

Review of Health Services for Children Looked After and Safeguarding in Stockton on Tees

Children Looked After and Safeguarding

The role of health services in Stockton on Tees

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Name(s) of CQC inspector:	Lea Pickerill (Lead) Mandy Burton Daniel Carrick
Provider services included:	North Tees & Hartlepool NHS Foundation Tees Esk Wear Valley Mental Health NHS Trust Virgin Healthcare Contraception & Sexual Health Services Primary Care GP Services
CCGs included:	NHS Hartlepool & Stockton Clinical Commissioning Group
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CQC Regional Director:	Malcolm Bower-Brown

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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 Stockton on Tees. 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 Stockton on Tees, 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 all aspects of 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. This includes the statutory guidance, Working Together to Safeguard Children 2013.

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 a corroborated set of evidence.

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 52 children and young people.

Context of the review

Stockton-on-Tees is a unitary authority and borough in the Tees Valley, in north-east England, with a population of 191,600 shown in the 2011 census.

The borough of Stockton-on-Tees consists of the market town of Stockton (population 82,880), and the smaller outlying settlements of Billingham (pop. 36,720) and Thornaby-on-Tees (pop. 23,200), including Ingleby Barwick (pop.16,280). Durham Tees Valley Airport is also partly within the borough. The Stockton-on-Tees borough accounts for the largest number of residents within the Teesside and Hartlepool urban area.

The health and well-being of children in Stockton on Tees is generally worse than the England average. Infant and child mortality rates are similar to the England average. 24.8% of the population of Stockton on Tees is under the age of twenty. 8.8% of school children are from a black or minority ethnic group.

The level of child poverty is worse than the England average with 22.8% of children aged under 16 years living in poverty. The rate of family homelessness is better than the England average.

Commissioning and planning of most health services for children are carried out by the Hartlepool and Stockton on Tees CCG.

Acute hospital services and most community based services are provided by North Tees and Hartlepool NHS Foundation Trust. Contraceptive and sexual health services are provided by Virgin Healthcare.

Child and Adolescent Mental Health Services (CAMHS) and adult mental health services are provided by Tees, Esk Wear Valleys Mental Health NHS Trust.

The last inspection of health services for Stockton on Tees' children took place in October 2010 as a joint inspection, with Ofsted, of safeguarding and looked after children's services. Recommendations from that inspection are covered in this review.

The report

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

What people told us

We heard from:

The parents of one young boy aged 6 who was waiting for an x-ray. They told us that, "The ambulance staff were really good, they got down to his level and explained everything really well and then he calmed down." By the time the young boy arrived at the hospital he was able to co-operate with the nurses and doctors and his treatment went well.

We observed one doctor carefully and sympathetically explaining to a teenager the findings of an x-ray, showing her on the picture what the problem was, and advising her on the next steps.

The mother of a young infant who told us, "Health professionals have worked with me, not against me, so that we can both thrive." This is from a parent who has had problems in trusting health practitioners and has recently stepped down from a child protection plan to a child in need plan.

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. We saw many good examples of practitioners working together across health, education and social care to support families and safeguard children and young people as part of team around the child and team around the family. However, the use of Common Assessment Framework (CAF) remains under-utilised, with an over reliance on the child in need process. This means that sometimes there is a delay before families receive support. A lack of clarity and accountability within the existing CAF process resulted in some recommendations for CAF by children's social care not being actioned by any agency. In one case, a young girl and her family remain without any ongoing support despite unmet needs identified at a strategy meeting at which it was agreed that the threshold for child protection was not met but an expectation that some early help work would be delivered. In two other cases we tracked, we saw that maternity services were not using the CAF as a way of supporting a family and instead referred directly to children's social care; we were told that this was because both women were already known to children's social care, though not open to them. We did see how CAF is being used regularly, to good effect, within the adult substance misuse service and the uptake of pre - CAF within adult mental health and child and adolescent mental health services (CAMHS) is steadily increasing but from a low base

Child F attended A&E following a serious overdose and was admitted onto the paediatric ward where she was assessed by CAMHS once medically fit. CAMHS practitioners were concerned about the amount of stress the young person was under due to her caring responsibilities within the home. A referral was made, with her mother's permission, to children's social care to seek support for the family. A CAMHS appointment was given for Child F upon her discharge home. A referral was also made to the local young carers' service, Eastern Ravens. CAMHS liaised closely with the child's school who put in an excellent 'safety plan' to keep Child F safe in school. There was considerable delay and confusion between CAMHS and children's social care as to the outcome of the referral and children's social care's decision to close the case and recommend a CAF. The CAF was never initiated and the mother later told the CAMHS practitioner that she had felt, "Unsupported and let down by services."

