

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

Children Looked After and Safeguarding

The role of health services in Calderdale

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CCGs included:	NHS Calderdale
NHS England area:	North of England Region
CQC region:	North
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Summary of the review

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

Where the findings relate to children and families in local authority areas other than Calderdale cross-boundary arrangements have been considered and commented on. Arrangements for the health-related needs and risks for children placed out of area are also included.

About the review

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

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

How we carried out the review

We used a range of methods to gather information both during and before the visit. This included document reviews, interviews, focus groups and visits. Where possible we met and spoke with children and young people. This approach provided us with evidence that could be checked and confirmed in several ways.

We tracked a number of individual cases where there had been safeguarding concerns about children. This included some cases where children were referred to social care and also some cases where children and families were not referred, but where they were assessed as needing early help and received it from health services. We also sampled a spread of other such cases.

Our tracking and sampling also followed the experiences of looked after children to explore the effectiveness of health services in promoting their well-being.

In total, we took into account the experiences of 82 children and young people.

Context of the review

Calderdale is in West Yorkshire, between Manchester and Leeds with the district covering an area of 363 sq km, stretching 28 km from east to west and 20 km north to south. Over 80% of the district is rural in character. The resident population of Calderdale is 207,376 with almost half of all residents living in Halifax (NHS Calderdale CCG 2016).

The Indices of Deprivation (2014) ranked Calderdale as the 105th most deprived district in England with an estimated 10,050 children and young people growing up in poverty.

Child and Maternal Health Observatory (ChiMat) data indicates that 98.5% of Calderdale residents are registered with a GP practice that is a member of NHS Calderdale CCG.

Children and young people under the age of 20 years make up 24.3% of the population of Calderdale. 23.1% of school children are from a minority ethnic group. The health and wellbeing of children in Calderdale is mixed compared with the England average. Infant and child mortality rates are similar to the England average. The Indices of Deprivation (2014) ranked Calderdale as the 105th most deprived district in England with an estimated 10,050 children and young people growing up in poverty. This level of child poverty is worse than the England average.

The rate of family homelessness is better than the England average. Children in Calderdale have average levels of obesity: 8.4% of children aged 4-5 years and 18.2% of children aged 10-11 years are classified as obese.

In 2014/15, children in Calderdale that required admission for mental health conditions were lower than in England as a whole. The rate of inpatient admissions during the same period because of self-harm was similar to the England average.

In 2011-12, 39.2% of five year olds had one or more decayed, filled or missing teeth. This was higher than the England average. Hospital admission rates (2012-13 and 2014-15) for dental caries in children aged under 5 years are higher than the England average.

The Department for Education (DfE) provide annual statistics of outcome measures for children continuously looked after for at least 12 months. A strengths and difficulties questionnaire (SDQ) was used to screen the emotional and behavioural health of looked after children within Calderdale. The most recent average SDQ score of 14.2 is considered to be borderline cause for concern and is above the England average of 13.9.

As at 31 March 2014, there were 45 children aged five or younger who had been looked after for at least 12 months.

CCG data indicated that up until March 2016 there were:

- 193 children who are subject to a Child Protection Plan
- 297 children who are living in care
- 316 children who are subject to Child in Need Plans

Commissioning and planning of most health services for children are carried out by Calderdale CCG and the local authority

Acute hospital services are provided by Calderdale & Huddersfield Foundation Trust (CHFT).

Health visitor services are commissioned by Public Health (local authority) and provided by Calderdale & Huddersfield Foundation Trust (CHFT).

School nurse services are commissioned by Public Health (local authority) and provided by Locala Community Partnerships.

Contraception and sexual health services (CASH) are commissioned by Public Health (local authority) and provided by CHFT.

Child substance misuse services are commissioned by Public Health (local authority) and provided by Branching Out – Lifeline Project

Adult substance misuse services are commissioned by Public Health (local authority) and provided by Developing Initiatives for Support in the Community (DISC)

Child and adolescent mental health services (CAMHS) are provided by South West Yorkshire Partnerships NHS Foundation Trust (SWYPFT) for Tier 3, and Tier 2 is provided by Northpoint Wellbeing Limited

Adult mental health services are provided by South West Yorkshire Partnerships NHS Foundation Trust (SWYPFT)

The Calderdale integrated inspection of safeguarding and services for looked after children (SLAC) took place in January 2010. The inspection outcome for looked after children for being healthy was rated 'good'. However, the effectiveness of safeguarding services was judged as 'inadequate' whilst services for looked after children were 'adequate'. This led to the local area being made subject of an improvement notice by the Secretary of State. Recommendations from that inspection are covered in this review.

The report

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

What people told us

A family attending the emergency department told us:

"We are regular attenders here and have no problems with the service we receive. Staff always keep us informed and tell us what the plan is".

We talked to care leavers who told us:

"I have a book with all of my health contacts in which I like".

"I have been helped to control my asthma better by people explaining how to use my inhalers".

"My midwife was always different, I saw about five different midwives".

"[Hospital services] shouldn't discharge babies from hospital at particular times, I was discharged from the ward with my baby at 4am. I didn't feel listened to by the hospital staff, they were concerned about something that she always has and I was concerned about something new but they weren't listening to me".

"My family nurse is really positive for me. I look forward to seeing her and her reviewing my baby. I think the service is really good".

Care leavers talked about the environment at CAMHS services:

"Don't like the rooms that we meet CAMHS practitioners in".

"There was a toy for me to play with on the table, it was for babies".

"It is a box room with a table and a ticking clock".

Care leavers talked about the support they received for their emotional and mental health:

“Counselling I was offered was a waste of time, it was supposed to be every two weeks and it was every six weeks”.

“My GP really listened to me when I was feeling low”.

We talked to a foster carer who told us:

“I would like to have had the information about his birth. I didn’t know he was premature or had been intubated. The hospital staff found this out” [when the child was admitted four days after being placed with the carer and required intensive care].

Another carer stated:

“The physiotherapist and occupational therapist are good and bring things that he’s needed but, we are still waiting for a follow up hospital appointment that was due in February and I’m concerned about his posture. The social worker is helping with this”.

Another carer reported:

“The children looked after nurse has been supportive at health assessments but this has not helped to address concerns we have for his health. There was a lack of information available about his needs when he was placed with us”.

