. Child protection

3.1 It was positive that there was a health presence in the Integrated Safeguarding and Intervention Team (ISIT) to aid multi-agency decision making, however, this had not been developed to its fullest potential. The STSFT safeguarding representative that worked in the ISIT could access their own Trust health information. However, there were gaps in securing information from GPs, adult mental health and substance misuse services. GPs and adult services hold vital information not only about adults in their care but also about the health and development of children. This weakened the thoroughness of multi-agency decision making to safeguard children because not all risk and protective factors were known to partners. ***(Recommendation: 4.3*** *and* ***8.4)***

Inspectors observed a daily referral meeting in the ISIT

The meeting was well attended by a range of partners with health being represented by a nurse advisor for safeguarding children from STSFT.

In one case the nurse advisor shared relevant information available to them from the STSFT health records they could access. This included information gathered from the emergency department, health visiting and school nursing. However, no information from the GP was gathered or shared. This was a missed opportunity as the GP might have held important information about children and linked adults that if known would have strengthened the effectiveness of multi-agency decision making.

3.2 Information sharing with GPs was not always effective which limited their awareness of changed risk to unborn babies and children. Outcomes of ISIT discussions and strategy meetings were not always shared with GPs. In records examined, health staff from STSFT (safeguarding advisor, midwife, health visitor) had attended these meetings but they did not always share the outcome with GPs. Therefore, GPs would not be fully aware of changed risk to children and the level of help or protection they needed. This hindered the effectiveness of joint working to safeguard unborn babies and children should they access GP services. ***(Recommendation: 5.3)***

3.3 The quality of referrals made by health professionals to children's social care was too variable. Risks to unborn babies, children and young people had not always been articulated well, and some sections of the referral had not been completed. One referral made by CASH for a young person did not effectively consider the presence/absence of risks to a younger sibling despite their details being recorded in the referral. Staff in the ISIT focussed their attention on the young person referred and did not consider risks to the hidden younger sibling. However, staff took appropriate action to correct that omission of care. The unintended consequence of poor-quality referrals is delayed access to the help, support and protection that children needed. ***(Recommendation: 4.1** and **8.6)***

3.4 Some health services had not done enough to ensure children received the help and protection they needed. While it was positive that Lifecycle, CASH, GPs and Humankind identified and referred children that required safeguarding they had not checked the outcome of referrals. Consequently, it was unclear what support children had received which contributed to drift. In one GP practice a child was referred to children's social care in 2018, but their primary record did not show what, if any, level of help and support the child went on to receive. GPs as the primary record holder needed access to that important information to help enhance their assessment and decision making should children attend the practice. This limited assurance that appropriate action was taken, and children were effectively safeguarded. ***(Recommendation: 9.1)***. *Public Health commissioners will also be notified of this finding.*

3.5 The electronic Child Protection Information Sharing system (CP-IS) was fully implemented in South Tyneside which ensured that key child safeguarding information could be considered by unscheduled care services. When a child was known to children's social care or children looked after (CLA) or on a child protection plan, basic information about that plan was shared securely with STDH. The ED, maternity and UCC at STDH had access to this information which helped to improve the identification of vulnerable people, so their needs could be better met.

3.6 Vulnerable children were not always highly visible to frontline health staff. Flags and alerts in health records that highlighted children with additional needs and vulnerabilities were not used effectively which limited their value to inform children's ongoing care. In both adult mental health services, flags were not used consistently to raise the profile of family safeguarding issues or if clients were care leavers. The named doctor at STSFT (November 2018) found that clinicians use of alerts was weak and that resulted in under-recording of children's known vulnerabilities in hospital letters. ***(Recommendation: 4.2)***

3.7 Child protection meetings were well attended by midwives, health visitors, school nurses. This ensured there was a focus on unborn babies and children's health and development needs which enhanced multi-agency decision making. However, adult mental health services and Humankind reported that this could be a challenge when meetings were convened at short notice. Inspectors saw evidence that adult mental health services had not been invited to attend child protection meetings. This prevented adult practitioners from sharing their unique perspective of the impact that adult behaviours had on the safe care of children and could impact on the robustness of multi-agency child safeguarding plans. ***(Recommendation: 4.5)***. *Public Health commissioners will also be notified of this finding.*

3.8 Leaders had not ensured that written reports completed by health staff for child protection conferences were consistently of a good standard and accessible in patient records. Overall, we saw good quality reports in maternity and school nursing with risks being articulated well, but this important practice was not embedded across South Tyneside. In CYPS, standards were too variable and key information was missed, such as; family details; analysis of risk and recommendations to inform a safeguarding plan. In GP practices visited, their reports lacked analysis and professional consideration of what the impact was for the child. In maternity and Humankind, inspectors could not evaluate the quality of some reports as these had not been secured into the health record which meant records were incomplete. ***(Recommendation: 4.4*** *and* ***8.2)***. *Public Health commissioners will also be notified of this finding.*

3.9 In maternity, safeguarding information sharing was not always effective when women's care was transferred. In two cases examined, the transfer of care between hospital to community midwives was not thorough enough. This limited community midwives awareness of safeguarding concerns at a key point of care and limited awareness of what safeguarding action was required as part of their care in the community. ***(Recommendation: 5.4)***