1.2 Children and Adolescent Mental Health Services - Targeted Support at Tier 2 is under resourced and practitioners are working with unsustainable case loads. This means that whilst Tier 3 CAMHS are able to offer appointments within four weeks of referral, they are unable to step down their interventions due to the lack of resources at Tier 2, and are continuing to work with children and young people that no longer need such specialist resource but cannot be discharged into Tier 2 services because of capacity. We were told that additional resource for Tier 2 services had been identified and would be in place in Spring 2014.

1.3 The flexible approach to delivering the CAMHS targeted support in community bases, schools and in general practice is most welcome. One voluntary sector provider told us that it was, "Brilliant being able to refer families to the drop in service and families appreciate the quick access and continuity of support." We heard a similar comment from a GP.

1.4 We found evidence of a flexible and responsive approach to allocating appointments within CAMHS when additional concerns were raised or when urgent cases were referred.

D was a 14 year old young person who was referred to CAMHS by children's social care. Based on the information in the referral letter a routine appointment was offered within four weeks. The social worker contacted CAMHS to provide them with additional information and two days later D's mother also contacted CAMHS to advise on a deteriorating situation. The team discussed the referral and an emergency appointment was offered for the following day.

1.5 Practitioners working in CAMHS are vigilant to the pressures on children who may also be young carers and refer promptly to the Eastern Raven's service along with other local support services to enable these children and young people to access support for them in this challenging role.

1.6 Good arrangements are in place within the adult substance misuse service for establishing the presence of children and family/household circumstances as part of the initial assessment process when meeting new clients. Where a client discloses information about children in their care, practitioners routinely liaise with colleagues, including health visiting teams, to determine if the child is known to them. The service has a child protection safeguarding lead who meets with clients who are known to have children. Records seen indicate that where risk had been identified to a child, practitioners were making timely referrals to children's social care and actively following up cases to ensure action had been taken to safeguard the safety and wellbeing of the child.

1.7 A multi-agency assessment tool, developed across Tees, has been adopted by the Tees, Esk Wear Valleys Mental Health NHS Trust. The tool prompts practitioners to assess the impact of parental mental health on children. This activity continues to strengthen the awareness of keeping a child focus when caring for adults with mental health problems.

1.8 Safeguarding arrangements to protect young people accessing contraceptive and sexual health (CASH) services in Stockton are not sufficiently robust. Practitioners complete a risk assessment when young people aged 16 or under access CASH services practitioners to identify areas of potential concern, including the presence of abuse and exploitation. However, the records seen did not contain sufficient detail to demonstrate any actions undertaken by the team to respond to risk. Similarly, records seen showed little detail, and therefore there was limited evidence, of engagement with other professionals or evidence that young people had been asked for their views about other professionals involved in their care. (*Recommendation 2.1*)

1.9 All children under the age of 13 who present at CASH are referred to children's social care in line with local and national guidance. However, referrals are not routinely followed up; the team are not involved in any strategy meetings or core groups and so typically have no idea of the outcome of their referrals. Additionally, there is no facility built into the IT system to enable staff to place alerts when safeguarding referrals had been made and any knowledge about previous concerns would only be evident if and when the practitioner looked at former records of attendance. This means that vulnerabilities may be overlooked.

1.10 Good assessment processes in accident and emergency (A&E) identify potential safeguarding and child protection concerns. All files seen had the local "ACHILD" safeguarding triage assessment tool completed. We saw how staff had identified potential concerns about safety in the home and made a referral for the health visitor to visit the family to discuss the issue in more detail. However, the pre-printed documentation does not prompt or provide space to record who the child is accompanied by and this is a feature identified in Serious Case Reviews. (*Recommendation 5.2*)

1.11 Young people aged 14 and over attending A&E are usually seen in the adult A&E department and as a result their assessment is not 'child centred'. For example, records seen indicated that their pain was not immediately assessed and recorded. The department recognise the difficulties in treating young people in the adult area and plans are well advanced to create a dedicated adolescent space.