The child's journey

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

1. Early help

- 1.1 Calderdale has an effective early intervention strategy delivered through the four geographical areas; Central Halifax, Halifax North and East, Upper Valley and Lower Valley. Locality panels are multi-agency with representatives from health, the local authority, education, police and voluntary services delivered under the leadership of a service manager. This is a structured community approach to meeting the additional needs of children, young people and families in Calderdale that facilitates multi-agency decision making and planning to improve their outcomes. Professionals refer children and young people that meet level two or three in the five tier continuum of need by completing a Single Assessment Form. Health staff made 28 referrals for early help for children and young people and families in Calderdale in 2014 to 2015; health staff also attend hub meetings where these cases are discussed and decisions are made about the support that can be offered to help meet their needs. The aim is that the timely initiation of early help will help to prevent children's needs escalating into level four and five of the continuum of need.
- 1.2 Midwives use the early intervention locality hubs to refer women that require additional support early in pregnancy. Access to support services early in pregnancy contributes to improved health and wellbeing outcomes for mothers-to-be and their babies, helping them to achieve the best start.
- 1.3 Pregnant women access their maternity booking appointment with the midwife at children's centres as per local policy. Whilst this helps to link the expectant mother to the support network of the children's centre, it limits the opportunity to consider fully the impact of any environmental and social risk factors that can be identified during home visits. Whilst there is no national standard that requires midwives to undertake a home visit midwives locally are expected to complete this at around the stage of 36 weeks of pregnancy. However, the achievement of this is variable and is not being monitored. When undertaken this can aid the identification of additional needs or risk factors that may benefit from early help.

- 1.4 Midwives notify the health visitor and GP of a woman's pregnancy when they have booked and this is updated at the 28 to 30 week stage of pregnancy. This indicates to the GP and the health visitor that the pregnancy is viable enabling the health visiting team to plan for ante and postnatal contacts and participate in any ongoing joint work for those likely to require additional support above the universal contacts. Furthermore, this information sharing approach prevents inappropriate contacts by health visitors to parents that have experienced a miscarriage.
- 1.5 In maternity the record keeping systems were being developed with a move from paper to an electronic record keeping system called Athena. We found that record keeping arrangements are fragmented with community midwives having limited access to women's complete records. This prevents maternity staff from having an effective oversight of the needs, risks and wishes of the women they are caring for. We saw limited evidence of maternity birth plans, or multi-disciplinary or multi-agency plans. Whilst some records reviewed had a separate comprehensive paper plan, for those women booked since January 2016 this had ceased. The functionality of the Athena electronic system prevents midwives from creating or uploading women's birth plans. As a consequence this reduces the visibility and effectiveness of plans that inform midwives of women's ongoing care whether universal or targeted to help safeguard the unborn or newborn. (**Recommendation 1.1**)
- 1.6 The arrangements for midwives to assess risk consistently for women throughout their care are not robust, with limited access to women's records that detailed escalating or de-escalating concerns effectively. We saw case evidence that whilst midwives reviewed risks identified at previous visits but this was recorded in different parts of the Athena record keeping system. This makes it difficult to locate this vital information and therefore we are not assured that this enables midwives to be fully considerate of this as part of their ongoing care planning and case management of women. (**Recommendation 1.4, 1.6**)
- 1.7 Routine enquiries made by midwives to women regarding domestic abuse were variable and not considered throughout their episode of care. This approach is not proactive safeguarding practice given the well documented evidence that domestic abuse can begin or escalate during pregnancy which places women at risk of harm. We could not be assured that the existing arrangements to aid the identification of domestic abuse in pregnant women are effective. (**Recommendation 1.24**)
- 1.8 Case notes demonstrated that midwives do not routinely undertake any ongoing review of risks around women's partners to inform their care. It was evident that midwives enquired about this once but this assessment is not repeated routinely to identify any changes or elevated risks that partners may pose. Whilst there is no national standard that requires midwives to repeat this assessment where risks are identified, this should form part of their ongoing risk assessment and care for the unborn child. This would ensure any changes, such as change of partner or changes in their health are considered to help safeguard and protect the unborn.

- 1.9 Midwives in Calderdale demonstrate they are responsive to the need for more enhanced and differentiated support in the community. Following feedback in one locality from a children's centre survey, midwives provide additional specialist parent education sessions to more vulnerable groups in the community. This is in addition to the standard parent education offer at evenings and weekends in that area which will benefit that cohort of expectant parents.
- 1.10 Families in Calderdale with children under five benefit from the effective delivery of the healthy child programme. This includes universal and enhanced contacts with children and families which aids the identification of additional need. Child development support workers provide support for toileting, sleep, safety, diet and play. This contributes to supporting children to have the best start.
- 1.11 There is good communication from the paediatric liaison nurse at Calderdale Royal Hospital to health visitors. However, an audit of 'cause for concern forms' by Calderdale and Huddersfield Foundation Trust (CHFT) in January 2016 identified variable health visitor practice. Whilst 75% of children and families reportedly received appropriate follow up 25% did not meet this standard. Furthermore, in most cases health visitors did not follow procedures to complete and return a template to the safeguarding team. This level of scrutiny identified actions that will help standardise practice and facilitate equitable care for children and families.
- 1.12 The health visiting team have established strong links with Early Years providers such as children's centres and nurseries in Calderdale. Every Early Years provider has a named health visitor or child development worker as a single point of contact. This makes the health visitor service more accessible and responsive so they are able to offer targeted early help to children with emerging needs that will help to improve their outcomes and aid school readiness
- 1.13 GP practices benefit from having a named link health visitor who regularly attends practice meetings to discuss vulnerable children, young people and families. The exchange of information between these services is contributing positively to the identification of emerging concerns and initiation of support for vulnerable children, young people and families. Review of child records demonstrated that when they discuss the child at a GP practice meeting health visitors record the actions agreed and resulting outcomes in the child's notes. This joined up approach helps to safeguard children and young people by ensuring all practitioners are aware of actions they should be taking and can take account of current concerns during consultations.
- 1.14 Some families in Calderdale are supported by the family nurse partnership (FNP) with this approach reported to be deemed successful locally. Access to this service provides vulnerable young first time mothers with an intensive and structured visiting programme. This service was under review at the time of the visit and the outcome is not known.