3.10 The quality of multi-agency birth plans to safeguard unborn babies/newborn babies were too varied which limited their robustness. Some were detailed and set out clearly the safeguarding action that was needed, but two were more vague and lacked specificity. Whilst midwives contacted children's social care and clarified the multi-agency safeguarding birth plan, this was often at a critical time during women's care which was risky and could have been avoided. ***(Recommendation: 5.11)***

3.11 We were not assured that the Sexual Assault Referral Centre pathway (SARC) for 16- and 17-year olds was effective. It was unclear whether young people that accessed the adult SARC in Newcastle secured improved outcomes following their intervention. In one case sampled, CASH practitioners appropriately referred a young person to children's social care and noted that a SARC assessment was needed. However, there was no evidence in the health record about how the young person continued to be supported and kept safe to achieve better physical, emotional and sexual health outcomes. Leaders had not yet fully evaluated the effectiveness of the SARC arrangements and agreed this was a gap. ***(Recommendation: 2.1)***

3.12 Matrix staff worked effectively to safeguard children and young people in their care. Assessments were robust and not only considered safeguarding issues which were the result of substance misusing behaviour, but also societal and familial factors. This improved the early identification of children's needs so they could be met.

3.13 The children's Lifecycle team used escalation procedures well to ensure children were safeguarded. We saw evidence that staff sought support from the safeguarding team when social care had not actioned a referral that resulted in, for example, support being offered instead through early help. The use of challenge and escalation procedures ensured that children received the help they needed.

3.14 Joint working and the exchange of safeguarding information between adult mental health and children's social care was not always effective. In some cases, the professional judgement and care planning of adult mental health staff demonstrated no intent to share important information with children's social care. Adult mental health staff had limited awareness of multi-agency child safeguarding plans for children linked to adults they cared for. In other cases, adult mental health records indicated that children's social care had not responded to repeated messages left by practitioners. This limited robust consideration of risks to children from linked adults that experienced mental ill health and weakened the effectiveness of multi-agency decision making to safeguard children. ***(Recommendation: 6.2)***

3.15 Safeguarding practitioners from NTWT and STSFT had good attendance at MARAC and Multi-Agency Public Protection Arrangement (MAPPA) meetings. Humankind did not have capacity to attend MARAC, but when informed they provided information and updated records when outcomes were shared. Overall, this ensured there was a health focus to partnership discussions about the management of adults with high risk behaviours that impacted on linked children. Humankind were well engaged in multi-agency partnership working in relation to adults with high risk offending behaviour. They attended MAPPA when they were aware a client was being discussed, Multi-Agency Tasking and Co-ordination (MATAC) meetings and Integrated Offender Management (IOM) meetings. This ensured that risks and the substance misuse need of offenders were fully understood by partners to inform ongoing planning and consideration for the safeguarding of the unborn, children and young people.

3.16 Information sharing about safeguarding was underdeveloped between Humankind and GPs. Consequently, Humankind did not share child safeguarding concerns they identified with GPs which weakened joint working. Managers were too reliant on children's social care to share concerns with GPs rather than ensuring good information sharing to safeguard children was embedded in their practice. Consequently, GPs were not fully sighted to the changed risk and safeguarding concerns Humankind had identified. This limited opportunities for GPs to be more vigilant in their assessment of children and adults should they attend the practice. ***(Recommendation: 7.3)***. *Public Health commissioners will also be notified of this finding.*

3.17 GPs were not always effective contributors to multi-agency working and decision making where adults posed a high risk to people. The existing arrangements to secure and embed input from primary care to MARAC and MAPPA were weak. Just prior to our review, a MARAC meeting was held where 28 cases were discussed, but no GP information was provided. The safeguarding team at STSFT were involved in the collation of GP information but the adult safeguarding dashboard for 2017-18 recorded 'N/A' against that indicator. We asked the CCG to address deficiencies to effective multi-agency working. ***(Recommendation: 8.4)***

3.18 UCC staff were not well engaged in local safeguarding arrangements. Staff had no recollection of making any safeguarding referrals. Clinicians described the action they would take should a safeguarding concern arise, which would be to hand this over to the ED or seek advice from their clinical lead. Assurance that standards of child safeguarding practice were effective was limited as this had not been monitored by named or designated professionals. ***(Recommendation 10.1)***

4. Looked after children

4.1 In South Tyneside the voice of children looked after (CLA) was heard and considered at an operational and strategic level. STDH consistently sought the views of CLA to evaluate the service they had received. Inspectors sampled some feedback forms completed by CLA that showed high levels of satisfaction with the service. Following an event with care leavers, CCG leaders pledged to extend the provision of health assessments up to the age of 25. However, at the time of our review progress to develop this provision remained at an early stage. ***(Recommendation: 1.2)***

4.2 The looked after children's (LAC) health team were good advocates for CLA. The team was made up of the named doctor and nurse for LAC. Initial health Assessments (IHA) were completed by the named doctor and the named nurse provided input to CLA with complex needs and vulnerabilities. Case examples showed diligent work was done to follow up children's outstanding health appointments and actions. This helped ensure that the health needs of CLA continued to be considered as part of multi-agency planning and worked towards the achievement of better outcomes.