1.12 Young people who attend A&E following self-harm are always admitted into either the paediatric ward if they are 13 or under, between 13 and 16 a decision is made as to the most appropriate environment (either the paediatric ward or the admissions unit), and if over 16, treated in the emergency admission unit. Young people are not discharged until medically fit and have been assessed by CAMHS. This good practice gives young people a 'cooling off' period as recommended by the National Institute of Clinical Excellence (NICE).

1.13 Accident and Emergency staff demonstrate good awareness on the impact of adults with risky behaviours on children and young people; the deliberate self-harm pathway is a useful tool to ensure that any children in the family are identified and any immediate risks escalated. Some clinicians are not completing this part of the form and there is a risk that some vulnerable children may not be identified

The use of the mental capacity screening tool within the A&E documentation is good practice and we saw how this had been used to good effect in assessing one young man's capacity to understand and consent to treatment following an incident of self-harm.

1.14 Arrangements to identify and support pregnant women with additional vulnerability safeguard the unborn child well. In the records seen appropriate antenatal assessments had taken place. Medical and social information had been documented and any personal risks such as domestic violence, mental health and drugs and alcohol had been assessed. Appointments were set for antenatal care and non-attendance was followed up.

1.15 We found innovative practice in how women were discreetly notified of a telephone helpline if they were concerned about domestic violence and wanted assistance or advice.

1.16 Appropriate risk assessments and continued management plans were evident in the maternity files we saw; they contained clear evidence of family background and father details. There was, however, no system in place within the patient records (paper files) to alert staff about vulnerable cases and the absence of any documentation with an ongoing chronology meant that potentially important information may be missed or overlooked.

1.17 Some health visiting teams are benefiting from the planned recruitment of additional health visitors. This has allowed for teams to respond to the increased ante natal contacts that are now part of the ante natal pathway. This is an improvement from the previous Safeguarding and Looked after Child inspection when it was identified that health visitors were not able to carry out key contacts recommended in the Healthy Child Programme. We note that there are plans to introduce the 16 week visit by 2015 which will increase visits to support new families as part of the universal offer.

2. Children in Need

2.1. The North Tees and Hartlepool NHS Foundation Trust recently launched a new ante natal pathway; the key improvement is that as soon as vulnerability is identified in a pregnancy, a liaison form is completed and shared with the health visitor early in the pregnancy. This facilitates early ante natal contact and support from health visiting teams.

2.2. Women who are pregnant and misuse substances are supported by a specialist (addiction) midwife who works creatively to support women and provide ante natal care to help optimise the health of the unborn baby.

2.3. Health visitors routinely attend any child protection conferences for the unborn child to ensure continuity and consistency in support for the new baby and family.

Child B was living with her mother and her partner. Professionals were concerned about Child B's emotional and physical neglect and the parent's inability to sustain improvements when support packages put in place by children's social care had finished. A written agreement was put in place by children's social care for the grandmother to care for Child B as an interim solution. However, following a strategy meeting called in response to police information, a decision was made to support the grandparents with a residence order for Child B. The health visitor continues to support the grandparents through regular visiting and reports that Child B is much happier, appears more confident and her behaviour has improved in school.

2.4. We saw variable practice in arrangements for receiving children of school age into Stockton on Tees; this depended on how effectively risk was assessed and communicated between the different school nursing teams and in one case the local authority. In one case, we saw how a school nurse who was allocated a family made contact quickly to ensure they were registered with a GP and dentist and contact details were exchanged. However, in a different case, where the school nurse had not been made aware of a family with a child with complex needs transferring in, by either the previous school nurse or the local authority's complex needs team, there was an unnecessary delay in supporting the child with their health needs in school.

2.5. Contraceptive and sexual health services are represented in the Vulnerable Exploitation Management Team Information Sharing Group. Information obtained via this forum is cross referenced to highlight young people, identified as 'at risk' who may be using the service. This is good practice as it enables those young people who are at most risk to be identified, monitored and provided with a co-ordinated package of support.