- 1.15 School nursing provision in Calderdale is focused on pathways and targeted support for school aged children and young people. The introduction of a duty role ensures children, young people and their families have good access to a service that is responsive to their needs and has reduced the numbers of children waiting for support. The duty worker can deliver, where appropriate, a brief intervention following an initial referral to the duty triage team. Whilst we saw that the duty nurse dealt promptly with information shared by the multi-agency safeguarding team (MAST) following two domestic abuse notifications; the action taken in one case did not follow the instructions from the MAST worker. As a consequence the school nurse was not planning to take any further action until the social worker contacted them. This demonstrates a passive approach that relies on social workers to provide updates about children rather than the school nurse pro-actively seeking this information to aid their ongoing care planning and support for the child.
- 1.16 School nurses are not engaged with formal GP practice meetings where discussions take place about vulnerable children and young people. The benefits to participating in such meetings would afford school aged children with the same level of oversight as those aged under five that we reported above. The school nursing service recognises the need to strengthen their operational links and ongoing communication with GP practices and Locala have focused on this since January 2016. However, outside of this arena we did see case examples that demonstrated effective liaison with the GPs and other services for children with complex needs.
- 1.17 School nurses maintain a good oversight of children and young people by recording significant events they encounter on chronologies in their individual health records. This enables school nurses to easily identify emerging needs or escalating concerns that helps to maintain oversight and respond to the child's needs. In one case we saw the school nurse respond effectively to a child's repeated attendance at the ED for asthma. The school nurse developed a robust asthma plan that improved management of the child's condition and reduced the number of ED attendances. There have been a number of child deaths nationally due to the poor management of this essentially reversible condition, so this practice is pro-active and commendable.
- 1.18 The data sharing arrangements between CHFT ED and school nurses do not appear robust with regard to children and young people that attended the department following a self-harming incident. The performance monitoring of Calderdale Safeguarding Children's Board(CSCB) in quarter three (February 2016) highlighted that CHFT reported 42 attendances but Locala were aware of 10 of these, with school nurses following up all 10. This continues to be monitored by the CSCB. Weak information sharing does not help to safeguard children and young people and is often cited in serious case reviews. (**Recommendation 1.16**)

- 1.19 The school nursing service is developing ways to make the team more visible to schools and young people following the service specification which saw the removal of school nurses drop-ins. They have consulted with service users and are considering alternative ways to reach children and young people through the use of electronic referral forms, social media and apps for access to the service or for advice and support. Being visible, accessible and confidential is important to children and young people as outlined by the British Youth Council (2011) and helps to identify opportunities to intervene early to improve the health and wellbeing of children and young people.

The school nursing open referral system facilitates access to the team for a wide range of agencies.

We saw a direct referral made by the police to the school nursing service to request support for a vulnerable young person with sexual health advice and relationship support. The police officer sent the referral to the school nurse team as they were deemed to be the most appropriate service.

Following a period of support this led to positive outcomes in developing the young person's awareness of appropriate relationships.

- 1.20 Children and young people have access to dedicated contraception and sexual health (CASH) services with queue and wait sessions available once per week in the central hub and two health centres across the locality. They can also access booked appointments or can attend the all ages drop-in. Whilst teenage pregnancy rates continue to reduce, figures in Calderdale remain higher than the regional and national average. There are no outreach clinics but the service has ambitions to increase their accessibility to harder to reach young people, for example, those in the pupil referral unit and young offenders. This is positive move to engage all young people.
- 1.21 The existing under 18s risk assessment used in the CASH service is superficial in its enquiry and staff are not universally assessing for the risk of child sexual exploitation (CSE) or female genital mutilation (FGM). As a consequence this may prevent the early identification of emerging risk or safeguarding concerns in children and young people, restricting the opportunity to offer protection. (**Recommendation 1.4**) *These concerns have been brought to the attention of the public health within Calderdale Metropolitan Borough Council as the commissioner of this service.*

- 1.22 In South West Yorkshire Partnerships NHS Foundation Trust (SWYPFT) adult mental health service, children and young people linked to adults they care for in the service are not easily identifiable. Whilst we could find details of children, the standard of recording was inconsistent with information about children buried in the adult's record. This reduces the visibility of children and may impact on the ability of staff to 'think family' and consider the needs and safeguarding risks to children as a consequence of the adult's condition. (**Recommendation 2.1**)
- 1.23 Information sharing from adult mental health to universal children services such as health visiting and school nursing is not robust. Managers expect adult mental health staff to routinely liaise with health visitors when they are caring for adults who live with children under five. However, frontline staff did not demonstrate their awareness and compliance with this and furthermore, there is a gap in the sharing of information with school nurses for children aged over five years old. Weak information sharing practice is a frequent finding in serious case reviews. (**Recommendation 2.2**)
- 1.24 In the adult substance misuse service children linked to service users were identifiable in the adult record. In addition, the provision of a dedicated family co-ordinator is helping to support frontline practitioners and advise on the 'think family' model. This practice approach increases the visibility of children and supports practitioners to be aware of the risks around the hidden child.
- 1.25 We saw innovative practice from a joint initiative between the maternity and adult substance misuse service that provides effective ante and post-natal support to women with substance misuse difficulties. The provision of the positive recovery and midwife support (PRAMS) group encourages positive parenting and helps to maintain the engagement of a vulnerable cohort of women with health services. This contributes to improved outcomes for women and the unborn helping to secure the best start.
- 1.26 The ED at Calderdale Hospital has made some improvements to cater for the needs of children and young people; the paediatric waiting room is brightly decorated and contains toys and equipment suitable for younger children. However, the layout of the paediatric waiting room does not facilitate an environment where children can be observed and monitored by staff due to restricted views. This may prevent staff from swiftly identifying signs that indicate a child's health is deteriorating and also restricts the opportunity to observe the nature of interactions between children and the adults accompanying them. (**Recommendation 1.21**)