4.3 The timeliness of CLA statutory health assessments had improved in recent months. Data from January to March 2019 showed that over 90% of CLA had their health needs assessed within statutory timescales. Notification arrangements had improved between the local authority and LAC health team which contributed to improved performance. The LAC health team proactively alerted health visitors and school nurses when review health assessments were due which meant staff could plan the prompt review of CLA health needs. This helped to avoid delayed identification of new or emerging health needs as children entered or remained in care.

4.4 The involvement of GPs and children's mental health services with statutory health assessments was limited. The LAC health team sought updated information from the GPs of CLA to check for changed health prior to their statutory health assessment, but GPs did not always respond. Where involved, children's mental health services did not routinely report on their care of CLA to LAC health professionals. As a consequence, this limited practitioners awareness of whether children's mental health outcomes had improved. This hindered working in more integrated ways to assess and meet CLA needs. This would lessen the need for CLA to repeatedly tell their story to the different professionals involved in their care. We also heard that cared for children and carers did not always experience joined up care from the different services and professionals involved. ***(Recommendation: 6.3** and **8.3)***

4.5 The LAC health team had set up good arrangements that kept GPs updated of CLA health needs linked to their practice. At the GPs we visited we saw that CLA primary records were up to date because their statutory health assessments had been shared. The presence of the assessments would help primary care staff to understand the health needs of CLA should they attend the practice.

4.6 Overall, the quality of CLA health assessments were good but some aspects could be strengthened. The use of tools such as Strength and Difficulty Questionnaires (SDQ) and a substance misuse tool enhanced analysis of CLA needs. This involved children in tracking their wellbeing and improved the identification of needs. However, clinicians' acquisition of parental health histories to inform CLA health assessments was inconsistent. We recognised that issues around consent could limit that practice. This hindered consideration of the possible future health needs of CLA that were familial in nature. ***(Recommendation: 5.5)***

4.7 The quality of health action plans was too varied. Plans reviewed were not always specific, measurable, and lacked timebound actions to address the needs identified during the assessment. While assessments found emotional wellbeing and risk-taking behaviour needs, the health action plans did not articulate well enough how these would be addressed and overseen. This weakened the effectiveness of planning to improve CLA identified health needs. ***(Recommendation: 5.6)***

However, public health messages were conveyed well in health plans following initial and review CLA health assessments. The messages were developmentally appropriate and tailored around the individual needs of children. This ensured CLA and carers received information to optimise their health and wellbeing.

4.8 Quality assurance arrangements for IHA were underdeveloped. This hindered opportunities to sustain good standards of practice and improve the identification of weaknesses. While the designated nurse for LAC had taken some more recent action this gap had drifted for too long as this had been identified on the CCGs LAC Compliance tool in March 2017. ***(Recommendation: 1.4)***

4.9 Named professionals had a good understanding of the complex needs of unaccompanied asylum-seeking children. They had strengthened links with named and designated professionals in Durham and Sunderland to aid joint working to meet these children's needs. The group had developed joint guidance to support health professionals to work with unaccompanied asylum-seeking children, but this had remained in draft format for some time.

4.10 Care leavers benefitted from comprehensive health passports that helped to prepare them for adulthood. Care leavers were the recipients of detailed information about their birth, parental health, childhood illnesses and accidents as well as copies of all their previous health care reviews. The named nurse had good links with personal advisors and provided ad-hoc health advice if required, but this was not commissioned which made this a fragile arrangement. ***(Recommendation: 1.2)***

4.11 Arrangements to provide CLA with a dedicated specialist CLA child and adolescent mental health service was yet to be established. This meant that children in the care system and cared for children experienced lengthy waits (as reported in 2.11) to have their emotional and mental health needs assessed and met. ***(Recommendation: 6.1)***

Connected carers told us while CYPS helped them to understand the behaviour of children in their care but they had not been helped more practically to manage their behaviours. The lack of prompt mental health assessment and intervention risked an increased likelihood of placement breakdown that required crisis intervention. Leaders across the partnership recognised the gap and worked jointly to develop a dedicated CLA psychology service but this was not operational at the time of the review.

4.12 NTW adult mental health services had a poor understanding of their role in helping CLA to achieve improved outcomes. Practitioners that supported parents/carers had insufficient awareness of how their assessments could help determine the stability and safety of where CLA were placed. Case examples highlighted that adult mental health staff did not share information about parental behaviour with children's social care as they believed that children were safely placed away from their parents, despite it being documented that the parents hoped to regain care of their children. This impeded effective decision-making about the safety of children's placements and the suitability of parents to resume the care of their children. ***(Recommendation: 11.4)***

Management

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

5.1 Leadership and management

5.1.1 In January 2018 local area leaders requested the LSCB signed off the Joint Targeted Area Inspection (JTAI) because of their progress against the action plan. Recognition was given to the improved structure and approach implemented at STDH (previously South Tyneside NHS Foundation Trust) and aspects of health input to the ISIT. As part of the recommendation to cease the action plan leaders regarded the ISIT as an innovative development that brought partners together to better safeguard children. However, as outlined earlier health leaders had not ensured that relevant information was secured from both child and adult health services, and primary care services. Consequently, this impacted on the robust analysis of risk and protective factors and weakened the effectiveness of multi-agency decision making to safeguard children. ***(Recommendation: 4.3*** *and* ***8.4)***

5.1.2 Good leadership was provided by both the designated nurse for safeguarding children and LAC. They were well engaged in partnership working and attended strategic boards locally and regional networks. Their presence facilitated appropriate challenge to safeguarding and CLA issues. An example of this was the challenge made by the designated nurse for safeguarding children about the low numbers of serious learning incidents/case reviews identified locally and referred to the national panel.

