

# **Review of health services for Children Looked After and Safeguarding in Wakefield**

# Children Looked After and Safeguarding The role of health services in Wakefield

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<b>CCGs included:</b>	NHS Wakefield
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<b>CQC region:</b>	North
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## Contents

<b>Summary of the review</b>	<b>3</b>
About the review	3
How we carried out the review	4
Context of the review	4
The report	6
What people told us	6
<b>The child's journey</b>	<b>8</b>
Early help	8
Children in need	15
Child protection	19
Looked after children	26
<b>Management</b>	<b>30</b>
Leadership & management	30
Governance	35
Training and supervision	38
<b>Recommendations</b>	<b>44</b>
<b>Next steps</b>	<b>46</b>

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## Summary of the review

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This report records the findings of the review of health services in safeguarding and looked after children services in Wakefield. It focuses on the experiences and outcomes for children within the geographical boundaries of the local authority area and reports on the performance of health providers serving the area including Clinical Commissioning Groups (CCGs) and NHS England Local Area Teams (LATs).

Where the findings relate to children and families in local authority areas other than Wakefield, 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.

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## About the review

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The review was conducted under Section 48 of the Health and Social Care Act 2008 which permits CQC to review the provision of healthcare and the exercise of functions of NHS England and Clinical Commissioning Groups.

- The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.
- The focus was on the experiences of looked after children and children and their families who receive safeguarding services.
- We looked at:
  - the role of healthcare providers and commissioners.
  - the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
  - the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.
- We also checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, Working Together to Safeguard Children 2015.
- Where we found areas for improvement in services provided by NHS but commissioned by the local authority then we will bring these issues to the attention of the local public health team in a separate letter.

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## How we carried out the review

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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. It also included some cases where children and families were not referred, but where they were assessed as needing early help that they received from health services. We also sampled a number 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 108 children and young people.

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## Context of the review

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Published information from the Child and Mental Health Observatory (ChiMat) shows that children and young people under the age of 20 make up 23.2% of the population of Wakefield. There are 11.1% of school age children from a minority ethnic group. The proportion of children under 16 in poverty is 20.6%, worse than the England average.

The data from ChiMat shows that, on the whole, the health and wellbeing of children in Wakefield is generally poorer than the England average. For example, whereas the proportion of children categorised as obese is similar to the England average, the proportion of children with poor dental health is significantly worse. Infant and child mortality rates are similar to the England average.

The data also shows that Wakefield is significantly worse than the England average for a number of other indicators of children's health. These include the rate of hospital admissions caused by injuries to children and young people and hospital admissions due to self-harm, alcohol or substance misuse. Hospital admissions for asthma and for mental health conditions is similar to the England average.

The data reflecting the proportion of teenaged mothers and of under 18 conceptions is also significantly worse than the England average. However, the data for childhood immunisations for Wakefield is significantly better than the England average and these include the MMR vaccinations and the five-in-one vaccine at two years. Immunisations of children in care are significantly worse.

The rate of family homelessness and the number of young people who enter the criminal justice system for the first time is also better than the England average.

The Department for Education (DfE) provide annual statistics derived from outcomes for children continuously looked after. As at March 2014, Wakefield had 335 children who had been continuously looked after for more than 12 months (excluding those children in respite care), 95 of whom were aged five or younger.

The DfE data indicated that a greater proportion of Wakefield's looked after children had received an annual health assessment and a dental check-up than the average for England. There were 89% of the children aged five and under who had been looked after for more than 12 months had an up-to-date development assessment, greater than the England average of 86%. However, only 82% of looked after children were up-to-date with their immunisations, fewer than the England average of 87%.

Commissioning and planning of most health services for children, including those for children who are looked after are carried out by NHS Wakefield Clinical Commissioning Group (CCG).

Acute hospital services, including emergency care and maternity, are provided by the Mid Yorkshire Hospitals NHS Trust (MYHT). Community based services such as health visiting and school nursing are commissioned by Wakefield Metropolitan District Council. These services and the services for looked after children are also provided by the MYHT.

Child and Adolescent Mental Health services (CAMHS) and adult mental health services are provided by South West Yorkshire Partnership NHS Foundation Trust (SWYPFT).

Sexual health services are provided by Spectrum Community Health C.I.C. Adult substance misuse services are provided by Inspiring Recovery, a collaboration between Turning Point and Spectrum Community Health C.I.C. Both of these services are commissioned by Wakefield Metropolitan District Council.

The last inspection of safeguarding and looked after children's services for Wakefield took place in December 2010. This was a joint inspection with Ofsted. At that time, the effectiveness of the arrangements for safeguarding children were judged to be 'adequate' whilst the services for looked after children were judged to be 'good'. Actions for the providers arising from our recommendations from that review were said by the CCG to have been completed by July 2011.

Of the NHS trusts identified above, only the MYHT have been subject to a recent regulatory inspection under the CQC's new inspection approach. At the time of this children looked after and safeguarding review the findings of that regulatory inspection have yet to be published and so they are not mentioned in this report.

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## The report

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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.

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## What people told us

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We spoke to a parent who had attended the children's emergency department with an infant and was receiving treatment.

She told us: *"The staff have been really good here. We have become regulars here and we are normally always seen quickly".*

She continued: *"We came here last Sunday and were seen in the adult emergency department because the children's emergency department was closed. They took my daughter straight to the resus area because it was really busy in the waiting room".*

A parent told us: *"The children's waiting area is much better here than at the (another) hospital and the nurses have been good. The only thing that I would say is the doctors were talking amongst themselves and the communication wasn't great, I would prefer them to talk more openly, but they have been very good with my daughter and have had plenty of patience with her."*

We spoke with a number of foster carers about their experience of the looked after children service. All of their comments were positive. Some of the comments we received were:

*"All the looked after children nurses we have come across have been brilliant, our current allocated looked after children nurse needs a gold medal."*

*“The looked after children nurses provide such a good service, I can’t praise them highly enough, they will go the extra mile every time to help sort out any problems.”*

*“The ‘health and care of looked after children’ course opened my eyes, it is one of the best courses I have been on and should be essential training for all foster carers.”*

*“There are plenty of opportunities for foster carers to attend training, and the events are a great way of meeting and supporting other foster carers.”*

*“We feel fully involved with the health assessments and always get a written copy.”*

*“I have never had a problem getting hold of a looked after children nurse, I can always speak to someone when I need to, and always received support for a child or myself when I have needed it.”*

*“I can’t think of anyway the looked after children team could improve their service, it is second to none.”*

*“The looked after children service in Wakefield is an excellent example of teamwork, everyone pulling together for the benefit of the child, it’s all about the needs of the child.”*

*“If you are thinking of becoming a foster carer you need to move to Wakefield!”*

We reviewed information provided to us by Healthwatch, who had carried out a young people’s GP access survey earlier in 2015. 84% of their respondents were aged between 11 and 16 years whilst 16% were aged between 17 and 24 years.

46% of young people told them that said that they usually got through to their doctor on the ‘phone while only 33% said it was easy to get a same-day appointment.

60% of young people said they had a good experience of their doctors.

30% of young people said they did not know they could be seen without a parent or carer present. 85% said they were involved or sometimes involved in decisions about their care.

Young people acting for Healthwatch carried out an ‘Enter and view’ visit to the children’s ward at Pinderfields hospital in September 2015. Some of their key findings were:

Signage to the children’s ward is not clear; the food is not particularly children friendly and there is no children’s menu; the majority of comments about staff were positive although communication was not always good; there were problems in nurses hearing buzzers in the high dependency unit.

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## The child's journey

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This section records children's experiences of health services in relation to safeguarding, child protection and being looked after.

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### 1. Early help

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1.1. Before examining the child's journey from the perspective of the health services, it is important to understand the pathway for referral to other services at each of the levels of intervention in this local authority area. This is important as it affects the liaison arrangements between the health disciplines and with other agencies for each level. The agencies in Wakefield use the Wakefield and District Safeguarding Children Board's (LSCB) guidance known as the 'Multi-agency Continuum of Need' to determine the level and nature of support offered to children, young people and their families. This guidance sets five levels of intervention with the purpose of ensuring that children and their families have early access to services that meet their needs. The five levels are categorised according to the nature of the service provision.

1.2. The five levels are:

- Universal – where children and families' needs are met by universal services;
- Universal plus – where additional needs are met by a single agency providing extra support;
- Coordinated support – where more than one agency's contribution is coordinated using the common assessment framework (CAF);
- Integrated early help – where intensive, targeted and coordinated support is required;
- Specialist or protective services – for children with more acute needs or who are at risk of significant harm.

1.3. Health services in Wakefield feature strongly at levels one and two where single agency support is required. The health visiting and school nursing services (the child health team), are pivotal to ensuring good outcomes for young children who require additional support. They will identify the need for early help following assessment of needs, either as part of their mandated contacts with children or following emergency department (ED) attendances, referrals or other contacts. Practitioners participate in and can be the lead professional in the common assessment framework (CAF) process described at level three.



1.4. The provision of support at level four is led by seven 'integrated early help hubs' (IEHH), which have been operational since April 2015. For those instances where there are concerns about a child who might require intervention by specialist or protective services at level five, the usual referral route is through the Wakefield Council's single point of access known as 'Social Care Direct' (SCD). Once a referral has been assessed by SCD, the Multi-agency Safeguarding Hub (MASH) is passed the referral for information sharing to take place and a decision as to the most appropriate intervention. It is in the context of this framework that health services' contribution to early help, children in need and child protection is assessed.

1.5. Children and young people up to the age of 18 are currently only able to access a dedicated children's ED at Pinderfields hospital during the hours of 9am to 10pm. Outside of these hours, children and young people are seen in the adult's emergency department. This is recognised by the MYHT as not being an appropriate environment for children and young people to wait in for their assessment or treatment. Following analysis of peak pressure times that showed that the number of young patients under 17 had increased over the previous year, the MYHT plan to extend the opening hours of the paediatric ED. The area will be open until midnight by June 2016 and then for 24 hours by 2017. When children and young people wait for assessment and treatment in the adult emergency care environment, they are identified on the electronic patient list as a child and this ensures that all staff are aware of their presence in the waiting area.

1.6. At Pontefract hospital there is a small paediatric waiting area for children up to 11 years and an examination cubicle area with a trolley and a cot separate from the area used by adults. The waiting area is behind the nurses' station and leads into the separate paediatric examination area. There is limited concession in the waiting area to suggest that this is a child friendly treatment area; although there are toys and a television to provide distraction there is no child friendly decoration. ([Recommendation 1.1](#)).