- 1.27 Young people aged 16 and 17 years that are being treated in the ED do not benefit from an approach that is sensitive to their developmental needs and vulnerabilities as they are considered as an adult. Furthermore, there is no distinction between adult and child records hence there is an over-reliance on individual practitioner professional curiosity to identify and record child safeguarding concerns. Whilst the provision of a paediatric liaison nurse is a positive safety net that provides an additional strand of clinical oversight for all under 18s attending the department this should not preclude the effective safeguarding practice of frontline staff. We saw case evidence that ED staff missed the opportunity to intervene for a 16 year old that attended the department a number of times with minor injuries. Whilst this was followed up by the paediatric liaison nurse the responsiveness of ED staff to intervene early was weak and delayed access for the young person to further support. (**Recommendation 1.22, 1.23**)
- 1.28 The existing arrangements in the ED to support practitioners to identify hidden harm to children are not robust. Practitioners caring for adults in the ED are not routinely enquiring or recording the details of children that they have responsibility for or have contact with. This is of particular concern for those adults that present with concerning behaviours that could impact on their child caring capacity; for example substance misuse, mental illness or following an alleged assault. Further, frequent attendance is not sufficiently explored; each is considered in isolation which limits the ongoing analysis of risk. This prevents the early identification of hidden harm or additional needs to children as a consequence of the adult's condition or behaviour and does not safeguard children effectively. (**Recommendation 1.2**)
- 1.29 Cases examined in the ED identified that the details of adults accompanying children or their next of kin are not routinely recorded by practitioners. Furthermore, in the absence of a dedicated field in ED records in which to complete this, practitioners are not prompted to record this important information. This limits the exploration of who is responsible for children in the department; the appropriateness of the adult and child relationship and whether the adult has parental responsibility to consent to the child receiving treatment. (**Recommendation 1.3**)

2. Children in need

- 2.1 Effective arrangements are in place in maternity services to support vulnerable women experiencing mental ill health, substance misuse issues or domestic violence. Specialist midwives ensure that women are well supported throughout their episode of care and help to safeguard the unborn. Specialist midwives hold small caseloads so that they are available to provide additional specialist support and expertise to community midwives hence broadening their reach to pregnant women. The named midwife screens all ED attendances related to the assault of expectant women. This helps to identify and respond to women and the unborn in need of further support or protection.
- 2.2 There is no commissioned multi-disciplinary perinatal mental health service in Calderdale. Pregnant women have access to an adult mental health practitioner which helps to facilitate some joint working between maternity and adult mental health. This is underpinned by a perinatal mental health pathway but its impact is limited and this arrangement is not NICE compliant. We saw a case example of a pregnant woman that, despite the persistent efforts made by the specialist midwife, failed to secure the timely involvement of the mental health team. This leaves women with emerging mental ill health in the care of midwives rather than that of mental health professionals which is not appropriate. (**Recommendation 4.3**)
- 2.3 Expectant and new parents with known substance misuse issues are fully supported by safe and efficient services working in a cohesive manner. This includes the joint provision of antenatal clinics and the PRaMS group. This helps parents to have good access to midwifery, substance misuse and the specialist health visitor services which can improve engagement with health services in this sometimes hard to reach population. This partnership approach actively supports women to mitigate the effect of their substance misuse on their unborn child and facilitates the new-born to receive specialist care if indicated.
- 2.4 There is a specialist health visitor that supports families linked to the multi-agency pregnancy liaison and assessment group (MAPLAG). This health visitor works either directly with mothers who have problems with substance misuse or will act in an advisory capacity to other health visitors who may have a more established relationship with the family. This ensures continuity for parents that may otherwise be hard to reach. Other parents are supported by the universal and targeted health visiting service.

- 2.5 There is good information sharing arrangements from the health staff in the police station MAST that supplies notifications of domestic abuse incidents to health visitors. This helps to alert health visitors of additional risks to children that can then be followed up and appropriate support given to the child and family. This information is uploaded in both the adult and child's record which ensures the record is complete and informative but the quality of scanned police notifications was difficult to read. However, following developments in the MAST we could see the safeguarding advisor inputting information directly into electronic health records that was clear and legible and then tasked to health practitioners.
- 2.6 There is a robust handover of vulnerable cases from health visiting to school nursing. This ensures information is exchanged on important safeguarding issues so that children and young people are well supported and kept safe at this transition point. In one case example the health visitor had flagged a child to the school nurse as child in need (CiN) but when reviewing their caseload two months after the handover the school nurse recognised there had been no CiN meetings since taking over. The school nurse raised this with the social worker who agreed it had been an oversight and immediately called a CiN meeting. The ongoing review of caseloads by school nurses helps to identify drift in cases and can ensure that children continue to receive the multi-agency support they need.
- 2.7 Practitioners in the child and adolescent mental health service (CAMHS) demonstrate a good focus on the needs of children for whom they care. Health records indicated that practitioners understood and articulated risks to children clearly so each successive reader, such as a new case holder, can fully understand the needs of a young person or the features of their life that gives rise to concern. Care plans were evident in records that were clear with underpinning rationale for actions taken by practitioners in their care of the child. This aids the review and evaluation of actions facilitating a child centred responsive service.
- 2.8 Young people in mental health crisis in Calderdale are seen quickly, either the same day by the crisis team or by a practitioner who has access to a CAMHS consultant psychiatrist outside the hours of 9am to 5pm. This ensures that children and young people receive timely support to assess their needs and intervene to prevent their condition from escalating.
- 2.9 Children and young people can experience delays of up to seven months waiting for treatment from CAMHS. This is not sufficiently responsive and the absence of any ongoing oversight being maintained by CAMHS staff creates the risk of the child or young person's needs escalating whilst waiting for treatment. Whilst the service acknowledges that it has work to do to continue to bring its waiting times down there was no evidence of how they intended to address this. (**Recommendation 2.4**)

- 2.10 The CASH team are well sighted on children at risk of child sexual exploitation (CSE) in Calderdale identified on the matrix and have developed good arrangements to increase the visibility in the service. The CSE matrix is sent securely each week to an identified staff member in CASH; this contains the names of those identified in the CSE hub as at risk or victims of CSE. This information is used to flag the child's existing CASH case record to help identify children and young people known to be at risk should they return to the service. For children and young people not previously known to the CASH service, a record is created with an alert so that staff will be immediately aware that the young person is known to be at risk of CSE should they attend. This proactive good practice will help to safeguard vulnerable children and young people and support information sharing with other professionals. CASH staff do not routinely attend the CSE hub meeting but reported that they prioritise this if they have a case to discuss.
- 2.11 Children and young people admitted to the paediatric ward as part of the deliberate self-harm pathway can be cared for in a safe environment with the provision of a discrete single room. The room contains a number of safety features without being overtly secure and can be used for short periods by young people awaiting CAMHS assessment due to their harming behaviours. These children and young people are cared for by staff trained to meet their needs. However, stays can be longer when a young person is waiting for a specialist tier four in-patient bed as there is no provision in the locality so children have to be transferred out of area. Whilst it is vital for such children and young people to receive the specialist care they require moving them out of area can isolate them from their family and friends, potentially slowing recovery and prolonging their in-patient stay.
(Recommendation 4.4)
- 2.12 We saw evidence that adult mental health services share crisis and contingency plans with maternity services to aid the early identification of deteriorating mental health in women during the perinatal period. This helps midwives to be alert to the changing mental wellbeing of women they care for. However, managers were not able to provide assurance that crisis and contingency plans were routinely shared with health visitors. This prevents health visitors from having information to aid the early identification of deteriorating mental health in adults caring for young children and restricts the opportunity for effective joined up working that pro-actively safeguards children. **(Recommendation 2.3)**