5.1.3 The resource allocated to key designated professionals in the CCG was stretched with some fragility to some roles. The resilience of the single professional resource allocated to the role of designated doctor for safeguarding, LAC and child death was exposed when the completion of child death reviews stalled for a time due to absence. The designated nurse for LAC post was temporary 0.5 Whole Time Equivalent (WTE) and the post holder also worked across South Tyneside and Sunderland CCGs as a safeguarding advisor 0.5 WTE. This combined was a sizable portfolio and the lack of permeance to the designated role made this a fragile arrangement. We noted some lag in the completion of some of the CCGs planned work which had limited leaders ability to address known weaknesses and drive the necessary improvement to safeguarding and CLA services. ***(Recommendation: 1.1)***

5.1.4 Local area leaders had not ensured that primary care were well engaged in the effective identification and response to domestic abuse which had a high prevalence in South Tyneside We found there were concerning deficiencies in GP contributions to multi-agency decision making at MARAC and asked the CCG to take action to address this. Contractual matters had also changed the way STDH reported MARAC and MAPPA activity on the safeguarding dashboard. While the designated nurse for safeguarding children and associate director of safeguarding at STSFT had engaged in discussion about MARAC and MAPPA arrangements (Quality and Review Meeting March 2019) the outcome was yet to strengthen multi-agency decision making to safeguard unborn babies and children. ***(Recommendation: 8.1** and **8.4)***

5.1.5 Leaders oversight and monitoring of the effectiveness of mental health services for CLA was fragmented. Commissioners monitored the block contract held with STSFT and NTWT, but these lacked specificity on the outcomes achieved by CLA and this was not reported to designated professionals. Plans to strengthen reporting were acknowledged but remained at an early stage of development. ***(Recommendation: 1.3)***

5.1.6 Leaders and safeguarding professionals at STSFT had made good progress to raise the profile of safeguarding and had strengthened their scrutiny of practice. Most named and safeguarding professionals would meet regularly through the operational safeguarding network with outcomes reported to senior leaders at the Trust and CCG. This forum helped the dissemination of information and provided good scrutiny of safeguarding practice and near misses and how they would be tackled. This aided the recognition of good practice and areas that required improvement to safeguard people in their care.

5.1.7 Designated professionals had not been fully sited on the findings of STDH externally commissioned review of safeguarding undertaken in July 2018. Appropriate action was taken to transfer child protection medicals to what was City Hospitals Sunderland NHS Foundation Trust where this remained following concern raised about the quality of practice. Plans to share these findings were recently agreed and were to be shared imminently which we were assured would form the basis of strategic planning about services and staff they commission.

5.1.8 The safeguarding structure at STSFT did not fully reflect all named roles with some staff holding busy portfolios that impacted on capacity to be more fully involved in development work. The named midwife at STDH was not included in the structure which was a gap and the resource available for this role was somewhat stretched. This had limited their regular involvement with the Trust safeguarding operational group. The named nurse for safeguarding children was a Trust wide post that covered both South Tyneside and Sunderland hospitals with support from safeguarding practitioners. The named doctor at STDH was resourced as an interim measure and was provided by the designated doctor aligned to Sunderland locality for one programmed activity per week. We recognised that at the time of the review the governance of the newly merged arrangements at STSFT continued to be developed.

5.1.9 Local area leaders had an increased focus on strengthening people's early access to mental health support, but actions to address this need were at different stages of implementation. Various plans were in development to review pathways which included neuro-disability, where children experienced some of the longest waiting times and the development of provision to vulnerable groups. South Tyneside successfully won a bid to become a child and adolescent mental health trailblazer site and were awarded funding in January 2019 to provide mental health support teams. However, plans were in the early stage of development and were yet to impact on the long waiting times some children experienced to access the mental help they needed.

5.1.10 Overall, health were well engaged in Multi-Agency Looked After Partnership (MALAP). Minutes indicated good attendance from a range of key partners that was chaired by the named nurse LAC. Where attendance was consistent this supported the development of joint approaches to address key workstreams such as dental health, consent, the use of SDQs and training for carers. This had worked well and ensured that services to CLA continued to be developed and enhanced.