1.7. Between 9am to 10pm children in the ED at Pinderfields Hospital have access to a paediatric consultant on site. Out-of-hours coverage is through an on-call paediatric consultant. The current pathway is working well, which means that children who are most vulnerable are seen in a timely manner to be assessed by a medical professional. Our review of records showed that children and young people are triaged quickly using the Manchester triage system. This enables children's emergency practitioners to see children within the recommended 15 minutes following the booking in process.

1.8. During triage at Pinderfields hospital, all parents, carers or young people are asked for their consent to allow GP records to be viewed if required during admission. This is currently a mandatory question on the electronic patient records template used in ED. There are, however, no signs to let parents, carers or young people know that their attendance will be shared with their GP, health visiting team or the school nursing service at Pinderfields hospital. This means that some patients may be unaware that their information will be shared in this way. ([Recommendation 1.2](#)).

1.9. All children and young people attending the ED at both hospitals have their details collected by the reception staff. This includes next of kin information, the name and relationship of the adult accompanying the child or young person, the name of the school, their GP details and any other demographic information. Although we were given reassurances that ED practitioners ask enough questions to establish the relationship between the adult and child patient, in records we looked at we saw that the full name of the accompanying adult was not always recorded in the patient's ED electronic records. A culture of curiosity is important at this point as it creates the opportunity to check that the child is with the person they should be with as they move between different staff members during their stay and any risks they might present would not be known. Staff would benefit from a better understanding of why this is important. ([Recommendation 1.3](#)).

1.10. We saw that the ED at Pinderfields and Pontefract hospitals are notified by children's social care of any children or young people who are looked after or subject of a child protection plan. This information is entered onto the patient electronic records by the clerical team, and flags are created to alert practitioners of any additional vulnerability that needs to be taken into consideration during assessment and treatment. This is important as ED practitioners need to consider any additional vulnerability when safeguarding children and young people.

1.11. There is a clear policy in place to guide practitioners when children and young people leave the children's ED at Pinderfields hospital without being seen for assessment or receiving treatment. We heard that ED practitioners contact parents and encourage them to return with their child for assessment and treatment. If ED practitioners have significant concerns then a referral to children's social care is completed. Having such a clear policy ensures that appropriate action is taken to safeguard children and young people who have not accessed care.

1.12. There is currently no paediatric liaison function in the children's ED at either hospital. However, we learned that children's ED practitioners have recently completed a two-month pilot with the health visitors and school nurses (referred to as the child health team) in order to meet the challenges of resourcing a follow up of every child coming to notice and ensure a more targeted approach instead. This pilot is intended to ensure that information about certain types of presentation is telephoned through to the child health team's message manager by an identified ED staff member according to certain referral criteria. These criteria include all children under one year old with an injury; children under five with ingestion or animal bite; all children and young people with a human bite; attendance following substance misuse or self-harm; any young person assessed as being at risk of child sexual exploitation (CSE) and any children and young people who have attended ED more than three times, although in the latter criterion this is subject to a judgment by the ED staff member about whether the three attendances merit a telephone notification prior to such a notification being made.

1.13. In a second phase of the pilot that began just prior to our review the responsibility for telephoning the child health team's message manager was passed to any ED staff member who deals with a child's attendance as opposed to an identified individual although the same referral criteria are used. The effect of this is that, whilst all children's attendances are still notified routinely to the child health team, practitioners are no longer tasked with following up attendances at hospital unless it relates to a child who meets the above criteria. In one of the cases we were tracking across services and in one other case we sampled, we found that this arrangement has been ineffective in ensuring vulnerable children are followed-up appropriately. ([Recommendation 1.4](#)).

1.14. In the first case a young person who had attended ED on five occasions in the last year, two of which were in the last month, was not subject of a telephone notification. Since the school nursing team were not 'tasked' with this follow-up through a telephone notification there was no alert or analysis of the five ED attendances. Even though the child had been subject of routine written notifications with limited detail, the absence of a formal 'task' meant that the follow up of the child's attendances had not been triggered.

1.15. In the second case, a child who had attended ED following a head injury and who did not meet the above referral criteria, was also not subject of a telephone notification to alert the child health team. There were two separate entries about domestic abuse logged on the child's record by the school nurse within the previous 18 months but because the latest attendance had not been notified in the overt manner set out in the pilot, there was no opportunity to consider or exclude any possible link between the domestic abuse concerns and the head injury. Furthermore, neither information about the domestic abuse nor the information about the child's attendance at hospital were logged on the safeguarding node of the patient record system and so the opportunity to alert staff of these important risk factors was missed. ([Recommendation 1.4](#), [recommendation 1.5](#)).

1.16. All GPs, health visitors and school nurses receive a discharge summary for all children and young people who attend the EDs at both hospitals. However, this does not always provide sufficient information about the reason for attendance or any subsequent treatment or action that may be required by other professionals. For example, in one case we looked at, the ED records indicated that a follow-up was required by the health visitor; however this was not identified in the discharge summary. This means that community practitioners would not be well informed and able to consider the full details of the ED attendance in the context of the child or young person's overall health needs. ([Recommendation 1.6](#)).

1.17. Children and young people who attend the children's ED at Pinderfields hospital following alcohol or substance misuse are discharged to the care of their parents or admitted onto the paediatric ward for treatment if required. A referral form to the local young people's substance misuse service is only completed if consent has been given by the young person or parents, as the referral will not be accepted without this. In the absence of any other pathway for children who do not provide consent, those particular, vulnerable children do not have access to help and support at an early opportunity although we acknowledge that the absence of consent is problematic.

1.18. Pregnant women access maternity services via their GP surgery. We saw evidence that midwives have a flexible approach to conducting antenatal appointments in a variety of settings including the woman's home address, although most contact is at midwifery antenatal clinics held within GP practices. Home visits are generally only conducted if concerns are identified.

1.19. Community midwives enter pregnancy information onto the electronic patient record system used by most primary care providers. This is so that GPs are aware of a patient's pregnancy and can discuss cases with the community midwife if necessary. GPs hold essential information about patients' current and historical health and social issues which may impact on parenting capacity so sharing this information is an essential part of risk-assessing potential harm to an unborn child.

1.20. Maternity unit specialist midwives support midwifery colleagues with complex cases and we saw good evidence of their role in intra and multi-agency liaison. This ensures that vulnerable women are well supported and receive co-ordinated services throughout their period of care.

1.21. Pregnant women are not routinely offered the chance to be seen alone at any stage in their pregnancy to discuss possible domestic abuse or any other personal issues. In some of the notes we sampled we saw evidence of enquiry about domestic abuse but this was opportunistic. This area could be strengthened by informing all women during their booking in process that at certain scheduled appointments they will be seen on their own. This will reduce the reliance on professional confidence in asking an accompanying adult to leave a consultation and will standardise practice. This will assist in the identification of vulnerable women who are experiencing domestic abuse and their referral to appropriate support services. ([Recommendation 1.7](#)).

1.22. We learned anecdotally that, following local authority reorganisation, there is no central oversight of the impact of CAF. Data is said to be gathered centrally with the local authority CAF team dispersed across the seven IEHH. There is some perceived lack of consistency in applying thresholds in Wakefield and the five levels in the continuum of need. Staff were reported to be clearer around child protection and child in need thresholds (at level five) and would refer to SCD. However, they are still uncertain about decisions made around the other thresholds, particularly around levels three and four and the expectations of the level of complexity of cases managed by the child health teams. For example, we learned of a case where there had been some disagreement about the levels of intervention in circumstances that had suggested intervention at a higher threshold such as child in need, but which had been assessed as suitable for work at the lower threshold four. This uncertainty is troubling and our view is that such dissonance should be dealt with through supervision and the use of the escalation process.

1.23. We saw evidence of good liaison between the community midwives and the health visiting service. Although there is no stipulated frequency for meetings, the community midwives we spoke to all held monthly meetings with their health visitor colleagues to discuss vulnerable women and families. The records we looked at also showed good liaison between the midwives and other health professionals such as ED, health visiting and the adult mental health service.

1.24. Furthermore, we saw that the designation of specialist areas of interest for some health visiting staff, such as travelling families, asylum seeking families and infant mental health, has led to effective working across different health disciplines. For example, in response to a public health priority, the infant mental health visitors are leading on the integration of an infant mental health care pathway intended to be used in conjunction with the healthy child programme. The overall aim of this initiative is to promote the health, social and emotional development of infants from conception to three years of age, thus promoting attachment and an awareness of parents to the needs of the infant.

1.25. In addition, health visiting staff can access the support of child and adult mental health services (CAMHS) at a dedicated, monthly, half-day session to discuss cases of concern and agree a plan. The long-term aim of this approach is to reduce the risk of disruptive issues later in the child's life thus improving their outcomes. This is good practice.

1.26. GPs use a contraception and sexual health template on the electronic records system, which prompts clinicians to assess young people for their competence to consent to treatment. However, we saw no evidence of GPs asking young people if they would like to be seen on their own when they are attending with their parents and this is a missed opportunity to consider risks of CSE. Further, the template in use could be strengthened to include more questioning about particular factors, such as the number of sexual partners, the use of coercion, concerns around domestic abuse, mental health and other vulnerabilities. These factors would help in the assessment of risk of CSE. ([Recommendation 2.1](#)).

1.27. GPs we spoke to told us that they have good liaison with CAMHS although they highlight that there are difficulties with getting children seen quickly. Whilst the waiting times from referral to assessment are relatively short, the waiting time from assessment to treatment are significantly longer with are insufficient services to support children while awaiting CAMHS treatment. As we have reported below, under 'Children in Need', however, CAMHS are addressing this with additional training to staff in universal services around support and anxiety management.

1.28. In the records we reviewed we saw that GPs do not routinely record the full details of the adult accompanying the child or young person to the clinic appointment, with the terms 'mum' or 'dad' frequently used. This is important, not only to ascertain who has parental responsibility for a child or young person, and therefore able to consent to treatment, but in a fractured family with complex dynamics, the recording of a name is as relevant as the reported relationship.

1.29. We saw that GPs receive discharge summaries from hospital. However, these are brief and do not include enough information to help GPs consider risk to a child in the context of their wider health needs and their home and family. For example, in one record we looked at, a primary school age boy had attended the ED following a needle-stick injury but there was no information on the discharge summary about the mechanism of the injury which the GP could have considered at the child's next visit. ([Recommendation 1.6](#)).