A woman was referred by the GP twice to the adult mental health team. The first referral contained insufficient detail about children in the household with no consideration given to any safeguarding risks. The GP focussed on the adult expressing concern for their self-neglect. This was a missed opportunity to identify potential safeguarding risks to the children.

A further referral was made by the GP eight days later that included a little more detail about the children and informed adult mental health that children's social care were involved.

The adult mental health worker liaised with children's social care and established that the case had been de-escalated with support from a family support worker who had not been able to effectively engage with the adult.

A joint home visit was undertaken which revealed very poor, unhygienic home conditions with some concerns for the care the children were receiving from their parent.

The adult mental health worker appropriately discussed the safeguarding issues concerning the children with the trust safeguarding advisor.

The worker demonstrated good information sharing by liaising with the schools that the children attended and the family support worker. However, when sharing information the mental health practitioner did not consider sharing this with the school nurse. The importance of information sharing is a common theme identified in serious case reviews.

The case will be escalated through children's social care via the next multi-agency early intervention hub with the safeguarding nurse continuing to maintain oversight of the case.

The GP did not consider the impact of the adult's mental health on their capacity to care and safeguard their children. (**Recommendation 3.1**)

3. Child protection

- 3.1 The partner agencies of Calderdale Safeguarding Children's Board offer support to vulnerable pregnant women through the Multi-Agency Pregnancy Liaison and Assessment Group (MAPLAG). This provides vulnerable pregnant women with access to early support leading to improved outcomes for the woman, the unborn and newborn and was developed following learning from serious case reviews. It is an effective forum for joint working helping to maintain links between maternity and children's social care. The partnership between adult substance misuse and maternity is further strengthened and well developed as part of MAPLAG. The positive benefits of this forum have seen it expand to include women with high risk mental health difficulties, victims of domestic abuse; children looked after and care leavers as part of a pilot. The benefits of timely access to early help are well documented which helps to secure the best start for the unborn and newborn babies in Calderdale. Furthermore maternity services are closely linked to the CSE hub via MAPLAG and therefore should a young person known to be at risk of CSE present at a booking clinic this would be flagged. This helps alert midwives of their vulnerability and lead to the offer of enhanced support to benefit the young person and the unborn.
- 3.2 Midwives are fully engaged in child protection processes with attendance at initial child protection conferences and core groups evident in records. This is important as midwives can contribute their knowledge and expertise to the multi-agency decision making process that will safeguard the unborn and newborn. However, we could not review the quality of any child protection reports written by midwives or plans as these documents were located in the written record not the electronic record. This approach to record keeping is fragmented and hinders access to a complete record that fully reflects escalating or de-escalating concerns and informs ongoing care. Whilst we are aware that the Athena electronic record is being developed the existing arrangement is not robust. (**Recommendation 1.1**)
- 3.3 The named midwife does not have complete oversight of referrals made to children's social care by maternity staff. This is because maternity staff do not consistently follow procedures to copy referrals to the named midwife. As a consequence we were only able to review one referral to the MAST and this was of poor quality, lacked analysis and risks were not clearly recorded. In the absence of any ongoing audit process that monitors the quality of completed referrals we could not be assured that risks were articulated effectively by midwives to secure the desired response from children's social care at times of professional concern for the unborn or new-born. (**Recommendation 1.5**)

- 3.4 The existing pre-birth assessment arrangements are not consistently contributing to the timely completion of multi-agency plans. Cases reviewed of expectant mothers due to deliver imminently were still awaiting a multi-agency plan. We heard that in the absence of an agreed pre-birth plan there is an expectation that maternity services will “hold” babies on the ward whilst plans are agreed. The delayed discharge of well mothers and babies as a consequence of delayed pre-birth planning is unacceptable practice that should be avoided. (**Recommendation 1.7**)

Case examples

One expectant mother was 36 weeks pregnant and staff reported it was unlikely that the baby would remain in her care, whilst another expectant mother was due to deliver her baby in three days. Neither had multi-agency safeguarding birth plans in their records that would support midwives in their protection of the unborn or newborn should the woman attend in labour.

Staff report they can usually resolve issues on an interpersonal level without the need for escalation. However, this approach is not effectively challenging these arrangements to facilitate the timely completion of safeguarding birth plans and avoid the delayed discharge of well mothers and babies.

- 3.5 The school nursing service is effective in their contribution to child protection proceedings. We saw case examples of good quality reports submitted for child protection case conferences and their commitment to attend child protection meetings where they have a defined role. For those children and young people subject to an initial child protection case conference, school nurses undertake a health assessment as part of their universal partnership plus work which helps to identify any unmet health needs. The outcome helps to determine whether there is a requirement for continued school nurse input. This helps to ensure that the most appropriate health professional involved with the child continues to be engaged in multi-agency child protection proceedings.
- 3.6 The school nursing service are fully sighted on the risks to young people discussed at the CSE hub and routinely complete a health needs assessment on all young people on the CSE matrix. This ensures their health needs are identified and met. The school nursing service has access to the West Yorkshire CSE risk assessment tool however this has not been used in practice. School nurses are not routinely assessing for risks of CSE in children and young people they have contact with that are not on the CSE matrix. (**Recommendation 6.1**) These concerns have been brought to the attention of the public health within Calderdale Metropolitan Borough Council as the commissioner of this service.