2.6. Once a child or young person is removed from child in need measures the health visitor or school does not discharge them to universal pathway until all health plans are in place or completed. This includes checking that they are appropriately registered with a GP and dentist and that all health appointments have been completed or are appropriately planned and booked. This ensures continued care and support once the child or young person moves away from protective measures.

Mother of Baby A had a history of mental health problems and historic substance misuse. She attended A&E following an incident of domestic violence and told clinicians that she was pregnant. A&E staff made a referral to children's social care. A pre-birth case conference was held and when Baby A was born a child protection plan was put in place. The family have continued to receive support through regular core group meetings which have been well attended by health practitioner from adult mental health services and health visiting service. The child protection plan was discontinued recently and the family are now being supported through child in need. The health visitor continues to provide enhanced support through frequent visits with good health outcomes for the baby to date; he has weaned successfully, meeting all his developmental milestones and the mother continues to increase in confidence.

2.7. A consistent feature in cases we reviewed was how effectively professionals were working together to support families who needed extra help. Information sharing across agencies, in cases seen, was appropriate and in most cases timely. There was evidence of how practitioners were seeking advice and support from their organisation's safeguarding team where they were unsure or needed more specialist advice, for example on breaching confidentiality. It was encouraging to see in one very complex child in need case we reviewed, how the adult mental health practitioner observed the interaction between the mother and child and had clearly documented her findings, escalating her concerns to the safeguarding team and children's social care when she believed the child to be at risk.

Child E is a 7 year old girl who has a mild learning disability. CAMHS Learning Disability services have been supporting the family with strategies to help manage her poor sleep patterns and challenging behaviour. Child E has had a disrupted education so far with four changes of school in a short time and currently attends a special school. CAMHS Learning Disability team are working closely with the new school to help put strategies in place to help manage Child E's behaviour. Practitioners across health, education and social care are working closely together to continue to support the family and safeguard Child E.

3. Child Protection

3.1. The introduction of neglect medicals for children to support the child process was introduced following a serious case review. However, the number of medicals has escalated and in a recent audit it was established that requests were not evidence based. The significant increase in numbers has led to unacceptable delays in child protection medicals taking place contributing to drift in meetings timeframes within child protection plans. This means that there is the risk that children may live with unmet need longer than is necessary. (*Recommendation 4.6*)

3.2. Appropriately trained and supervised paediatricians carry out child protection medicals, including those where historical sexual abuse is suspected. However, where there is suspicion of acute sexual abuse the children and young people are seen in the specialist facility based in Newcastle.

Child S is an 11 year old girl who has a learning disability and is cared for by her parents. The family have received intermittent contact from services over a number of years. The mother became pregnant again and the midwife raised concerns about the home environment and that the mother was potentially exaggerating Child S's emotional and physical health. A referral was made to children's social care. As part of the child protection plan a referral was made for a child protection neglect medical. The medical report provided clearly articulated the risk to Child S and the impact of her mother's behaviour on her development. A child protection plan is now in place and the family are being supported well. Child S is doing much better in school and presents as much happier.

3.3. We found many examples of joint visits between health professionals and also joint visits with social workers in supporting families with child protection plans in place.

A new mother was referred to the mental health crises team by the GP for low mood and self harming behaviour. The GP rang children's social care to advise them of the referral. The crises team provided intensive support and records seen show good observation by the practitioner on the mother's interaction with the baby and the baby's presentation throughout the episode of care. The practitioner sought regular supervision from the trust's safeguarding team and consulted with a senior manager when it became evident that her client's confidentiality had to be breached to safeguard the baby. Information was appropriately shared with children's social care and the family are now supported with a child protection plan

3.4. We found that most professionals understood the thresholds for referral to children's social care. We saw evidence of appropriate escalation to named nurses for advice and support when there were areas of professional disagreement. However, health professionals would benefit from further training on how to assess and articulate risk when completing referrals to social care as the children's social workers are not health experts and may not always understand the implications of what was often a chronological description of events. (*Recommendation 3.1*)

3.5. Some child protection plans seen were not child outcome focused or had no specific dates for when actions should be completed. This led to drift and parents were not held to account.