1.30. There is a clear and robust transition policy and pathway for young people from the CAMHS service to the secondary adult mental health teams. The transition process starts when the young person is 17 years and six months old, with all cases being assessed by the CAMHS and adult teams on an individual basis. The care programme approach is embedded within adult mental health services and this supports a co-ordinated approach between the two services being taken. During the transition period, there is joint working between the services with the young person in order to ensure the transition process runs smoothly for them. This is important as it helps ensure that young people have stability and are not lost in the system during this critical time, thereby helping to improve their mental health outcomes.

1.31. The transition process is further supported in part by an early intervention psychosis team, provided by the adult service and based in the community, who work with young people from the age of 14 and with adults up to the age of 35. This means that outcomes are improved for young people at risk of developing long-term mental health conditions because they are identified and treated at an early stage.

1.32. In the records we reviewed we saw evidence of good communication and joint working between adult mental health services, health visitors and social care. The benefit of this is that good information about adult mental health enables practitioners who deal with families to better assess risk to children and young people.

In the adult substance misuse service clients with families and their children are supported by the provider's innovative Family Support Team comprised of attached staff from other areas; a senior social worker, a substance misuse health visitor and a substance misuse midwife. This ensures that children whose health, wellbeing and safety are affected by the behaviour of their parents who are adult clients of the service benefit from the intervention and service co-ordinating role of staff with particular expertise. This was demonstrated in one of the cases we tracked across services where we saw extensive involvement by the substance misuse midwife. In this case, a child protection plan in respect of an unborn child of a mother-to-be who misused substances alongside other risky lifestyle factors was de-escalated to a child in need plan. The proactive and effective inter-service work co-ordinated by the adult substance misuse midwife led to an eventual normal delivery with the child remaining with mother.

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## 2. Children in need

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2.1 Our review of records showed that, at the point of triage, ED practitioners at Pinderfields and Pontefract hospitals ask about who has parental responsibility for children and young people under the age of 18 years and ascertain if the family has any social care involvement. Where there is a social worker involved with the family, their name and contact details are recorded on the admission paperwork. Other than this, children and young people do not currently benefit from a comprehensive safeguarding assessment when they are first seen by a clinician. Safeguarding questions that explore potential risks, such as those outlined below, should be asked and recorded, in order to enable the opportunity to share information and intervene early.

2.2 The patient records system in use in the ED does not support effective, consistent recording. The current safeguarding risk assessment tool used at Pinderfields hospital does not encourage practitioners to focus on young people. There is no exploration regarding any risk taking behaviours or vulnerabilities that they might exhibit or undertake, for example drugs and alcohol misuse. We saw no evidence, for example, of a CSE screening tool being used, so there is an over-reliance on practitioners to identify such additional vulnerabilities. This means that ED practitioners at Pinderfields hospital will not be able to assess for any additional vulnerabilities for young people who may be at risk of CSE. It is important that ED practitioners working closely with children and young people have the support and tools they require to help them identify and assess additional vulnerabilities in order to safeguard them and provide early help and support. This has consequences for the effectiveness of the pilot programme of notifications to the child health team of children who meet certain criteria as reported above in 'Early Help' since CSE is one of those criteria. ([Recommendation 1.8](#)).

2.3 Practitioners in the adult ED at both Pinderfields and Pontefract hospitals are expected to identify and record details of children or young people being cared for by an adult, who attend with risk-taking or concerning behaviours. However, such adults are not asked for details of any children that they have contact with; for example if they are living away from their children or if they are in a relationship with a partner who has children. This is a significant gap in information gathering for safeguarding purposes as it should feature in paediatric liaison with community health practitioners and children's social care. ([Recommendation 1.9](#)).

2.4 The adult admission paperwork does, however, prompt individual practitioners to explore and ask patients whether they have any dependent children at home. This question is a mandatory field on the admission paperwork and must be asked before moving on to the next stage. There is variation in practice, and in one record we reviewed we saw that the mandatory question had been asked, but the practitioners had not recorded the full details of the child such as their name age. This limits the opportunities of adult ED practitioners to identify the need for early intervention.

2.5 The support provided by CAMHS for children and young people who attend the children's ED at Pinderfields and Pontefract hospitals following an incident of self-harm, overdose or during a mental health crisis is reported to be good. ED practitioners told us that the CAMHS crisis team are very accessible and are always available by telephone for advice and support throughout the day and during out-of-hours. This support has promoted a more rapid assessment of these vulnerable children and young people and the current arrangements mean that children and young people are not facing unnecessary long waits in the emergency department.

2.6 Young people experiencing a mental health crisis in Wakefield receive a service from the dedicated CAMHS crisis team who operate between 9am and 5pm Monday to Friday and on an on-call basis outside of these hours. We were advised that CAMHS provide an assessment in person within 24 hours, whether this is in the ED, the children's admission unit or the children's ward. However, those children and young people who need to be admitted as medical patients are not seen by CAMHS until they are medically fit for an assessment. These children do not currently benefit from a formal risk assessment of their physical environment, emotional health or risk to others on the department. This has been identified as an area for development by the MYHT. We learned of work currently in progress involving CAMHS, the children's ED, the children's admissions unit and the children's ward to launch a new risk assessment tool by February 2016.

2.7 We learned that each of the IEHH has a dedicated CAMHS 'primary practitioner' who acts as the first, early point of contact for any young person experiencing, or at risk of experiencing mental ill-health. Every new referral into the service is initially assessed by the primary practitioner to determine the nature and timeliness of the response. In this way the CAMHS service is configured to respond to all young people with mental health needs whatever their level of complexity or seriousness.

2.8 Whilst young people are seen very quickly and those with high needs or at greater risk are given priority, the service understands that it has work to do to continue to bring its waiting times down. Currently these stand at four weeks until formal assessment and then as much as seven months from assessment to treatment for those young people who are not otherwise prioritised. The SWYPFT acknowledges that this is their biggest challenge.

2.9 In an effort to ensure that support is provided children and young people whose needs do not meet the threshold for intervention through the IEHH, the CAMHS primary practitioners are engaged in training the staff in universal services. The purpose of this is help those services to support young people with anxiety management. Additionally, the primary practitioners review each young person who is still on the waiting list to check whether their priority for treatment has changed. In this way, the CAMHS service has taken steps to ensure that children are not left unsupported whilst they are awaiting treatment, although as we reflected above under 'Early Help', the impact of this has not yet been seen by all GPs.



2.10 Children who require admission for urgent treatment due to the complexity of their illness or acute mental health need are usually placed out of area. Commonly this is in a nearby part of Yorkshire but young people can sometimes be placed in other areas further afield in England. We learned that the SWYPFT has allocated one of the beds in one of the adult units situated in the neighbouring Calderdale area where 16 and 17 year old young people could be placed in an emergency and for a period not exceeding 48 hours. Whilst this is not an ideal situation, we were nonetheless given reassurances that staff in this unit had undergone appropriate checks and additional training to ensure they were safe to work with young people.

2.11 There is a risk that there are hidden children in Wakefield with unmet health needs as a consequence of poor systems to identify them, such as the lack of paediatric liaison outlined above in 'Early Help'. Furthermore, it was reported to us that there is no robust system in place that informs the school nursing team of children being home schooled, moving schools or those missing from education. Additionally, we heard that there is no direct communication between the education admissions department and the school nursing service. This is exacerbated by the school nursing team only updating electronic records from class lists for years one and six; there are no agreed updates made for the other year groups. This is a significant gap as home educated children feature strongly in serious case reviews (SCR) nationally. ([Recommendation 1.10](#)).

2.12 The process for overseeing the primary care needs of vulnerable children is variable. GPs we spoke with in one practice told us that they hold regular, scheduled primary care meetings once every eight weeks when with the link health visitors are invited to attend. We saw notes of these meetings which showed that the needs of individual vulnerable children are discussed. However, as these are anonymised there is no means of checking whether the discussions or any plans are recorded as part of the child's electronic record. The lead GP for safeguarding children meets regularly with the health visitor safeguarding lead where particular children might be discussed but once again, there are no notes kept from these meetings. Further, we learned that midwives and school nurses do not attend these meetings. Therefore, there is a risk that key information from these services might be overlooked, although the community midwives hold regular clinics at the GP practice and so there is often face-to-face dialogue between them about individual families. ([Recommendation 2.2](#)).

2.13 In two other practices, monthly vulnerable families and children meetings are held with health visitors. Each child in need or at risk is routinely and regularly considered and a record made on the patients' electronic records. This is an important way of monitoring progress and improving outcomes for children, young people and their families.

2.14 The majority of GPs in the area use one particular type of electronic patient records system whilst a smaller number using another type of system. The school nursing and health visiting services use the same system as the majority of the GPs and share records with GPs through this medium. However, GPs are reported not to consistently share information in return with the health visiting team and this hinders access to a complete record. As a result, decision making about risk is compromised. ([Recommendation 2.2](#)).

2.15 The 'Think Family' approach is well embedded in the practices of the substance misuse service. We found that the adult substance misuse service's Family Support Team were key to this approach, both in terms of providing advice and guidance to the team in particular cases and in supporting the team with joint work. For example, in one of the cases we sampled we saw that concerns had been raised about the children of a client over the weekend prior to our visit. These concerns had been discussed with the Family Support Team's social worker and a record of the discussion made in the client's notes. We saw that the specialist social worker and the client's substance misuse worker planned a joint home visit during the week of our review in order to carry out an assessment of the client when their child was present. In this way the impact of the parenting behaviour and the environment upon the child would be critical in determining the nature of any referral onwards to other services.

In other cases we sampled, we saw that the approach to considering the impact on children of parental substance misuse is well embedded in the practice of staff. This is supported by clear and effective templates on the service's bespoke case management database, and by accessible guidance on each practitioner's computer desktop. For example, each client is asked a mandatory question about their parental status or about children they have access to during their initial discussion with the service. This triggers the completion of a safeguarding screening template followed by discussion with the Family Support Team or the client's social worker if identified.

The first page of the client's record on the database displays a family genogram, identifying children with a red spot, thus directing every staff member to further information in the record that relates to the child. The child that the client has contact with is then actively considered at each meeting with the client. This is directed by a children's care plan which runs alongside the client's treatment plan. This children's care plan is reviewed every three months. This is good practice as it ensures the needs of the child are foremost in both the procedures used in the service and the approach by practitioners.