- 3.7 In CAMHS, there is a strong safeguarding culture with practitioners that are committed to protecting children and young people and are alert to risks. Practitioners attend core group meetings where their work is relevant to the child protection plan which ensures the young person's mental health is considered as part of the multi-agency proceedings. Whilst practitioners attend child protection case conferences they provide their updates verbally rather than routinely using the format of a written report. This prevents access to a written account of the professional's analysis of risks and protective factors for the child at that time that is visible in the child's record. The absence of child protection reports from case records prevents practitioners from looking back and reflecting on ongoing progress or historic child protection work that could go on to inform future assessments and care planning. (**Recommendation 2.11**)

A young person receiving care from the CAMHS was continuing to have repeated episodes of self-harm.

The practitioner was alert to the possibility of emotional abuse within the young person's family.

Despite some aggressive and obstructive behaviour by family members and attempts by them to prevent effective engagement with the young person, the practitioner had been able to identify some parenting and environmental factors that indicated significant emotional abuse.

This triggered the CAMHS worker to take appropriate action to help safeguard the young person. The case was referred to children's social care and accepted as a child protection enquiry.

The practitioner demonstrated professional persistence and determination that considered the young person's home life through their own eyes.

- 3.8 The CASH service do not consider risks of female genital mutilation (FGM) in under 18s that access their service. Staff in the service reported that Calderdale did not have a high prevalence of FGM in its population. In the absence of a universally vigilant approach to FGM there is a risk that the CASH service may miss the opportunity to detect and safeguard not only the individuals using their service but also others in the family. (**Recommendation 1.4**) *These concerns have been brought to the attention of the public health within Calderdale Metropolitan Borough Council as the commissioner of this service*

- 3.9 The CASH service complete risk assessments for under 18s that access their service which includes some indicators of CSE. However, case examples identified that the under 18s risk assessment was not consistently completed by practitioners. This is a missed opportunity to aid the early identification of safeguarding risks and provide protection to children and young people. **(Recommendation 1.4)** *These concerns have been brought to the attention of the public health within Calderdale Metropolitan Borough Council as the commissioner of this service.*
- 3.10 The CASH service do not have strong arrangements that support staff to follow up children and young people who miss or fail to attend a pre-arranged appointment. Whilst managers expect these children to be followed up, staff described variable approaches in the undertaking and achievement of this. As a consequence we could not be assured that the service were striving to sufficiently engage under 18s that do not attend appointments with their service to ensure their needs were being met. **(Recommendation 7.1)**
- 3.11 Under 18 year olds that have been the victim of sexual abuse benefit from access to a recently commissioned forensic medical service that covers West Yorkshire. The contract was awarded to ensure that children and young people are cared for and examined by competent and forensically trained staff. The provider's service model indicates their intention to be engaged in strategy discussions prior to children accessing the sexual assault referral centre (SARC). The involvement of the SARC service in strategy discussions will enable greater multi-agency decision making and help to prevent children from having to repeat the history of their abuse.
- 3.12 Adult mental health staff are reported to attend child protection case conferences when it is appropriate to do so. However, we could not review the quality and impact of this work as these children could not be identified by managers. Adult mental health practitioners are not consistently recording escalating or de-escalating concerns regarding child safeguarding in the appropriate fields of the adult's record. This reduces the profile of children and young people rendering pertinent safeguarding information invisible to practitioners using the record and potentially limiting a 'think family' approach. **(Recommendation 2.6)**

- 3.13 The standard of child safeguarding practice in the adult substance misuse service was variable. Staff demonstrated their effectiveness in referring children appropriately to the MAST when they have safeguarding concerns. Additionally, practitioners attend child protection case conferences with case load holding staff providing written reports. Participation in this supports good multi-agency decision making about the impact of the adult's substance misuse on their ability to care and safeguard the child. However, records were often descriptive rather than analytical and risks were not always clearly evidenced. For example practitioners failed to demonstrate their analysis of the impact of the adult's behaviour on the child. Whilst cases seen demonstrated that staff implemented appropriate actions such as sharing information, the underpinning rationale to aid their decision making was absent. Recording analytically aids decision making and underpins actions practitioners take to help safeguard children and young people. (**Recommendation 8.2**)
- 3.14 GP attendance at child protection case conferences and meetings is not universally undertaken. GPs often report in and share information into such meetings by way of completing a single point of access template. However, one GP told us they prioritise attendance at initial child protection case conferences, professionals, and core group meetings if they had specific and significant concerns to share about a young person. GPs often hold rich information about children, young people and their carers being the holder of the full record and the provider of primary care services. Hence GP engagement in child protection processes is vital. In other areas we have seen technology such as tele-conferencing used to help achieve this.

In adult substance misuse we saw a case that indicated the presenting behaviour of two very young children had been correctly identified by the practitioner as potential signs of abuse.

The physical presentation of the children and the risks derived from the parent's erratic behaviour had been properly articulated to identify risks and protective factors had also been recorded.

The safeguarding practice in this case was effective in identifying risk of harm to both children resulting in a timely referral to children's social care that has led to an ongoing child protection enquiry.

- 3.15 The named GP has been effective in sharing good practice with GPs to support them to consider and assess for CSE. The named GP has produced a colour coded CSE screening tool for use by GPs based on work undertaken with Northamptonshire Safeguarding Children's Board. This aide memoire is quick and easy to use; helps to highlight risks associated with CSE and can assist GPs in decision making. The screening sheet also includes contact details for referral of concerns to MAST and prompts the GP to complete the risk assessment tool as part of the process. However, the impact of this is yet to be measured.