3.6. Overall, there is good attendance at child protection conference and core groups by health practitioners. Adult mental health practitioners are increasingly attending child protection conferences and we were told that they are encouraged to provide advice to social workers on cases that are going to child protection conference where the client's file is closed to adult mental health practitioners. This means that the conference is better informed as to the potential impact of parental mental health on the child in the family and can make a more informed plan.

3.7. Birth response plans produced by the Senior Nurses in the Safeguarding Children Team, in conjunction with midwives and other agencies, were seen to be comprehensive and offered advice to health and other multi agency professionals regarding the care and safety of the mother and baby whilst both on the ward and after discharge. This information was seen to be shared with neonatal ward staff, the GP, social workers and health visitors. This process serves to inform and re-assure staff in relation to their responsibilities when providing care and support to the mothers and their newborn baby.

3.8. School nurses complete comprehensive health needs assessments on those children and young people who are at school and have a child protection plan in place. On the files inspected we noted how these assessments were used to effectively assess risk and identify need with well thought out action planning and monitoring of outcomes through robust supervision

3.9. Generally, the involvement of GPs in child protection is underdeveloped. General practitioners we spoke to are frustrated at their perceived lack of consultation and communication. We saw how minutes of child protection meetings are not routinely copied to GPs and how correspondence had not been acknowledged or responded to by social workers. Despite some high quality partnership working being evident in the files we reviewed, it is of note that GPs are not routinely consulted or informed in the same way; particularly in relation to adult mental health, health visiting and school nursing. This impacts on their ability to support and understand families when they visit the surgery as they do not always have the most up to date information on their records. (*Recommendation 1.1*)

3.10. GPs are aware of children who have a child protection plan in place. An electronic flag is easily identifiable on the patient record. They are also able to identify when a child is removed or historically has been supported by a child protection plan. We heard how practice staff are vigilant in their child safeguarding awareness.

A grandmother and aunt attended the GP practice to register a baby. The receptionist identified that neither parent was able to attend and that the baby was living with grandmother. The practice staff sought advice from the safeguarding team who made enquiries. A social worker contacted the GP practice to give permission for the grandmother to register the baby.

4. Children Looked After

4.1. The CCG has responded well to the challenge of improving awareness on the health needs of children looked after and the responsibilities of the CCG and provider organisations in meeting those needs. However, much work is still needed to enable accurate identification and reporting on the specific health needs of the cohort of looked after children and for commissioners and providers to demonstrate improvements in their health following intervention and support.

4.2. The lack of an appropriate IT electronic system to support the children looked after team means that ongoing monitoring and reporting on key health performance indicators is unreliable and information missed. On one file we reviewed there was nothing to indicate when the young person had last seen a dentist. The electronic health records held by the team were very limited with most information held as paper copies. (*Recommendation 4.3*)

4.3. There is no designated doctor for children looked after and there is no quality assurance of initial health assessments. This means that the opportunity to drive forward a programme of continuous improvement is being missed. (*Recommendation 4.4*)

4.4. Health plans for children and young people placed out of area are currently carried out by other providers but are reportedly received and monitored by the children looked after nurse as part of her quality assurance process. One of the proposed recommendations from the Children Looked After Annual Report 2012/13 included improving arrangements for out of area placements. We were unable to ascertain how and if this had been achieved. Therefore there is the potential for children placed out of Stockton to be receiving a less equitable service than their counterparts.

4.5. All initial health assessments reviewed had been completed by a registered medical practitioner and there was evidence that information from the assessments had been shared appropriately.

4.6. We found unacceptable delays in children and young people becoming looked after being seen by a paediatrician for initial health assessments. In the majority of cases this had been because confirmation of consent had not been received from the local authority and is a long standing concern. Resources had also affected the paediatrician's capacity to complete initial health assessments during the Autumn of 2013 when there had only been one doctor available to undertake the assessments. We were assured that this deficit has been resolved. *(Recommendation 4.1)*

4.7. GPs are aware of children who are looked after who are registered at their practice through an icon on their electronic record. GPs told us that they are routinely asked to provide information for initial and review health assessments and that they receive copies of their health plans. This is good practice and enables the GP to consider the additional vulnerability during a consultation with the child or their carer. All files for children looked after seen demonstrated that children and young people were permanently registered with a GP.