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### 3. Child protection

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3.1 ED practitioners use a standardised referral form to refer concerns to Wakefield's Social Care Direct. Initial concerns are raised by telephone and followed-up in writing within 24 hours. A copy of the referral form is then forwarded to the MYHT safeguarding team and scanned onto the patient's electronic records. The trust's safeguarding team quality-assures the referrals, feeds back to individual practitioners and requests additional information if required. However, despite management oversight the referrals we looked at were variable in terms of the quality of information and the practitioner's ability to fully articulate risk and concerns. This is an area which we are assured is about to be strengthened by the incorporation of the 'Signs of Safety' risk identification model into the referral form to coincide with the training of the model across the area

3.2 There is a good protocol to review all under one year old non-ambulant babies who attend with burns, head injuries, bruises or fractures at both hospitals by a paediatric middle-grade doctor or a senior paediatric consultant. However, in records we reviewed we saw that not all under one year old children were being reviewed in accordance with the protocol. This means that infants are not being assessed by appropriately trained medical professionals and the significance of the presenting injury may be overlooked. ([Recommendation 1.11](#)).

3.3 A comprehensive Pregnancy Vulnerabilities Risk Assessment form is in use in maternity. This is updated at pre-defined points throughout pregnancy and into the postnatal period. We saw evidence of this being completed and appropriate action taken when risks are identified. We understand that reference to this checklist will be incorporated into the next version of the maternal hand-held notes to alert practitioners of its existence. This will ensure the notes are a more robust record as there is currently no ongoing safeguarding risk assessment within them.

3.4 We saw good evidence in the maternity cases we reviewed of relevant safeguarding information being held within maternal notes on the maternity services bespoke patient records system. Use of the alert system and case notes ensures that all staff accessing the system have up to date information. This could be strengthened, however, by having a dedicated safeguarding node or icon within the records. Currently a generic section of the system is used and this could potentially get merged with other general medical information and therefore overlooked.

3.5 We saw that the use of the integrated care pathway document is an effective way for community midwives to record all relevant safeguarding information in a single document. This ensures a complete paper record of significant events, referrals, safeguarding discussions or supervision throughout pregnancy to discharge from care. The document is then scanned onto the baby's electronic health record so that any ongoing safeguarding issues are shared with hospital practitioners involved with the baby after discharge from midwifery care. This supports the flow of relevant information between services and is good practice.

3.6 The postnatal ward has a swipe card entry system but only a push button release exit. Whilst it is good practice to restrict access to the ward in this way, it does not mitigate the risk of some women who already on the ward from absconding with their babies where, for instance, there may be pending care proceedings. ([Recommendation 1.12](#)).

3.7 The majority of the referrals we saw from midwifery services to Social Care Direct are good. The referrals show that practitioners share information, analyse risk, the potential impact of parenting behaviour on a new-born and specify the required outcome of the referral. We were advised, though, that there was a perception among midwifery staff that there was some inconsistency between the different Integrated Early Help Hubs in the way that the appropriate levels of intervention are interpreted.

3.8 Community midwives are encouraged to attend safeguarding meetings and provide conference reports; however, attendance is not monitored within the maternity service or the MYHT safeguarding team. If midwives are not able to attend safeguarding meetings, either due to capacity issues, short notice or professional development needs then this should be escalated to and addressed by relevant managers in order to strengthen information sharing and multi-agency working.

3.9 Cases we looked at highlight that health visitors complete new referrals to Social Care Direct that are underpinned by detailed information of the concerns and an analysis of risk. However, there is some variability in the standard of articulating and analysing such risk in reports submitted by the health visiting service to child protection conferences. An initial child protection conference report we reviewed showed a holistic assessment of need with analysis of risk in the body of the initial referral but the summary report for conference did not reflect this detail and lacked impact. Whilst the health visitor made a recommendation that the child should be subject of child protection plan there was no linked underpinning rationale. This potentially could lead to ineffective decision making by the conference. As we have advised above, however, it is anticipated that the roll-out of Signs of Safety training across the area and the imminent incorporation of the model into the reporting documents will strengthen the quality of information provided to conferences.

3.10 Although the GPs we spoke with are confident about making referrals to social care whenever they identify concerns, the approach is variable across the three practices we visited. In two practices the use of coding on the electronic records system is used to identify and track children at risk so that progress can be monitored and discussed at vulnerable families meetings. In those practices information is placed on to the safeguarding section of the electronic records system so that it can be shared. However, it is usually the case that other health services in Wakefield do not have access to some information due to restrictions in sharing rights. We have commented on this in more detail in 'Leadership and Management' below. ([Recommendation 2.2](#)).

3.11 In both of these practices referrals are made by telephone and followed up in writing. However, in one practice the written follow-up is by way of a brief, free text letter as opposed to the standardised referral form. The referral letters we looked at had adequate detail about the risk but there is a potential for incomplete information to be passed over if the correct templated forms are not utilised fully.

3.12 In another practice the use of coding on the system is not used to identify particular children. In the absence of any formal notes of meetings where children are discussed, there is no other means of auditing the number of referrals made or of monitoring their progress other than to rely on the personal knowledge of the GPs. In this practice, although we saw that the correct templated form had been used in one case we reviewed the form did not fully articulate the concerns or identify risk to the child.

3.13 Commonly, all GPs are routinely invited to attend child protection meetings or conferences. However, due to short notice and clinic commitments they are often unable to attend. As GPs do not currently prioritise attendance at initial or review conferences, they send their apologies and submit any health related information they hold by way of a report. In two of the practices such reports are scanned on to the records system whilst in the third they were not. The reports we looked at were variable in the extent of detail and the articulation of any risk and this does not help good decision making at conference. ([Recommendation 2.3](#)).

3.14 GPs are not routinely sent minutes from child protection core groups meetings or the resulting updated child protection plans, nor are they sent child in need plans for children they have primary care responsibility for. This creates a risk of leaving GPs poorly informed about the current issues or concerns surrounding particular vulnerable children or families and any progress they have made whilst being subject of child protection or child in need plans.. We were advised that minutes of child protection conferences are, however, routinely sent to GPs. These are generally scanned onto the electronic records system, although one practice relied on this being done by the child health team. Where sharing rights on the system existed, we saw that minutes and other documents that had been scanned into the system by the child health team were visible to the GPs. In those cases the risks arising out of being uninformed about particular children are reduced, provided the practice holds regular, focused multi-disciplinary safeguarding discussion with the child health team and has an effective monitoring process in place. However, the risks are heightened where these discussions are not held, or where there is no formal monitoring of cases. ([Recommendation 2.2](#), [Recommendation 2.4](#)).

3.15 The CAMHS service is currently using a hybrid system for patient information, the well-established electronic case management database and detailed paper records about clients. This hybrid system has been in operation for some time because the particular, earlier version of the software in use does not have newer facilities for scanning in documentation or for using electronic templates for clinical or risk assessments. This means that copies of key documents such as child protection conference minutes or child protection plans are not readily available electronically. However, in the cases we tracked across services and in those we sampled, we consistently found that all database entries are completed in exceptional detail, are focused on the needs of the child and clearly articulated risks. This is also the case for all paper based templates used in assessing clinical need and risk.

3.16 The CAMHS practitioners are proficient at identifying risk to children and young people and are supported in doing so by effective internal safeguarding processes. For example, in two of the sampled cases we looked at we saw that risks had been assessed by the crisis team at the point of referral in relation to self-harm and suicide, violence, serious self-neglect and exploitation or abuse by others. In some instances further information had been sought from parents or carers and through other records. The resulting risk management plans are comprehensive, are outcome based and are subject of a planned review date depending on the significance of the risk.

In both crisis team cases we looked at and in one other sampled case, we saw that the assessment of risk was ongoing throughout each interaction with the young person. In each case new risk factors had been identified and guidance had been sought appropriately from the safeguarding team. In one of the cases, a separate risk assessment in relation to CSE had been completed and new concerns identified as a result. The analysis of the risks and agreed actions were documented in the young person's notes including an action to refer the matter as a child protection issue.

These cases show that the CAMHS service uses robust, safe and effective systems, including skilled staff, to identify and respond appropriately to potential abuse.

3.17 Adult mental health practitioners informed us that they are aware of the process to follow when referring cases to Social Care Direct. All referrals are made by telephone, followed up in writing within 24 hours, and reported as an incident through the 'Datix' reporting system. Copies of all referrals are also expected to be sent to the trust named nurse for safeguarding children in order for them to be quality-assured. In the records we reviewed, we saw that referrals to children's social care were variable in their quality. We saw evidence of good, detailed referrals that clearly articulated the practitioners concerns and what was being expected from social care. However, we also saw evidence of poor quality referrals that did not rationalise the risk or what the impact of a parent's mental health would be on the child. ([Recommendation 3.1](#)).

3.18 Adult mental health practitioners do not flag patient records to alert other practitioners of any additional vulnerability for consideration during assessment. There is currently no management oversight of the number of clients that have children who are categorised as a child in need, on a child protection plan, or looked after. Further we saw that the 'think family' model is not fully embedded into practice. Practitioners are not currently prompted to ask adult patients questions during their initial or routine risk assessments that will enable them to collect important information about dependent children and of any caring responsibilities. This means that key information might be missed that would affect treatment and care planning in the context of the impact of the adult's illness on the child. ([Recommendation 3.2](#)).

3.19 We saw that adult mental health practitioners routinely visit patients at home. This is a good opportunity to assess the home environment and to validate information, particularly when there are children and young people concerned. We were advised that practitioners are required to complete a separate child protection risk assessment template to help them consider the impact on children and young people. However, in records we reviewed we saw that this is only completed when practitioners have overtly identified safeguarding concerns and is not completed routinely for patients with access to children. The trust recognise this as a gap, and we heard of ongoing plans to place a mandatory question on the mental health risk assessment template on the patient records to prompt practitioners to collect this important information. This is planned to be implemented within three weeks after our visit. As reported above, the new, updated version of the electronic case management database is being launched by the end of this year which has greater functionality to support practitioners to assess risks to children and to add alerts.

3.20 Adult mental health practitioners are invited to pre-birth, child protection and looked after review meetings. However, in records we looked at we saw that not all safeguarding related meetings are attended by practitioners and reports are not routinely being produced to assist the meetings. The absence of information about mental health and its impact on children means that decision making about the welfare and needs of children may be compromised. ([Recommendation 3.3](#)).