5.1.11 Leaders had not ensured that record keeping systems were developed and used effectively to benefit safeguarding practice. Opportunities to develop more integrated record keeping had not been achieved where shared electronic systems were used (EMIS) which reduced the visibility of safeguarding information. This had resulted in fragmented record keeping that required frontline staff to navigate and retrieve information from different sources which was inefficient and risky. However, we recognised that EMIS was set up at STSFT just prior to the review (April 2019) and continued to be developed. ***(Recommendation: 4.2)***. *Public Health commissioners will also be notified of this finding.*

5.1.12 The safeguarding policy and dashboard at NTWT lacked specificity about their impact and role in improving CLA outcomes. The visibility of CLA was low on the safeguarding dashboard and safeguarding children policy. While CYPS had engaged in MALAP meetings, their attendance was not always consistent which limited opportunities to strengthen joint work regarding CLA and their parents/carers. ***(Recommendation: 11.1)***

5.1.13 Humankind had good recognition of the quality of their safeguarding practice and what needed improvement. Their Safeguarding Action Plan 2019-20 provided a good overview of the key areas for development but the plan lacked measurable timescales. While leaders updated the plan the absence of clear milestones to track progress weakened the opportunity to identify drift to ensure planned improvements were achieved within expected timescales. ***(Recommendation: 7.5)***

5.1.14 Leaders oversight of the safeguarding practice of subcontracted health services was weak. This hindered challenge and assurance that child safeguarding practice was effective in the UCC that STSFT had subcontracted to Vocare. We reviewed Vocare's online safeguarding children statement and found this was not based on more recent national guidance. We were aware that leaders intended to include subcontracted services at the May 2019 Quality Review Group however, leaders were yet to implement effective watchfulness of Vocare's safeguarding practice. ***(Recommendation: 10.1)***

5.2 Governance

5.2.1 Both NTWT and STSFT safeguarding dashboards provided good evidence of safeguarding performance and, where recorded, CLA activity. The CCG had oversight of this data through regular quality review meetings with providers. The dashboards contained a broad range of information that helped to track trends such as; the numbers of referrals made to CSC, training and timeliness of CLA health assessments.

5.2.2 Leaders, named and other safeguarding professionals at STSFT worked proactively to improve standards of child safeguarding practice. Regular audits were completed that included safeguarding supervision, safeguarding checks in both emergency departments, routine enquiry of domestic abuse in maternity and completion of problem lists in paediatrics. This helped to sustain good practice and exposed areas that needed improvement. Completed audits had action plans that overall, were linked to the findings. This level of scrutiny facilitated professional challenge of practice to raise standards and keep children safe.

However, in one audit limited action was taken to address gaps in safeguarding supervision that focussed on unborn babies with known vulnerabilities. Consequently, this hindered opportunities to strengthen safeguarding supervision practice further. We noted some lag in the completion and updating of some actions and that capacity issues had delayed the start of two planned audits which had delayed improvement work. ***(Recommendation: 5.7)***

5.2.3 Both NTWT and STSFT were well engaged in the partnership's improvement work and contributed to safeguarding thematic reviews. This strengthened partnership working to safeguard unborn babies and children at a strategic and operational level. Themes varied and included pre-birth assessment and domestic abuse with recommendations created where areas for improvement were identified. It was positive that the experience of CLA were considered as part of multi-agency thematic audits completed by STSFT. The domestic abuse themed audit in April 2018 identified recommendations to ensure the voice of the child was captured at each contact and that school health records contained CLA health assessments. This had enhanced standards of practice.

5.2.4 The safeguarding team responded well to address deficits in standards of child safeguarding practice in the PED and AED at STDH. They established additional scrutiny of all paediatric attendances and strengthened their oversight of adult attendances. The addition of a retrospective layer of scrutiny to children and young people's attendance helped find missed chances to safeguard children and young people that could be rectified. However, the findings of the review and the Trusts own audit and monitoring had found there was more to do to embed child safeguarding practice to prevent an unsafe discharge. ***(Recommendation: 3.1** and **12.1)***

5.2.5 Record keeping systems at STDH and NTWT were too fragmented and did not provide frontline staff with good access to a complete record of safeguarding risks and care. At STSFT information and entries made by the safeguarding team could not be viewed by health visitors and school nurses as the EMIS electronic patient records system had not been set up to support this. The Trust were aware and were working with information technology services, but at the time of our review this had not been resolved. We also noted that safeguarding information, such as child protection plans for children to who school nurses were providing care, had not been scanned onto the EMIS record. At NTWT important safeguarding information such as a MARAC safety plan and other child safeguarding information were missing from the patient's electronic record. Consequently, the use of fractured health records limited practitioners' awareness of risks and protective factors to effectively safeguard unborn babies and children and young people. ***(Recommendation: 4.2)***

5.2.6 Audit of frontline practice was well established by heath visitor managers. They completed regular audit of children's case files to quality assure the work of health visitors. This helped to ensure that risks to children had been accurately identified and that the action they took was correct and met the needs of those in their care.