4.8. Overall, initial health assessments and subsequent review health assessments contained a good and appropriate level of detail. The files reviewed included health care information in respect of family history and previous and current health care needs. In addition, there was reference to emotional and mental health care needs where applicable. Where reviews and initial health assessments had been completed for children under 5 years of age, information included detail about developmental milestones.

4.9. Information had been shared with the children looked team when children or young people had attended the A & E department and records of those visits were held on file in readiness for reviews.

4.10. In cases where health needs were identified there was good evidence to show that appropriate and timely referrals had been to specialist professionals in accordance with needs.

It had been identified that prior to Child Z becoming looked after she had required support from an ophthalmologist. There was information to indicate that family members had failed to take her to appointments and a review was overdue. The issue was picked up as part of her initial health assessment and a referral was made; the child has been seen and her health needs are now being met.

4.11. Systems are in place to identify and respond to need around any additional emotional health and wellbeing support for children looked after. Social workers and the health team for children looked after are able to make direct referrals to the specialist CAMHS service and the process was reported to be satisfactory. The health team for children looked after lead on the use of Strengths & Difficulties Questionnaires (SDQs) as a monitoring tool to identify concern around the emotional health of children looked after and as a prompt for discussion amongst professionals in the child's wider team. However, from records seen we were unable to identify how the completed assessments were used as part of the ongoing health reviews.

4.12. Young people spoken with were aware they were expected to have reviews of their health undertaken, although they did not understand the reasoning behind this. We were told, "It's just something you have to do...I don't know what it's for." This demonstrated a lack of involvement and ownership in the health review and as such could impact on young people fully engaging with health professionals. (*Recommendation 4.5*). Young people did tell us that they were supplied with information regarding sexual health, healthy living and smoking cessation advice and that they also knew who to speak with in confidence should they feel the need.

4.13. We saw how the involvement of the Family Nurse Partnership is helping to support a young female who is currently looked after and is pregnant. The flexibility and understanding on the part of FNP practitioner is helping the young person to trust practitioners and engage more effectively during the ante natal period to improve outcomes for the young woman and her baby.

4.14. Health files reviewed for care leavers showed good practice. They demonstrated that final health reviews were taking place in a timely manner and contained information from previous reviews and also from the GP. Other files showed that young people were engaging in the process and in some cases identifying their own health care needs and planning for the future. Stockton on Tees do not currently provide their young people leaving care with a health summary, though discussions are ongoing with groups of children and young people looked after to explore this further. (*Recommendation 4.2*)

Management

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

5.1 Leadership and management

5.1.1 The NHS England Area Team (LAT) are making good progress in implementing the accountability framework for safeguarding. In the absence of a national model the LAT has agreed a local framework with the five CCG's and the respective local children safeguarding boards to facilitate local compliance with the LAT's statutory responsibilities and obtain assurance across the regional on safeguarding practice.

5.1.2 A quality surveillance group has been set up, with a sub group for safeguarding children and adults to ensure an ongoing emphasis on the care of vulnerable children and adults.

5.1.3 The Executive Nurse and Designated Safeguarding Children professionals provide clear and effective leadership on safeguarding children practice across Stockton on Tees. Regular 'Monday morning meetings' between key professionals and the designated safeguarding team continue to embed safeguarding children awareness across the CCG. Other departments, such as finance are demonstrating a deeper understanding on the impact of their work, for example when processing requests for payment for out of area placements for a child look after.

5.1.4 Involvement of children, young people, their families and carers in the development and evaluation of services, on behalf of the CCG is underdeveloped and this is fully acknowledged as an area for improvement. The local Healthwatch manager is invited to their board meetings and members of Healthwatch will participate in quality visits to local health services.

5.1.5 Arrangements put in place by the CCG are providing the Board with robust assurance on safeguarding children practice across the local authority area. The ongoing work to develop stronger key performance indicators around practice will increase accountability of provider organisations. The work programme for 2013/2014 sets out clearly the priorities for the forthcoming year and there are good arrangements in place to monitor the delivery and impact of this work.

5.1.6 The designated nurse for Stockton on Tees is supporting the development of a number of forums across the local area and Tees-wide to strengthen and standardise safeguarding children practice. This will help to share best practice and learning from serious case reviews and other learning events. A senior nurse development group is in its infancy, included in the terms of reference is to promote best practice and prepare for succession planning within the named and designated professional Tees-wide network.