- 3.16 There are good links between the ED at Calderdale Hospital and children's social care that supports the exchange of information about vulnerable children. This ensures that ED staff are well placed to be alert to those children attending the department that are the subject of child protection plans. The Emergency Department Information System (EDIS) record keeping system has a flagging facility that identifies children known to be the subject of child protection plans. This indicates to clinicians the presence of additional vulnerability that should go on to inform their assessment and examination of the child. The details of the child's attendance is notified to Calderdale children's social care through the paediatric liaison nurse so that the ED attendance can feature in future child protection plans or core group work.
- 3.17 The standard of risk assessment for older children and young people attending the ED is insufficient and does not include the assessment of risks for CSE. As a consequence staff may miss the opportunity to initiate early help or child protection proceedings for those at risk of harm. A case sampled of a 15 year old who attended with urinary symptoms revealed the practitioners focus was not holistic with no exploration made of their sexual health or any other vulnerability. This demonstrated a lack of professional curiosity with the practitioner failing to consider and exclude the presence of any other risks for this young person indicating ineffective child safeguarding practice. (**Recommendation 1.4**)

4. Looked after children

- 4.1 Children that enter care in Calderdale benefit from having their initial health assessment undertaken by the designated doctor for children looked-after. This ensures that children's physical health and wellbeing needs at this key stage are assessed by an appropriately qualified and experienced medical professional. The designated doctor for children looked-after demonstrated a public health focus in her contacts with children looked-after. This involved engaging in health promotion activities such as discussions on sexual health and smoking cessation. These discussions maximise the opportunity to make every contact count which can contribute to improving and sustaining good health outcomes.
- 4.2 Arrangements for the completion of review health assessments (RHA) by a range of health professionals are well defined. Children looked-after aged under-five are reviewed by health visitors, whilst school nurses undertake those for school aged children in education. The children looked-after named nurse completes the assessments for young people who are aged 16-18 years or for those not in education or training. Children looked-after placed out and in area continue to have their health needs reviewed as part of a reciprocal arrangement. However, a significant number of children looked-after are not benefitting from having their health needs reviewed within statutory timescales. Performance monitoring data indicates that whilst 97% of 313 RHA were completed in the 2015-16 only 78% were completed within statutory timeframes. This is poorer performance than in 2013-14 when 86% were completed in timescales. There is a risk that children looked-after experiencing delays in having their RHA may have continuing or unmet health needs that are not being addressed. This may delay the achievement of improved health outcomes for children looked-after. **(Recommendation 1.8)** *These concerns have been brought to the attention of the Public Health within Calderdale Metropolitan Borough Council as the commissioner for health visiting and school nursing services.*
- 4.3 The electronic records of children looked-after do not include Part A of the health assessment form; therefore, important information such as legal status, length of time in care, consent, parental responsibility, birth family and carer details is absent from the record. This renders the health assessment incomplete. Calderdale & Huddersfield Foundation Trust (CHFT) is reported to have concerns about information sharing and holding third party information in another person's record. The children looked after team have access to this information from the local authority system. However, health visitors and school nurses who complete RHAs do not have access to this to help inform their assessments. **(Recommendation 1.9)**

- 4.4 On the whole we saw that completed health assessments were child centred in their approach giving a sense of the uniqueness of the individual. Where this was strong we could see health professionals' observations documented and the child's wishes and feelings quoted, allowing the voice of the child to be heard through the assessment process. These assessments demonstrated that children looked-after are engaged well by staff enabling stronger co-production; however, we would like to see more widespread use of this approach to reach all children looked-after by Calderdale health services.
- 4.5 Where appropriate children looked-after are offered a choice of location by school nurses and the named nurse for their RHA. This helps to promote engagement with health services and means that young people are seen in a location where they are comfortable.
- 4.6 The children looked-after team have developed quality assurance arrangements to improve the standard of health assessments undertaken in Calderdale. On the whole case evidence demonstrated that health plans in both initial and review health assessments were SMART but we saw a disconnect in actions and dynamic follow up was not always evident. In one case the practitioner appropriately identified symptoms of a health need in the health assessment but the ongoing management of this and rationale for not including this in the health action plan was absent. Hence, this may not be the subject of any further ongoing review by health staff involved in their care. In another case, updates recorded on the child's electronic record about the progress of a health issue did not go on to inform the most recent RHA so this matter appeared unresolved. The principles of good assessment and care planning is that it should be part of a dynamic and continuous cycle that builds on information already known from health professionals, parents, carers and the child. (**Recommendation 1.10**) *These concerns have been brought to the attention of the Public Health within Calderdale Metropolitan Borough Council as the commissioner of health visiting and school nursing services.*
- 4.7 The arrangements for the exchange of health information held by GPs to inform the completion of children looked-after health assessments is not always effective. The record sharing agreements in GP practices that use SystemOne are not facilitating consistent access to the health records of children that could inform initial and review health assessments. As a consequence, health visitors and school nurses do not have access to pertinent health information about children looked-after that may benefit from a health action in the health assessment. Furthermore, GPs are not routinely invited to contribute to the children looked-after review health assessments. (**Recommendation 1.15, 3.2**)

- 4.8 The children looked-after team endeavour to maintain a good oversight of those children looked-after in and out of area. They have developed a database known as a health needs analysis document that enables quick reference to cohorts of looked-after children to include unaccompanied asylum seeking children (UASC) and initial health assessments. However, its effectiveness is limited as some records were not up to date, and we also saw inaccuracies indicating arrangements to ensure this is updated are not strong.
- 4.9 Care leavers in Calderdale are not benefitting from the provision of health passports as they prepare to transition into adult services. The provider is commissioned to undertake this important work but this is not being achieved by the existing workforce due to resources and other competing priorities. This is a significant gap that must be addressed to ensure children and young people have the health information they need to support them in later years. (**Recommendation 1.12**)
- 4.10 Children looked-after are not able to track their own emotional journey and mental health through the use of strength and difficulty questionnaires (SDQs) in their health assessments. SDQs are not routinely used or shared with health staff to inform either the review health assessments or those initial health assessments where complex mental health needs have been identified. The use of SDQs as part of health assessments can help to identify emerging mental health problems that if identified would help to secure early help and support that would contribute to improving their health outcomes. (**Recommendation 1.11**)
- 4.11 Information sharing arrangements from CAMHS and CTS to the children's looked-after team are not robust. In the absence of any routine liaison the children looked-after team are not well informed about the outcome of interventions offered by CAMHS and CTS to improve the emotional and mental health of children looked-after. This restricts the opportunity to evaluate the impact of this work in particular when the health needs of children looked-after are being reviewed that could then inform and update the assessment. Improving communication between these services would reduce the risk of silo working and promote a joined up approach to improving the outcomes of children looked-after.
- 4.12 The flagging of children looked-after in the ED on the EDIS record system ensures that the looked after children's health team are informed when they attend the department. Staff are expected to take into account the flagged status when examining the child and for every stage of the child's journey through the department. This approach to information sharing is effective and enables the looked after children's health team can take account of the child's attendances at ED when reviewing their health plans.