5.2.7 Operational management oversight of CASH practitioner's child safeguarding work was not robust. This had stalled for around a year following changed staffing. Existing audit in CASH services concentrated on record keeping, but this lacked a rigorous focus on safeguarding practice. Safeguarding professionals had good oversight of standards of practice such as the quality of referrals CASH staff made to children's social care. However, this was done in isolation as CASH operational managers were unaware of any quality issues, so they could not support improvement to practice. The Trust informed us they planned to improve management oversight of safeguarding practice by providing a safe care lead, but the timescale of this was not specified at the time of our review. ***(Recommendation: 5.7)***. *Public Health commissioners will also be notified of this finding.*

5.2.8 Quality assurance of reports written by CYPS staff for child protection conference were underdeveloped which hindered improvement to this practice. In case examples the dedicated report template within NTWT safeguarding children policy was not used by staff. As a consequence, reports completed by staff lacked structure and analysis and failed to include some key detail. One report examined had been signed off by a duty worker, but the quality was not of a good standard which weakened multi-agency information sharing and decision making. The absence of effective quality assurance impeded improvement to standards of practice and multi-agency working to safeguard children. ***(Recommendation: 4.4)***

5.2.9 The existing audit of child safeguarding practice in primary care had limited effectiveness at driving improvement. In the two GP practices we visited the section 11 self-evaluation audit was over optimistic in some fields. The presence of safeguarding policies and dedicated leads had not ensured that child safeguarding practice was robust. As a consequence, this prevented the accurate identification of good standards of safeguarding practice and areas that required improvement. ***(Recommendation: 8.7)***

5.2.10 Safeguarding professionals and managers at STSFT, NTWT and Humankind had strengthened their oversight of the safeguarding practice of frontline staff. They had developed individual electronic systems that helped them to monitor and track the safeguarding activity of frontline staff. This did rely on staff using the relevant system which overall worked well. This provided managers and safeguarding professionals with good oversight of the action taken by staff to safeguard children and facilitated additional follow up where required.

5.2.11 Progress by leaders at Humankind had not been swift enough to address the low number of referrals that children's social care accepted. Leaders had tracked the outcome of referrals and found that 38% were not accepted. This risked children and young people not being provided with timely access to the help and protection they needed. ***(Recommendation: 4.1** and **7.4)***. *Public Health commissioners will also be notified of this finding.*

5.3 Training and supervision

5.3.1 The safeguarding children policies at STSFT and NTWT contained insufficient detail about safeguarding training requirements. The policies lacked specificity about the number of child safeguarding and CLA training hours staff needed commensurate to their role. Training data did not distinguish clearly enough that relevant staff met the Royal Colleges Safeguarding Children and Young People (2019) and Looked After Children (2015) Roles and Competency standards for enhanced level three training. This limited assurance that staff were trained to effectively safeguard children and meet the needs of CLA. ***(Recommendation: 6.4)***

5.3.2 Aspects of learning from a serious case review was yet to be embedded in some health services. The PED and health visiting made good progress to implement recommendations that helped to safeguard children. However, this was less developed in child and adult mental health services. Practitioners in child and adult mental health services were yet to embed what was learned about the management of young people that refuse treatment which was a recommendation locally. ***(Recommendation: 6.5)***

5.3.3 At STDH medical staff did not have good access to peer review, that included safeguarding and CLA practice. This hindered opportunities to discuss complex case management and further medical staff's professional development. Access to one-to-one supervision for the named doctors with the designated doctor was yet to be established which was a gap. This limited assurance that standards of practice effectively safeguarded children and hindered professional development of frontline staff. ***(Recommendation: 5.8)***

5.3.4 Named nurse for safeguarding children and looked after children at STSFT reported they had good access to support and regular supervision with both designated nurses. This was valued by staff and facilitated where indicated sensitive professional challenge to aid improvement.

5.3.5 There were deficiencies in AED staff completion of child safeguarding training. Almost half of medical staff had not completed level three child safeguarding training and had not consistently accessed monthly reflective practice sessions provided by the named doctor. This limited opportunities to develop frontline staff skills and raise standards of child safeguarding practice. ***(Recommendation: 5.9)***

5.3.6 There was some inconsistency in midwives' uptake of safeguarding training and supervision. Community midwives were fully compliant, but midwives based in the antenatal clinic and labour ward had not all achieved that standard. ***(Recommendation: 5.9)***

5.3.7 Good compliance with a range of safeguarding training and supervision was evident in the health visiting and school nursing service. Staff had received training from the named LAC nurse to ensure they had the skill and recognition required to respond to the health needs of looked after children. Staff had good access to ad-hoc and quarterly safeguarding supervision that facilitated analysis of safeguarding practice and the formulation of additional recommendations that informed the ongoing care of children.

5.3.8 In CASH some staff had not received child safeguarding training commensurate with their role. The training that band three staff had received was not in line with national guidance for the duties they carried out which meant staff did not have enough expertise to safeguard children effectively. CASH staff made good use of ad-hoc advice from the safeguarding team that helped inform decision making and the action needed to safeguard children. Staff accessed twice yearly group safeguarding supervision which provided opportunities for further professional development. ***(Recommendation: 5.9)***. *Public Health commissioners will also be notified of this finding.*

5.3.9 Matrix staff had good access to safeguarding training that included training around adverse childhood experiences. This enabled practitioners to adopt a more contextualised approach to safeguarding which strengthened their practice. Furthermore, learning from regional serious case reviews had informed safeguarding practice. Matrix trained practitioners from the local authority and wider health partnership which raised the profile of substance misusing behaviour and associated safeguarding risk factors.