5.1.7 The CCG recognise the impact of not having a named GP appointed to support the Stockton LSCB and to work with local general practitioners in embedding safeguarding children practice. This is a long standing deficit and despite ongoing attempts by the former primary care trust to recruit to the post the vacancy still exists. Action to mitigate risk includes support visits to GP practices and these are starting to impact positively with an increase in numbers of practices requesting visits.

5.1.8 Arrangements within provider organisations for the named professionals are mainly compliant with "Working Together" and the intercollegiate guidance. However, the role of named midwife is incorporated into the job description for the Head of Midwifery and Children's Services; there is a lack of specific responsibility around the named midwife role and there is no resource allocated to the post holder in terms of time or support. (*Recommendation 5.1*)

5.1.9 The North Tees and Hartlepool NHS Foundation Trust have responded effectively to the recent findings of their gap analysis on how clinicians are meeting their responsibilities in safeguarding children. There is now a network of safeguarding champions across the trust who are taking responsibility for promulgating and promoting good practice within their clinical areas.

5.1.10 Tees, Esk Wear Valleys Mental Health NHS Trust have a well established link professional network across the organisation. However, a recent audit highlighted that the role was not sufficiently well known or understood. The trust is in the midst of an internal publicity campaign to highlight the support that link professionals can offer to practitioners around good safeguarding children practice.

5.2 Governance

5.2.1 NHS Hartlepool and Stockton CCG effectively monitor the health care providers' performance in safeguarding children practice through provider quarterly Clinical Quality Review Group. We saw how the quality group for the CCG had responded effectively to concerns with increased frequency of meetings until they were assured on practice.

5.2.2 Designated professionals are welcomed by the two NHS provider trusts at their safeguarding board and are an integral part of their safeguarding governance and reporting framework. The Stockton LSCB has recently formed a multi-agency Learning Lessons and Improving Practice Sub Group of which the designated nurse is the vice chair. This group is managing the investigations of a recent spate of incidents across member organisations and will monitor the progress of actions against agreed action plans.

5.2.3 Tees, Esk Wear Valleys Mental Health NHS Trust are in the midst of reviewing their governance structures as part of earlier work with the CQC. The proposed structures are now in draft form and have been shared with the CCG who have sought further clarification and asked the trust to provide mapping of the reporting and governance arrangements.

5.2.4 Improvements implemented by the Tees, Esk Wear Valleys Mental Health NHS Trust, since the previous Safeguarding and Looked After Child Inspection, include an electronic flag to highlight where there is a child protection plan in place within a family that the service are working with. In addition, children's social care now copy invitations to child protection conferences to the safeguarding team who monitor attendance.

5.2.5 The safeguarding team for North Tees and Hartlepool NHS Foundation Trust regularly audits the child's journey across community and acute services to ensure compliance with local safeguarding best practice. The looked after children nurse routinely reviews all health review assessments, including those for children placed out of area. In addition she also randomly samples four review health assessments every two months as part of the trust's approach to quality monitoring. Findings from the audits are shared with the responsible practitioners and discussed in supervision to promote improvement in practice.

5.2.6 Reporting systems within midwifery include monitoring and audit on the use of the maternity pathway, attendance at strategy meetings, timeliness of safeguarding referrals and the use of extended stay plans.

5.3 Training and Supervision

5.3.1 Designated and named professionals continue to access training and supervision appropriate to their roles. The designated doctor has recently participated in work led by the Royal College of Paediatricians to develop modules for designated doctors.

5.3.2 Practitioners working in the specialist substance misuse general practice are not accessing training at the level recommended by the Intercollegiate Guidance. Practitioners are working with some of the most vulnerable families and should access Level 3 multi-agency safeguarding training. (*Recommendation 2.2*) We found a similar situation with practitioners working in the contraceptive and sexual health service who had only received Level 2 training. There is recognition that Level 3 is more appropriate but practitioners reported limited availability for local training. (*Recommendation 2.1*).