3.21 The service receives timely minutes from child protection conferences, but these are currently being held in paper records. As before, the updated electronic system due to be launched will enable records to be held in single place so that all practitioners have access to key information. However, in the meantime, the patient records are fragmented and we could not see any evidence of how child protection action plans support clinicians to develop more detailed service plans with adult patients in the context of their family circumstances. ([Recommendation 3.3](#)).

3.22 As with the CAMHS service, Adult mental health practitioners have daily access to the SWYPFT safeguarding duty team for advice and support, where there are any safeguarding concerns or queries. We were advised that the introduction of a duty team has shown an increase in practitioners' responsiveness in dealing with safeguarding cases. The duty team guarantee that they will respond to practitioners within four hours and we saw evidence of this in cases we looked at. This means that practitioners are supported with timely advice and guidance where they have any safeguarding concerns. We saw that, once advice has been provided to individual practitioners, a secure email is sent with a very detailed plan of action. However, we saw that action plans are not always time-bound and they are not copied over to the electronic patient records by practitioners. This restricts practitioners who work elsewhere in the service from having access to key information when needed if they do not have access to the paper records.

3.23 In the contraception and sexual health service we saw that an assessment template had been developed by the team for use on the electronic patient database, the same database as is used by most health service providers and the majority of GPs. This template requires the practitioner to complete mandatory fields that examine risks to young people. This means that questions about sexual activity and risky behaviour are considered at each episode of care for young people aged up to 18. This includes a probing of information about risks of CSE. In the cases we were tracking across services and those we sampled we saw that these assessments were carried out comprehensively on each occasion and that they showed evolving risk over time to reflect changes in the young person's behaviour.

3.24 Whilst the information created by CASH practitioners was detailed and relevant, the data sharing capabilities of the electronic records system meant that key pieces of information arising from the young person's engagement with other services was missing. Therefore, practitioners were not able to take full account of the young person's other health needs. We were assured by the CASH team that if they had had concerns about a person's engagement with another service then they would follow this up, however, the records did not support this. We have commented in other places in this report about the difficulties in exchanging information as a result of the sharing arrangements of the prevailing system in use in Wakefield. ([Recommendation 2.2](#)).

3.25 This was not just an issue confined to the CASH service. In one of the cases we were tracking across services we saw that a young person who presented extreme harmful behaviour was receiving care and support from the CASH service, the school nursing team and CAMHS. In the chronologies prepared for us by those services we noted that there was a disparity between the perception of risk to the young person by different services, particularly in a period around March and April 2015. Such differences mean that the health services cannot be delivered in a co-ordinated way to best meet the needs of the young person. We have brought this particular case to the attention of the CCG and we understand that they will carry out a review of the information flows between services for this young person.



3.26 We learned that staff from the adult substance misuse service attend child protection conferences when they are able to, often supported by a member of the provider's Family Support Team. Written reports are submitted in all cases when they are not able to attend. However, in cases we sampled there was no correspondence from the local authority, such as child protection conference minutes or a copy of the child protection plan, logged on either of the electronic systems being used by the service. Staff told us that such correspondence was rarely received even though practitioners generally attend the meetings. Therefore, there is no formal record of the current child protection information or the up to date multi-agency assessment of risks within a family that staff can rely upon for their work with clients and their families. This hinders adult substance misuse practitioners in understanding any observations they have during interaction with their clients and prevents effective decision making about risks to children. This has been brought to the attention of Public Health England.

3.27 In one case we sampled in the adult substance misuse service we saw that escalating concerns about the children of two substance misusing clients had been discussed during a supervision session. All of the children in the family were already subject of a child protection plan but these escalating concerns were numerous and were deemed significant, warranting more robust action. However, only the most significant of the catalogue of concerns was passed on to the family's social work manager by way of a formal free text letter (which was according to the local procedures for escalation of open cases) and only in relation to one of the children. Therefore, the information passed to the social work manager was incomplete although we accept that these concerns have been shared over time with the social worker during core group meetings. This means that the free text letter was insufficient to convey the impact of the totality of the concerns on each child. This compromises effective decision making about the risks to these children. This has been brought to the attention of Public Health England.

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## 4. Looked after children

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4.1 Appropriate arrangements are in place for looked after children in Wakefield to receive timely initial health assessments and health reviews by appropriately qualified practitioners. Initial health assessments are carried out by a paediatrician. Health reviews are carried out by health visitors for children under five years old and by school nurses for children over five and up to 16 years. In a case we looked at in the health visiting service we noted that there was good continuity of information between the initial assessment carried out by the paediatrician and the subsequent actions and then review assessment carried out by the health visitor. This ensured good continuity of care for this particular infant.

4.2 Nurses in the looked after children team carry out reviews for cohorts of children and young people, including those out of education, children over 16, young people in residential care and those placed out of area but within a 50 mile radius.

4.3 The most vulnerable children and young people clearly benefited from the specialist input of the looked after children nurses. We saw good practice by the looked after children nurses who comprehensively review all children moving into residential care to take account of their changing circumstances and increasing vulnerability. We learned how the team are proposing to take on the health reviews of all looked after children from 13 years old so that a more intensive and targeted approach is taken to supporting children as they enter into adolescence. This approach, combined with the enhanced screening around risk, will provide opportunities for earlier identification of need and support.

4.4 Children and young people who refuse health assessments and health reviews are rigorously followed up. Where there is continued non-engagement, a virtual assessment is completed through information gathering and collation. However, this is not yet formulated into a plan or the outcome shared with the young person. It is important that findings from these virtual assessments are consolidated into a plan, especially if non-engagement continues over a prolonged period of time.

4.5 Children and young people looked after by Wakefield are starting to benefit from an improved approach to the way risk is considered during health assessments and reviews. More in-depth screening is being introduced to identify risk taking behaviours and potential vulnerability around exploitation. The looked after children nurses work with the young person to deliver targeted, evidenced based brief interventions for those identified with lower risk or refer onwards to specialist services if more intensive work is required to manage higher risk.

4.6 Children and young people who attend local EDs have the details of their care shared with the looked after children health team and their social worker. We saw evidence of how the attendances are considered as part of ongoing health reviews to help identify any emerging or unmet health need.

4.7 Children and young people looked after by Wakefield also benefit from person centred health reviews that demonstrate a continuum of their health journey during their time in care. The voice of the child is clear in the majority of reviews we looked at. Young people are given the choice in terms of location and timing of the review to encourage them to start to take responsibility for their health. There is the potential for young people to start to become involved in negotiating their own outcomes in health plans, however, this is not being fully exploited at this time.

4.8 GPs are not routinely requested to contribute to a child or young person's initial health assessment or health review. Although there are arrangements in place for looked after children nurses or public health nurses to access electronic patient records where sharing permissions are in place, it is important that the GP has the opportunity, as the primary record holder, to provide input to the process. We are not assured that recommendations and health plans are being shared with the child's GP. Currently, the looked after children health team only send a copy to the child's social worker who then sends out copies to relevant people. ([Recommendation 1.13](#)).

4.9 Most initial health assessments of young children and infants in Wakefield are well informed by parental health histories. However, this becomes less evident in the assessments of older children. Nationally, young people leaving care frequently tell us of the importance of having access to this information as it is part of their identity.

4.10 We also saw that front sheets of health review documentation are missing information around the reasons for a child coming into care, the number of carers the child has experienced and the length of time a child has been in care. Whilst all this information is contained elsewhere in the electronic patient record, this also needs to form part of the health review to ensure as complete a picture as possible is presented in one place. For example, during our visit to the school nursing service we identified one case of a school aged child with complex needs who has been assessed by the looked after children team where the documentation was incomplete. Part B of the standard BAAF form had not been completed and there was no reason recorded to account for why this was so. ([Recommendation 1.14](#)).

4.11 In addition, where parental health histories have been obtained, this information is not routinely being brought through to subsequent health reviews. Again, this information is invaluable and should be considered alongside any emerging health need. The importance of this was demonstrated in one case we saw, where foster carers brought to the attention of the GP concerns about a potential squint. In his referral to ophthalmology the GP referred to the family history and occurrence of similar conditions in siblings.

4.12 Health plans arising from health assessments and reviews, although appropriately identifying need, are often not SMART. Plans are not usually outcome focussed, often generic and do not specify timescales for action. During our visit to the school nursing service we identified another case where a review health assessment for a six year old child was completed by a band five nurse. The record showed that there had been no handover to the school nurses of this case from the health visitors or the looked after children nurse who had both had involvement with the child and carers. The health assessment action plan had health needs identified but actions and outcomes were not SMART. There was no evidence of any intention to review the impact of the action plan at addressing the health needs identified for the child. Both this case and the case mentioned above where documentation was incomplete had been subject of a looked after children team quality assurance process that did not identify or challenge these health assessments. ([Recommendation 1.15](#)).

4.13 Strengths and Difficulties Questionnaires (SDQ) are currently completed by children's social workers. The SDQ scores are not shared with the looked after children health team and so do not inform health reviews. This is a missed opportunity to identify need in a review and to monitor a child's emotional health over the period of time they are looked after.

4.14 We were advised that MYHT policy is that any missed appointment for outpatient services results in removal from the service, even when a child is looked after. In one of the cases we looked at we saw that a letter is sent to foster carers to advise that the child's social worker will be informed and that re-referral can be made. However, this creates delay in a vulnerable cohort of children where outcomes remain poorer than that of their peers.

4.15 Young people leaving care at 18 are provided with a health summary. These are young people focussed and are shared with the young person, their GP and the leaving care worker. The summary includes any parental health information that is available to the team. This information is important to young people as it helps with their identity and is also useful when they register for health services where questions around family history are often asked.

4.16 We heard of how children's social care have recently refused to accept a referral of a looked after child, aged 17, who is in the early stages of pregnancy. The reason is because they do not accept any referral until a viability scan has been performed. However, the same young person has also been referred to the Family Nurse Partnership who are trying to engage the young person. Looked after children and care leavers are a priority for the Family Nurse partnership.

4.17 Children and young people who are looked after and are identified as needing additional support for their emotional health can be referred to a dedicated emotional health and wellbeing team. This service is led by a psychologist and provides consultation for professionals and foster carers working with looked after children. The service also carries out therapeutic work with children and young people directly. Where a child is identified as needing more specialist CAMHS input, then the team can facilitate speedy transfer into the service. We saw evidence of where the support of the team was essential in maintaining fragile placements by working with foster carers and their child.