5.3.10 There were gaps in the safeguarding training in some mental health services at STDH. Some staff had not met the Trust standard in level one and three safeguarding children training which could affect the ability of staff to safeguard children effectively. Children's practitioners had good access to ad-hoc advice from safeguarding professionals that was documented well and actioned. While adult mental health staff could access ad-hoc advice and twice-yearly children's safeguarding supervision, there was no policy requirement to access safeguarding supervision when they worked with families at child protection level. While we acknowledge staff could access advice for such cases this had not been formalised. This prevented opportunities for staff to have dedicated time to critically reflect on complex cases they were involved in that could further strengthen and enhance their 'think family' practice. ***(Recommendation: 5.9)***

5.3.11 Leaders at NTWT reported staff had good compliance of level three training that was 96%. This had improved since quarter four from 86%. However, adult mental health practitioners did not benefit from good access to important multi-agency training. This hindered awareness of partnership working and the importance that role that each agency had to safeguard children effectively. Staff had good access to ad-hoc supervision from managers and the safeguarding and public protection team that was evidenced well in children's records. The safeguarding supervisor had some oversight of children that were the subject of child protection plans and reviewed those cases every six months. ***(Recommendation: 11.2)***

5.3.12 While most staff in Humankind had completed their safeguarding training, the findings of the review showed there was more to do to develop and embed good standards of practice. Gaps in the provision of PREVENT training had been addressed and plans were established to complete this in June 2019.

5.3.13 In Humankind the provision of safeguarding supervision had been strengthened. Although this was at an early stage of implementation (April 2019) staff had received an update about the changed threshold document. Leaders had arranged for the safeguarding supervisor to attend dedicated training to enhance their expertise further. Staff accessed regular management supervision where safeguarding could be discussed, and we saw case records that demonstrated the outcome well.

5.3.14 UCC staff reported they accessed annual safeguarding children and adults training and quarterly supervision through Vocare. Assurance that this fulfilled the national standard and ensured competence were unclear as outlined earlier. ***(Recommendation: 10.1)***

5.3.15 Safeguarding leads in GPs had good access to support through dedicated safeguarding forums provided by the CCG. This facilitated the dissemination of safeguarding updates and information, but this was shared in different formats with staff at both practices. There was limited assurance about the effectiveness this had on the development of safeguarding practice of frontline primary care staff.

5.3.16 GP practices visited had not ensured that staff met national standards of child safeguarding training. We found that practice nurses were trained to level two and key administrative tasks that related to children and safeguarding information were completed by level one trained administrators. This meant staff may not have important skills to safeguard children and young people effectively. ***(Recommendation: 8.5)***

Recommendations

1. South Tyneside CCG should:

1.1 Ensure designated safeguarding and children looked after roles are resourced to effectively discharge their strategic and operational duties.

1.2 Implement their pledge to CLA and reduce the gap in provision by commissioning health assessments beyond the age of 18 years.

1.3 Ensure commissioners establish effective reporting of the provision and impact of mental health services to children looked after and the outcomes achieved to key designated professionals.

1.4 That leaders establish effective quality assurance of initial health assessments to ensure standards of practice achieve a good quality.

2. South Tyneside CCG and NHS England should:

2.1 Improve oversight of the effectiveness of the adult SARC provision to under 18 year olds to ensure young people are supported to achieve improved outcomes and are safeguarded.

3. South Tyneside and Sunderland NHS Foundation Trust, Northumberland Tyne and Wear NHS Foundation Trust, Humankind, Vocare should:

3.1 Ensure practitioners 'Think Family' and check whether adults have caring responsibilities for linked children and record family compositions to strengthen their awareness of risks to children and avoid hidden harm.

4. South Tyneside and Sunderland NHS Foundation Trust, Northumberland Tyne and Wear NHS Foundation Trust, Humankind should ensure:

4.1 Unborn babies, children and young people receive the help and protection they need because referrals made to children's social care are of good quality; convey appropriate information; analyse and articulate risk and helps safeguard them from harm.

4.2 Record keeping is effective so staff have efficient and effective access to a complete health record about people in their care that contains information about known additional needs; alerts and flags: vulnerabilities and safeguarding and this is used to inform assessments and safe decision making.

4.3 Multi-agency decision making to safeguard children in the ISIT is strengthened and effective because relevant information is secured and shared from child and adult health services and primary care.

4.4 Multi-agency safeguarding children work and decision making is strengthened through the effective completion of good quality reports that are secured in the health records.

4.5 The CCG and adult health services work with the Local Authority to strengthen the effectiveness of multi-agency working so that adult services can be invited and active participants to relevant multi-agency meetings/decision making to safeguard children.

4.6 Strengthen joint working from adult mental health and substance misuse services with health visitors and school nurses to help meet the needs children and families.

5. South Tyneside and Sunderland NHS Foundation Trust should ensure:

5.1 Women receive effective care from midwives that have been trained and are competent in mental health that secures better maternal and infant outcomes.

5.2 There are improved monitoring and risk assessment of children and young people waiting for mental health services to aid the early identification of changed need and swift access to help if required.

5.3 Information sharing is effective by working with partners so GPs are notified of outcomes of multi-agency safeguarding decision making so risk is understood and can inform children's ongoing healthcare.