5.3.3 We observed a meeting of the North Tees & Hartlepool NHS Foundation trust where we heard about the 'Professional Challenge in Children Processes' training being provided to health professionals regularly involved in multi-agency safeguarding work. This training is to equip staff with the skills and confidence in taking forward professional challenge and be pro-active in the safeguarding process; better promoting the quality of care provided to vulnerable children and young people.

5.3.4 Safeguarding training data provided for December 2013 demonstrates a high level of compliance. The trust has made a commitment to increase training opportunities with the proviso that safeguarding training must not be cancelled.

5.3.5 Tees Esk Wear Valleys Mental Health NHS Trust are in the midst of interrogating their training data following a data migration and are working closely with the CCG to resolve the discrepancies in their training figures. During the review we identified that a number of adult mental health professionals working in an 'assistant' role with vulnerable families in the community are not accessing Level 3 safeguarding children training. (*Recommendation 6.1*).

5.3.6 The looked after child health team are not sufficiently resourced to assist with direct training of health staff who carry out health reviews. They have developed an induction pack for all new staff to help support them and increase awareness around the health needs of children looked after and the associated processes. There is no involvement with the training of foster carers, but the looked after children's nurse provides advice as needed.

5.3.7 An early success of the Tees-wide nurse development group is the roll out of an accredited model of supervision. This will help improve and standardise the supervision of practitioners who are working to safeguard children and their families across the local area and tees-wide.

5.3.8 There is a renewed commitment to supervision within Tees Esk Wear Valleys Mental Health NHS Trust, with an emphasis to staff that it is their responsibility to seek supervision when they are working with a family where there is a child protection plan in place. The supervision we have seen within North Tees & Hartlepool Foundation Trust is exemplary, it is reflective, challenging and has clear planning with timeframes for action.

Recommendations

1. **Stockton on Tees and Hartlepool CCG, in partnership with the NHS England Area Team and the local authority should:**
 - 1.1 identify mechanisms to support and strengthen the contribution of primary care in local child protection and safeguarding children practice.
 - 1.2 Review the training within the General Practice that provides substance misuse support to ensure it complies with the Intercollegiate Guidance.

2. **Stockton on Tees & Hartlepool CCG should:**
 - 2.1 Ensure the designated professionals provide expert guidance and advice to CASH services in conjunction with Public Health (Local Authority) with regard to child protection and safeguarding practices, including training and supervision, to ensure that risk is appropriately identified, recorded and responded so as to keep young people safe

3. **Stockton on Tees and Hartlepool CCG, North Tees & Hartlepool NHS Foundation Trust and Tees, Esk Wear Valley Mental Health NHS Trust should:**
 - 3.1 Ensure that practitioners are assessing and describing the risk to children and families when making referrals to children's social care to enable social workers to make informed decisions.

4. Stockton on Tees and Hartlepool CCG and North Tees & Hartlepool NHS Foundation Trust, in partnership with the local authority should:

- 4.1 Ensure that all children who become looked after should receive their initial health assessment within statutory timescales.
- 4.2 Ensure that all young people who are leaving care are provided with a comprehensive leaving care health summary.
- 4.3 Provide the children looked after healthcare team with appropriate I.T. support to enable meaningful and accurate reporting on the health of children looked after.
- 4.4 Recruit to the post of designated doctor for looked after children to ensure that the health needs of this vulnerable group of children are represented strategically and that initial health assessments are quality assured.
- 4.5 Ensure that children and young people, looked after, are aware of the importance of their contribution to the initial and review health assessments to promote a developing sense of personal responsibility for their own health.
- 4.6 Review the pathway and resource for child neglect medicals as part of the child protection process to ensure that the medicals take place within a planned timeframe.

5. North Tees & Hartlepool NHS Foundation Trust should:

- 5.1 Review the job description and resource of the named midwife post to ensure it reflects the roles and responsibilities as outlined in the Intercollegiate Guidance and sufficient resource is allocated to the postholder.
- 5.2 Review the A&E documentation to ensure this facilitates practitioners to record the details of adults who accompany children to the department.

6. Tees, Esk & Wear Valley Mental Health NHS Trust should:

- 6.1 Assess the training requirements of practitioners working in a supporting role to ensure that they are accessing safeguarding training at a level commensurate with their duties.

Next Steps

An action plan addressing the recommendations above is required from Stockton on Tees & Hartlepool 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.