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## 5. Management

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

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### 5.1 Leadership and management

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5.1.1 We found that the CCG have a robust approach to developing and improving safeguarding practice across Wakefield's health services. To ensure this approach is effective, we saw that the CCG provide visible and proactive leadership to the network of named safeguarding professionals across the providers and within primary care. For example, we saw that GPs benefit from regular safeguarding lead forums chaired by the Head of Safeguarding and by regular newsletter updates of topical issues prepared by the named GP. GPs said they value the meetings and attend when possible.

5.1.2 We saw that the CCG has a strong internal culture around safeguarding as shown by the accountability processes below under 'Governance'. This culture enables the CCG to have influence as key strategic partners within the local safeguarding network. In this capacity, for instance, they have been influential in the development of safeguarding policy within the LSCB; such as the policy on a more targeted approach to attending child protection meetings and the development of the LSCB's neglect and female genital mutilation (FGM) protocols as part of a consortium that includes MYHT.

5.1.3 Further, the CCG's relationship with the safeguarding leads enables it to take an active role in monitoring and making recommendations for improvement. For instance, we saw that an audit of non-accidental injuries in 2014 provided data and analysis to support recommendations to the health visiting and midwifery teams about their engagement with new mothers and families. Part of those recommendations related to the questioning about and recording of risk of domestic abuse. However, as we have reported in several places above, although questions were asked by practitioners there was still some inconsistent practice in recording keeping about these questions.

5.1.4 The CCG are currently working with community paediatricians to meet the challenge of providing a skilled cohort of medical staff to carry out forensic examinations of children and young people at the recently opened sexual assault referral centre (SARC) used by the agencies in West Yorkshire. This challenge of matching the numbers of paediatricians with the number of examinations required to maintain their forensic competence has arisen since police forensic medical examiners no longer carry out joint examinations of children and young people. This will ensure that forensically viable examinations are carried out by doctors with expertise in child development and with a focus on children's needs

In order to consider how the local processes and agencies comply with any changes implemented as a result of SCR findings, the LSCB set up a 'Challenge Panel' system. Each agency is invited to a challenge panel chaired independently by a senior professional of another agency. For example, the CCG designated nurse chairs challenge panels for social care whilst the LSCB's independent chair chairs the panels with health agencies. Panels take place after the final due date of the last recommendation of each SCR, then again one year on, to see whether they have 'mainstreamed' the changes required into practice.

Challenge panels are robust in examining information provided by the agencies. One of the questions in the challenge process is 'what is the impact on children?' The CCG told us that the health agencies have been effective in mainstreaming changes into practice by helping to embed a safeguarding culture among senior staff such that the impact on children of such changes has been significant.

For example, one of the recommendations of a SCR was to separate the children's fracture clinic from the adults clinic so that instances of non-attendance (DNA) can be properly identified and followed-up. As a result of changes implemented any habitual re-arranging of appointments is notified to GPs who are alerted to look in detail at a child's history and encouraged to consider the rest of the family, particularly for evidence of further DNAs and can respond accordingly.

5.1.5 We learned from the named GP that the LSCB also has a sitting GP representative. We were advised that this has been helpful in enabling the LSCB to understand the primary care landscape in Wakefield. For example, the support of the Local Medical Committee, through the GP representative has been instrumental in the adoption by the LSCB of a non-ambulant bruises protocol (part of the bruises, burns and scalds protocol used by the acute trust) so that all such cases are now referred automatically to the local authority.

We learned of an initiative in the Spring of 2015 derived from the West Yorkshire Police and Wakefield Council response to reports published about CSE in Rotherham in 2014. The police and local authority had identified 44 legacy cases which had met certain risk criteria and which required further investigation by the agencies. The health services were asked to review health records of the young people concerned to determine whether all risks had been properly identified. The governance of this information was challenging, particularly since many of the young people were over 18 at the time of the review. As a whole, health economy approach, the CCG worked with providers and GPs to individually audit each case to see if any hidden risk had been missed initially. This led to the safe and meaningful sharing of information from relevant cases.

In this instance, the CCG's involvement and leadership was key to ensuring a successful outcome to this challenging circumstance.

5.1.6 Safeguarding children has a high profile within the MYHT and staff work within a culture where this is promoted. For example, the named midwife and safeguarding adviser promote and prioritise safeguarding within the maternity services at Pinderfields hospital and are available to provide expert advice and guidance to staff as needed. Additionally, they have good oversight of cases where vulnerabilities have been identified.

5.1.7 The health visiting team have increased in volume in the wake of the 'Health visitor implementation plan, a call to action'. Practitioners told us their caseload sizes were around 240 and were manageable. This is below the minimum floor standard of 300 as outlined by the Institute of health visiting guidance. As a result, families have a named health visitor allocated to them until the child is aged five and this supports the identification of and response to risk.

5.1.8 As we have outlined in 'Early Help' the health visitors work in partnership with GPs in Wakefield through regular meetings albeit to a variable extent and without the benefit of an input from school nursing and midwifery.

5.1.9 The current pathway to review and respond to the gap in paediatric liaison is not robust. We were told that the criteria for sharing of information about ED attendances had changed in response to the challenges around the resources needed to review every ED attendance that the school nursing team received. A more targeted approach was considered to be a solution and we have reported above under 'Early Help' about pilot designed to ensure a more focussed approach. This is an ongoing piece of work and is currently in phase two. Our sampling of case has shown that this arrangement is not working effectively and that liaison between the two services is too variable. As a consequence there is a risk that some children and young people had hidden health and wellbeing needs that will not be met whilst others will showing that the service is inequitable. ([Recommendation 1.4](#)).

5.1.10 The school nurse team are commissioned to deliver the healthy child programme to children and young people aged five to 18 (19 for those with special needs) and immunisations. The population size is around 63,000 children and young people with diverse needs. The universal caseload size currently exceeds that which is recommended by the guidance from the Community and Public Health Visitors Association.

5.1.11 The universal public health offer has developed further to include more immunisation campaigns. This offers greater health protection for the school aged child with very successful uptakes reported of human papilloma virus and diphtheria, tetanus and polio campaigns. However, this has become part of the core offer and is delivered with no additional workforce. ([Recommendation 1.16](#)).



5.1.12 We heard about the significant challenges the school nurses are encountering in response to the demands and complexity of their work with stretched and limited resources. There is additional pressure in the team at present as four experienced members of staff are off work long-term. Staff report that they have been unable to complete incident forms on the datix system due to their workload and this under-reporting has exacerbated the problem. We learned anecdotally that these capacity issues have been escalated to the management team and commissioners although there is a perception among staff that this is not considered an organisational risk. ([Recommendation 1.16](#)).

One of the cases we looked at in the CAMHS service showed that differences of opinion between professionals from different agencies are properly escalated through the SWYPFT safeguarding team. In this instance they were escalated in a timely way that ensured the young person was not left at risk for a protracted period. The resulting professional meetings about the risks led to an eventual safer outcome for the young person concerned.

5.1.13 In both CAMHS and adult mental health services, practitioners use both paper and electronic patient records, which the trust recognises as a risk. As we have outlined in 'Child Protection' above, the electronic patient records does not currently allow practitioners to scan referral forms, child protection minutes, or any other third party information on to the patient records. We have been advised that a new release of the software is imminent and staff hope that this will support better record keeping and information sharing.

5.1.14 The interim lead looked after children nurse has negotiated IT support and is now able to produce reports on initial health assessments and health reviews. This facilitates more effective scheduling and reporting on compliance with timescales. A balanced scorecard now incorporates performance around initial and review health assessments and exceptions are reported to the designated nurse for looked after children.

5.1.15 Use of new codes on the patient electronic record is helping to develop a more intelligent and accurate health profile of Wakefield's cohort of looked after children. This will help in commissioning services and evaluating the impact of health interventions.

5.1.16 The predominating electronic patient record system in use across most health services in Wakefield, known as SystmOne, has functionality that allows information about vulnerable children or those at risk to be shared across service boundaries by use of a discrete safeguarding node. However, the sharing arrangements on the system are inconsistently applied and do not conform to any particular data entry standards. For example, the cases we looked at in the health visiting service highlight that the safeguarding node is underutilised by health visitors. We also saw that whilst GPs can view entries on patient records made by other practitioners such as health visitors or school nurses, the same is not true of information entered by other services or by the GPs themselves. Such a variable use of the safeguarding node across all services that used the records system to such an extent that there is a risk of it being an unreliable repository of information. ([Recommendation 2.2](#)).

5.1.17 This is exacerbated by the use of several other different electronic records systems used by different health disciplines, often those in the same trust. This does not allow effective oversight of children at risk and inhibits effective collaborative work as information is missed. One particular case we were tracking across services that we have reported on under 'Child Protection' highlights the dangers in this arrangement where the risks to the young person are perceived differently by three different services.

We visited the MASH service at Normanton police station and reviewed both the health service's contribution to decisions made at the MASH as well as the effectiveness of referrals made by health practitioners. We saw that the health information presented to the individual case discussions was extensive, well-researched and comprehensively analysed in terms of its effect on the risk to the child or young person subject of the referral. This means it was also very influential on the MASH decision making processes. This is despite the inherent difficulties in extracting information from six different databases and where information is often hidden between different health services. We saw that the team had developed an extensive range of contacts in the health services in order to help them to interpret information or to obtain information that was hidden from view.

In the cases we sampled where the health services had referred concerns into the MASH team we found that the level of detail was variable. However, each referral was timely and showed vigilance by the practitioners involved. In one particular case we noted that an effective escalation process had been used by the health team and that urgent action had been taken to protect a young person as a result.

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## 5.2 Governance

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5.2.1 As shown above, the CCG play a key role in safeguarding governance in the Wakefield LSCB. The CCG's chief of service delivery for safeguarding (and executive nurse on the CCG board) is the deputy chair of the LSCB whilst the designated nurse for safeguarding and looked after children chairs the Audit sub-committee of the LSCB. There is also representation from the GP community and from midwifery on the LSCB or its sub-groups and this ensures that the health service is in a position of strategic influence within the local safeguarding landscape.

5.2.2 We learned from the CCG that reporting on safeguarding has become systematic as opposed to being by exception. This was borne out by the ready availability of data forwarded to us by the CCG in short, advance notice of this inspection. For example, all referrals of abuse through health that are classified as serious incidents are raised through the serious incident reporting process on STEIS and then discussed at CCG quality board. This ensures robust oversight of safeguarding performance at senior level.