5.4 Information sharing is effective at key points of care to ensure people are safeguarded effectively.

5.5 Work jointly with children's social care to obtain parental health histories to strengthen children in care health assessments to aid the early identification of future health needs of children looked after.

5.6 That children looked after health action plans are robust and have actions that are specific, measurable and timebound and that these are overseen to ensure outcomes can be improved before the next statutory assessment.

5.7 Improvement to safeguarding and children looked after practice is achieved through effective audit activity and that findings are used to enhance standards of practice.

5.8 Continuous professional development of safeguarding and children looked after practice is enhanced through the provision of peer review and supervision of named doctors by the designated doctor.

5.9 Unborn babies, children and young people are effectively safeguarded by trained, skilled and competent staff and that child safeguarding training is commensurate with their roles and responsibilities and complies with national guidance.

5.10 Midwives complete effective risk assessments of the home environment to aid the early identification of hazards that could be harmful to those in their care.

5.11 They work with children's social care to improve the quality and specificity of birth plans to better safeguard those in their care.

5.12 Work with partners to strengthen early help arrangements to unborn babies and expectant parents/carers and track progress using measurable timescales to aid oversight and scrutiny.

5.13 Women are provided with continuity of carer from midwives in line with national standards.

6. South Tyneside and Sunderland NHS Foundation Trust, Northumberland Tyne and Wear NHS Foundation Trust should ensure:

6.1 That they address the unacceptable waiting times children and young people experience whilst waiting for support/treatment with their emotional and mental health.

6.2 Information sharing, and multi-agency decision making is effective between adult health services and children's social care to help safeguard children.

6.3 Improve joint working and the effectiveness of statutory health assessments for children looked after through the strengthened input of child mental health services.

6.4 Improve the specificity of safeguarding children and children looked after training and policies to provide greater clarity about role specific and enhanced skills required by staff to meet national guidance.

6.5 Learning from serious safeguarding incidents and reviews is embedded to improve standards of safeguarding children practice.

6.6 Clinical pathways are NICE compliant and enhanced to ensure women receive effective integrated mental health care during the peri-natal period.

7. Humankind should ensure:

7.1 Ensure children and young people are effectively safeguarded from the harmful effects of opiate substitution replacement therapy prescribed to adult clients by implementing procedures that give robust assurance of this.

7.2 Risk assessments to include enquiries about domestic abuse are completed effectively to reflect changing risks and needs so that adults and linked children can be safeguarded.

7.3 Effective information sharing with GPs is implemented to strengthen joint working to safeguard children.

7.4 Leaders address the low uptake of referrals made to children's social care to avoid children's delayed access to help and protection.

7.5 Strengthen scrutiny of planned improvements to safeguarding practice and ensure action plans are specific, measurable, attainable, realistic and timely to aid tracking of progress to avoid lag.

8. NHS South Tyneside CCG together with primary care practices should ensure:

8.1 Improve the early identification of domestic abuse in primary care and provide an effective safeguarding response if identified.

8.2 Multi-agency safeguarding children work and decision making is strengthened through the effective completion of good quality reports that are secured in the health records.

8.3 Improve joint working and the effectiveness of statutory health assessments for children looked after through the strengthened input of GPs.

8.4 Information sharing is robust so that GPs are effective safeguarding partners in contributing to multi-agency decision making at MARAC, MAPPA and the ISIT.

8.5 Unborn babies, children and young people are effectively safeguarded by trained, skilled and competent staff and that child safeguarding training is commensurate with their roles and responsibilities and complies with national guidance.

8.6 Unborn babies, children and young people receive the help and protection they need because referrals made to children's social care are of good quality; convey appropriate information; analyse and articulate risk and helps safeguard them from harm.

8.7 Improvement to safeguarding and children looked after practice is achieved through effective audit activity and that its findings are used to enhance standards of practice.

9. South Tyneside CCG together with, South Tyneside and Sunderland NHS Foundation Trust, Primary care and Humankind should ensure:

9.1 Work with social care partners to ensure that outcomes of referrals made to children's social care are proactively sought to ensure children get the help and protection requested.

10. South Tyneside CCG together with, South Tyneside and Sunderland NHS Foundation Trust and Vocare should:

10.1 Ensure children are effectively safeguarded by subcontracted services by strengthening the scrutiny and challenge of child safeguarding practice.

11. Northumberland Tyne and Wear NHS Foundation Trust should ensure:

11.1 Children looked after have an increased profile to ensure they are the recipients of effective care and are supported to achieve better outcomes.

11.2 Strengthen the safeguarding expertise of staff through improved uptake of multi-agency child safeguarding training to enhance their skills further and comply with national guidance.

11.3 Improved access for children and young people to 24-hour specialist crisis provision in child and adolescent mental health services.

11.4 Adult mental health services to work more closely with partners to ensure the impact of adult client behaviours and changed risk is shared effectively to inform and strengthen decision making for linked children looked after.

12. South Tyneside CCG, South Tyneside and Sunderland NHS Foundation Trust, Northumberland Tyne and Wear NHS Foundation Trust, Humankind, Vocare should:

12.1 Strengthen the identification of risks to children through frontline staffs effective use of assessment tools and prompts so children can be effectively safeguarded.

Next steps

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