5.2.3 In addition we saw that the CCG audited its safeguarding performance in March 2015. This was in order to determine its compliance with the NHS England accountability and assurance framework for safeguarding two years on from the transition of commissioning arrangements from PCT to CCG. In its report to the CCG's Integrated Governance Committee of August 2015, the CCG concluded that "NHS Wakefield CCG is in a strong position regarding the revised accountability framework, and will continue to reform and improve provider assurance." This assertion was based on the assurances obtained from the audit of compliance with all of the requirements of the NHS' framework.

5.2.4 All strategic governance roles are in place with clear lines of accountability. The designated doctor for safeguarding is part of the medical staff at the MYHT, thus ensuring strategic liaison with the city's biggest health service employer. The named GP is also a practicing GP and provides one session per week safeguarding duty. Both the MYHT and the SWYPFT have dedicated safeguarding teams lead by named professionals, as does the largest independent health provider, Spectrum C.I.C. Thus there are clear processes that enable safeguarding to be managed at both executive and operational levels. For example, we found that there is a clear governance structure and regular meetings with the MYHT that ensure safeguarding issues within maternity services are reported appropriately to the trust senior management and board. We have been assured that this process is mirrored across all MYHT services.

5.2.5 We also saw that the SWYPFT had a clear and robust structure for managing safeguarding performance in their service provision for both adults and children. Safeguarding was a clear priority for the trust and was part of the remit of the trust's Clinical Governance and Safety Committee with clear lines of accountability. For example, we looked at the trust's annual safeguarding plan for 2015 to 2016 which set out key objectives for the executive lead and their deputies, the named professionals and their team of safeguarding advisers and the link professionals that directly support the operational teams. We noted that named people or identified roles in the trust's safeguarding structure are accountable for key objectives of the plan. These objectives include, for instance, attendance at local safeguarding children's board meetings, safeguarding training compliance, quality of safeguarding supervision sessions and ensuring that views of children are reflected in assessments and records in individual cases. Monitoring of these objectives is through the trust's clinical audit and practice evaluation plan (CAPE) which shows that safeguarding is embedded as a key feature at both strategic and operational level of the trust's functions.

We were interested to hear of a 'challenge event' run by the local safeguarding children board of a neighbouring local authority area which is also covered by the SWYPFT (Kirklees) and with a similar demographic. At this event, each of the agencies involved in safeguarding presented to the board the findings of their self-assessment audit carried out to measure the effectiveness of their safeguarding arrangements, in particular, their training and governance arrangements. The trust's safeguarding team presented the findings on behalf of the Trust. This was followed by interviews by a panel of children and young people about each agency's performance, including their approach to child sexual exploitation, after which the agencies were 'scored' by the panel. We note that the trust's scores were the highest of each of the agencies represented showing a general level of confidence of young people in the safeguarding service offered by the trust.

Whilst this event relate to a council that bordered Wakefield – a similar event is planned for Wakefield in 2016 – we nonetheless consider it indicative of the overall effectiveness of the trust's approach to safeguarding.

5.2.6 We saw that SWYPFT consult with a group known as the CAMHS young people's advisory group to ensure their services meet the needs of young people. This group had been effectively engaged in, for example, CAMHS staff selection. Clinicians of band six and above who were appointed in the last five years had been subject to interviews by young people as part of their selection process. This initiative had provided the trust with assurance that newly recruited staff were focused on the needs of young people and were committed to ensuring good outcomes for them. This was borne out in our discussions with staff and our review of records, where we found that there was an overall child centred culture among the CAMHS staff team and their managers.

5.2.7 All initial and health review assessments of looked after children are subject to a quality assurance process using a standard tool. The looked after children nurses review all completed assessments and peer review each other's. This helps to ensure that all children and young people benefit from meaningful reviews, including those children and young people placed out of area.

5.2.8 The looked after children nursing team has been in flux for a prolonged period of time with changes in operational leadership and reduced capacity of looked after children nurses due to sickness and maternity leave. We have been advised that these issues are recently resolved. Despite this, the team has worked closely with partners in social care to improve the timeliness of initial health assessments and recent performance shows 100% of assessments have been carried out within 28 days of a child becoming looked after. This is good, as very often the initial health assessment is the first opportunity to fully assess a child's health and make a plan to improve their health outcomes.

Since April 2015, the two major providers of adult substance misuse services, Spectrum and Turning Point, have combined their operations under a single commissioned umbrella organisation, Inspiring Recovery. The new organisation has made great efforts in a short space of time to ensure that their operating models are aligned. Of note, is the monthly, dedicated safeguarding working group whose role is to produce a new set of procedures and policies and the implementation of a single case management database. In our review of sampled cases we found that staff were knowledgeable of the procedures and had applied them effectively to assess risks to children of, or accessible to their clients.

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## 5.3 Training and supervision

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5.3.1 Practitioners caring for vulnerable children and young people in a mental health crisis on the children's assessment unit or children's ward at Pinderfields hospital have not had any training in CAMHS. We heard that CAMHS have recently started running monthly briefing sessions available for staff to access. This increases the level of knowledge and understanding about children and young people's mental health among paediatric staff.

5.3.2 ED practitioners at Pinderfields Hospital have received level three safeguarding training as outlined by the intercollegiate guidance on safeguarding roles and competences for health care staff. However, the majority of staff have only accessed in-house training and that not all ED practitioners have accessed multi-agency training provided by the LSCB. This is not in line with the guidance. ([Recommendation 1.17](#)).

5.3.3 We learned that the MYHT safeguarding team have recently introduced dedicated safeguarding supervision across both Pinderfields and Pontefract hospitals. This supervision is separate from routine clinical or other supervision. Children's ED practitioners have access to quarterly safeguarding supervision, where cases are discussed. However, the impact of these new arrangements has yet to be measured and it is not clear whether part-time practitioners or those on annual leave have the same access to such timely safeguarding supervision.

5.3.4 In the maternity unit we saw that patients' integrated care pathway documents are noted whenever their case has been subject to discussion at a safeguarding supervision session. Action plans arising from supervision, however, are not incorporated into any patient records, either in paper format or on the electronic database. This means that patient records are incomplete, that any staff who need to use the records are not fully apprised of any relevant issues and the practice does not support auditable decision making. This is contrary to guidance issued by both the Royal College of Nursing and the Nursing and Midwifery Council on good record keeping. ([Recommendation 1.18](#)).

5.3.5 Midwives are specifically identified within the intercollegiate guidance as requiring level three training at specialist level (a minimum of 12-16 hours over a three year period) which has a multi-disciplinary and inter-agency component. We were advised that community midwives at Pinderfields hospital are required to attend level three safeguarding training but that hospital midwives are only required to attend level two. This does not comply with the intercollegiate guidance.

5.3.6 Compliance with attendance at the single agency, in-house training is monitored, however the running total of a midwife's learning over a three year period is not monitored. This would benefit from a safeguarding training element included in annual appraisals so that running total of hours of relevant learning could be discussed and signed off by the line manager and a plan of how to achieve any outstanding hours over the next year developed.

5.3.7 As reported above, multi-agency training opportunities are available through the LSCB but midwives perceive that work pressures and capacity limit their availability to attend. This is a missed opportunity to better understand the roles and responsibilities of other agencies involved in safeguarding children work and also promote the principles of working together for this key group of staff. ([Recommendation 1.17](#)).

5.3.8 Safeguarding supervision is offered three-monthly to health visitors in a one-to-one scheduled format and on an *ad hoc* basis if required. The child health team matron maintains oversight of this and is proactive in ensuring health visitors take their supervision opportunities. Safeguarding supervision is reportedly recorded in the journal of the child's record and in the safeguarding node on the electronic records. However, in one of the cases we were tracking across services we saw that a record that such a discussion had been held was logged in the safeguarding node of the electronic record but there was no corresponding entry in the child's journal that showed what actions had been taken or the outcome. In another case we sampled we saw that there was no record of such a discussion shown in the safeguarding node of the electronic record. Team leaders use a dip-sample methodology to quality assure safeguarding cases are but the variability of the use of the safeguarding node shows that this was not effective. ([Recommendation 1.18](#)).

5.3.9 Newly qualified health visitors receive a period of preceptorship for a minimum of three months with the option to extend further based on the individual's need of further development. They are supported by a mentor from their team for day-to-day support and are allocated a safeguarding supervisor soon after coming into post. The health visitor preceptorship lacks a formal structured approach to measure the skills and competences that underpin good safeguarding practice. Newly qualified staff are required to complete LSCB level three multi-agency training within their first year of practice. However, this arrangement could be strengthened if this were prioritised within their first three months of preceptorship to help the early identification of any further areas of development around safeguarding.

5.3.10 Health visitors have over 94% compliance with safeguarding training. They are expected to attend level three training provided by the trust safeguarding team once every three years for a full day. Other than their initial multi-agency training, they are encouraged to undertake training via the LSCB but this is not mandatory. As with the maternity staff, this limits the opportunity to consider and reflect on other agencies roles within safeguarding. ([Recommendation 1.17](#)).

5.3.11 Band six caseload holders in the school nursing service receive one-to-one safeguarding supervision from a named supervisor every three months. The process is practitioner driven in that cases are selected for discussion by the case holder which enables the discussion to be focussed on the most appropriate children. *Ad-hoc* safeguarding discussions also take place as required. We saw examples of the positive impact of safeguarding supervision that contributed to the safety and wellbeing of vulnerable children and also examples of a lack of robust oversight of some cases. This showed that standards of supervision practice were variable.

5.3.12 We were told that band five nurses in the school nursing service are not caseload holders and are therefore not offered the same formal package of one-to-one safeguarding supervision as their band six colleagues. This is despite band five staff delivering early help, looked after children work and safeguarding work at CAF and child in need level. This does not provide band five staff with opportunities to examine cases in more detail and agree formal actions that would benefit the child. Furthermore, it inhibits their learning around a key aspect of their role. ([Recommendation 1.19](#)).

5.3.13 The MYHT teams, including the school nursing and health visiting services, looked after children team, community midwifery and family nurse practitioners are undergoing a programme of training in the 'Signs of Safety' model of risk assessment and management. At the time of our inspection the trust had already achieved a significant proportion of trained staff across all the disciplines with more places planned. This means that children accessing all of the MYHT services would experience standardised safeguarding practice with the emphasis on their needs.

5.3.14 We also learned that the MYHT include training on the 'Prevent' programme as part of their level two and level three safeguarding training refresher courses. This ensures that staff who might have contact with young people, their families and communities are better able to identify young people vulnerable to radicalisation and to respond appropriately.

5.3.15 In all of the GP practices we visited we saw that GPs are trained at level three of the standards set by the intercollegiate guidance. This is currently done through a blended approach where online training augments taught sessions. The online package has a number of modules that require completion such as parental risk factors, unexplained injuries, disabilities and neglect, fabricated or induced illness and substance misuse. In addition, the CCG has recently promoted the use of a bespoke online programme for FGM. Taught sessions are led by the CCG designated nurse for safeguarding who provides level three training for a half-day once every year for each of the seven primary care localities. In this way, bespoke sessions are devised according to the needs of each locality. Over the last year training has included CSE, domestic abuse, FGM, learning from SCRs, private fostering and health of looked after children.



5.3.16 GPs also receive safeguarding updates through quarterly primary care network meetings for practice safeguarding leads. This has included training on MASH and the 'Prevent' programme, with occasional speakers from other agencies although attendance at both these events and the CCG annual events is not currently mandatory. GPs are offered LSCB multi-agency training but none of the GPs we spoke with had taken up this opportunity. This means that those GPs who rely solely on the online package are not being trained to the standards set out by the guidance. Nonetheless, we acknowledge that the content of GP training, and its take-up, has improved significantly over the last three years due to a proactive approach taken by the CCG.

5.3.17 In the CAMHS service we found that the levels of support offered to practitioners in relation to safeguarding is meaningful and robust. Not only do staff receive group safeguarding supervision every three months where they can share and learn from case discussion, they also have dedicated one-to-one safeguarding supervision sessions. In addition, each of the SWYPFT CAMHS and adult mental health teams have a safeguarding link practitioner who benefits from additional training and their own peer network. This role is further supported by a lead professional for safeguarding participation for Wakefield CAMHS. This equips link practitioners with knowledge and expertise to act as a point of contact for their team colleagues. Further, the trust's safeguarding team have a dedicated advice line for practitioners to call at any time for guidance on safeguarding matters, with a firm commitment to call the practitioner back within four hours.

5.3.18 In our review of cases we noted clear documented supervision sessions in the client's records which set out full details of the particular concerns to a child or young person and an analysis of the risk to the young person. The records also contained a list of agreed and time-bound actions arising out of the advice including a timescale for following up the actions. These entries were completed by the supervisor providing the advice which means that the direction provided was clear, unambiguous and supportive of the staff member. This is best practice.

5.3.19 Similarly, there is an expectation that adult mental health practitioners will access group safeguarding supervision every three months. However, there is currently no formal arrangement for one-to-one safeguarding supervision except for the crisis and mental health liaison teams. We saw that all practitioners have one-to-one line management supervision monthly. This session also includes an element of safeguarding supervision and case management although this is over-reliant on individual practitioners to identify cases for discussion. The trust recognises this as a gap, and we were informed of plans to roll out child safeguarding supervision to all community mental health teams as well.

5.3.20 Like the CAMHS service, adult practitioners who access safeguarding supervision are expected to record outcomes following the discussions in the patient's electronic records. However, in the cases we reviewed, we saw that this practice is too variable and for those case where there no such record is made decision making is compromised. The trust is also aware of this shortfall and as we have previously reported, a newer version of the patient record software is expected soon. This will allow documents, such as supervision notes, to be scanned into the record to ensure that everyone who uses the notes has access to all information.

5.3.21 Learning from SCRs is sent out to all practitioners in the CAMHS and adult mental health service and this is recorded on training records by the learning and development team. This ensures that staff have access to lessons learned and can consider their practice in light of emerging themes.

5.3.22 All adult mental health practitioners are required to access level three safeguarding training every three years, and this is reported to be in line with the intercollegiate guidelines. We were informed that compliance has been monitored and the trust compliance figures for attendance at mandatory training have increased significantly over the past year.

5.3.23 Adult mental health practitioners have also had access to additional training to support them in their roles to safeguard children and young people. This includes training on FGM, domestic abuse and the 'Prevent' programme. All practitioners are provided with a workbook to complete in order to demonstrate their learning and understanding of safeguarding related topics.

5.3.24 We were informed that community psychiatric nurses, midwifery services and health visitors have delivered training on perinatal mental health to a group of professionals in order to raise their awareness. This provides some assurance that practitioners are being trained on how to appropriately support this vulnerable client group especially with the lack of a formally commissioned perinatal mental health service.

5.3.25 The adult substance misuse service provides training for all of its staff at level two. This has either taken the form of a scenario based workbook supported by line manager discussion or face-to-face workshop. This does not meet the requirements of the intercollegiate guidance as all staff may be called upon to assess family life. However, staff also have access to LSCB multi-agency training and the provider plans to roll out 'Signs of Safety' training in the coming year. This has been brought to the attention of Public Health England.

5.3.26 We noted that the adult substance misuse service track clients who have access to children by use of a spreadsheet. This is checked by team managers for accuracy and current status during monthly supervision discussions. Whilst this is not formal safeguarding supervision, we were told that the check sometimes triggers discussion on individual cases. Additionally staff can bring concerns to managers or to members of the Family Support Team as and when they arise. In the cases we sampled, we saw that such discussions were documented and time bound actions that arose from those discussions, such as the planned joint visit to a particular family home reported above under 'Children in Need'. This supports accountable decision making.

5.3.27 In the CASH service we saw that safeguarding supervision is not robust. Supervision is offered as part of a one-to-one meeting between the staff member and a supervisor three times in every 13 month period and also as and when it is required if concerns are identified. During these meetings the supervisor uses a handwritten template to make notes of the meeting and on which the practitioners' cases under discussion are listed. However, there is no record of the concerns or the discussion about each case and there are no specific time-bound actions recorded. Furthermore, the documents are in a supervision file attributable to the staff member and there was no record of the supervision discussion shown on the client's records in the cases we looked at. This is not good practice as it does not allow for decisions made about children to be properly audited. Furthermore there is a risk that key decisions might be overlooked. This has been brought to the attention of Public Health England.

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# Recommendations

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1. **Mid Yorkshire Hospitals NHS Trust (MYHT) should:**
  - 1.1. Develop facilities for the reception, assessment and treatment of children and young people in the emergency department at Pontefract hospital comply with the 'Standards for Children and Young People in Emergency Care Settings' issued by the Royal College of Paediatrics and Child Health (RCPCH).
  - 1.2. Ensure clear information is posted in the ED at both Pinderfields and Pontefract hospitals to inform children and their parents or carers that their hospital attendance may be shared with other professionals.
  - 1.3. Ensure that the details of adults who accompany children and young people who present at the ED at Pinderfields and Pontefract hospitals is always recorded in the young patient's ED electronic records.
  - 1.4. Develop the paediatric liaison arrangements at Pinderfields and Pontefract hospitals to ensure they are effective in enabling vulnerable children to be followed-up appropriately by community health and primary care teams.
  - 1.5. Implement a process for capturing all information about risks to vulnerable children and young people on the safeguarding node of the electronic patient records.
  - 1.6. Implement a system to quality assure the level of detail in discharge summaries of children and young people discharged from the ED so that community teams are better informed.
  - 1.7. Reinforce the protocols for speaking with pregnant women alone during their pregnancy to ensure the risk of domestic abuse is explored fully.
  - 1.8. Update the current risk assessment tool In use for all children and young people who attend ED at Pinderfields and Pontefract hospitals so that it includes a full exploration of risks, particularly the risk of CSE, and ensure that full records are made of the assessment.
  - 1.9. Implement a system for capturing and responding to information from adults who present at ED with risk taking behaviours about children they might have access to.
  - 1.10. Develop arrangements for more effective information sharing between the school nursing service and the education admissions department of the local authority in order to identify additional support needs of children being home schooled, moving schools or those missing from education.

- 1.11. Ensure that the protocol for reviewing all under one year old non-ambulant babies who attend with burns, head injuries, bruises or fractures at both hospitals is adhered to in relation to the experience and skill of the examining doctor.
- 1.12. Install a secure exit system from the postnatal ward that complements the secure system already in place for entry to the ward.
- 1.13. Ensure that the health assessments and health plans of looked after children are shared directly with the child's GP so that they are apprised of all recommendations.
- 1.14. Ensure that looked after children health assessment documentation is completed fully to enable a complete picture of the child to be conveyed to all practitioners who need to use the records.
- 1.15. Ensure that quality assurance processes for looked after children health assessments are effective in identifying shortfalls in those assessments and the documentation relating to them.
- 1.16. Ensure that the capacity of the school nursing service reflects the increase in the demand for its service.
- 1.17. Ensure that all staff at Pinderfields hospital ED and maternity and also in the health visiting service have access to level three training that has a multi-agency component and that training complies with the intercollegiate guidance.
- 1.18. Ensure that safeguarding supervision discussions and action plans arising from the supervision of midwifery and health visiting staff are incorporated into patient records.
- 1.19. Provide the same safeguarding supervision arrangements for band five nurses in the school nursing service as their band six colleagues.

## **2. The Wakefield CCG should:**

- 2.1 Develop a protocol and tools for use in primary care to enable GPs to make sufficient enquiries of young patients about the risks of CSE.
- 2.2 Formalise arrangements for the multi-disciplinary exchange of information between GPs, the community health teams about vulnerable children or those at risk, including the means to ensure a formal note is made of discussions in the electronic patient records which can be shared across the health services.

- 2.3 Ensure that GP practices follow standardised processes and templates for engaging with safeguarding processes, including the use of templated forms for referring cases to social care and the use of standardised content of reports submitted to conferences.
- 2.4 Develop arrangements with the local authority for GP practices to be sent copies of updated child protection plans, core group minutes and child in need meeting minutes and plans so that they can be held on the patient records.

**3. South West Yorkshire Partnership NHS Foundation Trust should:**

- 3.1 Implement a system to quality assure the level of detail provided in referrals to children’s social care by the adult mental health service, including a clear articulation of the risks to the child or young person.
- 3.2 Implement a system that enables staff to fully embed the ‘think family’ model into practice in the adult mental health service as well as the management oversight to ensure this is applied effectively.
- 3.3 Formalise the arrangements in the adult mental health service for providing written information to child protection conferences in lieu of attendance and for using information received from conferences to help plan their clients’ care.

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## Next steps

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An action plan addressing the recommendations above is required from NHS Wakefield CCG within **20 working days** of receipt of this report.

Please submit your action plan to CQC through [childrens-services-inspection@cqc.org.uk](mailto: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.