An adolescent unaccompanied asylum seeker (UASC) was placed in Calderdale as part of a dispersal programme. The young person was self-reporting nightmares with graphic descriptions of being scared and being locked in a dark cupboard. The practitioner recorded this information in the health assessment.

However, this did not trigger the inclusion of any follow up, advice or referral to CAMHS or other services in the health action plan.

It is not clear why an action was not identified against the concerning experiences the young person was describing.

The health assessment document did not demonstrate the practitioner's rationale for failing to identify a health action against this disclosure.

There is a risk that this young person may continue to have unmet health needs.

The case sampled demonstrated that the voice of the child did not inform the health action plan. Additionally, it illustrates the need for health professionals undertaking health assessments of unaccompanied asylum seeking children to receive specialist training in order to be attuned to the potential impact of the experiences of this cohort and how these can impact on the young person's health and wellbeing.

Management

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

5.1 Leadership and management

- 5.1.1 The local area was made the subject of an improvement notice under the Secretary of State following the SLAC joint inspection (2010) and subsequent inspections by the Ofsted. The CCG report that good progress has been made across the partnership but the Minister will continue to maintain an oversight of performance against the improvement plan until September 2016. The CCG and partners continue to contribute to the improvement board.
- 5.1.2 The CCG and associated health providers are fully engaged with the LSCB in sub-groups and operational groups. The LSCB monitors the performance of Calderdale's partnership towards early help, child protection, children looked-after and adoption and leadership and governance arrangements. The CSCB performance indicator report scrutinises the safeguarding performance of the partnership which facilitates challenge and improvement. The report for quarter three (2016) demonstrates health are working to deliver on the key areas relevant to their agency. We saw evidence of appropriate challenge made by the CCG about the strength and depth of health information recorded in a report about children looked-after in Calderdale. The report did not reflect the performance and contributions made by health services to children looked-after. This level of scrutiny by the CCG increased the visibility and impact of the health service for children looked-after and demonstrates strong leadership to ensure health not only have a voice but are equal partners.
- 5.1.3 There is no distinct reference made to child safeguarding performance by the CCG, CHFT, SWYPFT in their annual reports from 2014-15. However, the CCG have a strong focus on safeguarding children in their quarterly reports that provide strategic and operational updates of progress. CHFT safeguarding committees and quarterly updates are inclusive of child safeguarding. Much of the content does lack impact regarding the outcomes that are identified or relate to children and young people. The quarter two and three reports usefully shared data of the numbers of referrals made and the outcomes of adult safeguarding referrals. However, there is no similar data set relating to the trust's child safeguarding referrals. If an equal approach to reporting for children was applied this would help to inform the organisation of their activity and responsiveness to child safeguarding as it does currently for adults. (**Recommendation 1.18**)

- 5.1.4 The joint strategic needs assessment (JSNA) in Calderdale is a live online site with a section relating to children and young people that was updated in April 2016. The site is structured to cover children with special educational needs and disabilities (SEND), drugs alcohol and tobacco use in children and young people, early years: school readiness, long term conditions in childhood, parent carer's of children with complex needs, sexual health, stillbirths, infant mortality and child deaths. Children and young people have contributed to appropriate areas of the JSNA by completing e-health needs assessments. There is however, no dedicated section relating to children looked-after in the JSNA. Further, data gathered from strength and difficulty questionnaires is not utilised in the JSNA to inform of the emotional and mental health of children looked-after placed in Calderdale.
(Recommendation 5.1)
- 5.1.5 The Calderdale partnership has been involved in five serious case reviews with two yet to be published since 2009; there is also an ongoing domestic homicide review. We have seen the positive impact of the MAPLAG in supporting pregnant women with additional vulnerabilities; its inception stemmed from learning following a serious case review in 2007. The reach of this group is planned to expand to benefit other groups of vulnerable pregnant women which demonstrates the responsiveness of the partnership to securing the best start for children.
- 5.1.6 There is active engagement in facilitating a continued health presence in the multi-agency safeguarding team (MAST) provided by CHFT staff. Health practitioners in the MAST are contributing to multi-agency information sharing and decision making regarding child safeguarding. This approach ensures that the health and wellbeing of children can be considered when referrals are received that may involve or affect children. We could see in children's case records that actions and outcomes are recorded in the SystemOne health record with some good use demonstrated of its safeguarding facilities to highlight in the record that safeguarding information has been added. The effectiveness of this can be hindered by those GPs that have not shared the electronic SystemOne health record or by the use of other record keeping systems. This restricted access prevents the MAST practitioner from viewing important health and social information held in the complete primary care record that, if known, could then go on to better inform multi-agency decision making to ensure children receive the support and protection they require. **(Recommendation 4.1)**
- 5.1.7 The designated nurse has been effective in securing health input to further multi-agency working at the recently developed domestic abuse hub co-located in the MAST at the police station. A business case she presented to the senior management team at the CCG has released funding for a commissioned health presence in the domestic abuse hub that is provided by CHFT staff. This currently consists of one dedicated health practitioner but there are plans to recruit another worker to facilitate a consistent health presence. During our site visit resources were limited with health oversight into the hub being provided by the MAST practitioner as the domestic abuse hub worker was on leave.

- 5.1.8 Currently the police are the only agency that can refer directly into the domestic abuse hub; health practitioners with safeguarding concerns for children due to domestic abuse make referrals to the MAST and can also refer cases to the multi-agency risk assessment conference (MARAC). This has not reportedly affected the impact of this initiative which has reportedly contributed to a more responsive approach for the victim and the alleged perpetrator that will also help to safeguard the children of Calderdale.
- 5.1.9 The CSE hub enables health services to offer proactive practice to help meet the needs of these vulnerable children and young people. The hub facilitates robust information sharing across the health landscape of children that are of concern which helps to ensure that health services are aware of their vulnerabilities and can offer enhanced support if indicated. Whilst the function of the CSE hub is effective and safeguards those known to be at risk the opportunity to identify children earlier are weak as frontline health staff are failing to assess for CSE universally in the children and young people they care for. This lack of professional curiosity is a significant gap in the early identification and initiation of support and protection for those children and young people not known to the CSE hub.
- 5.1.10 The health practitioner in the MAST is reported to have access to administrative support located off site. The practitioner's role entails reviewing the health records for all those in the household or those associated (children and adults) with the address on the referral. This can be a huge task where there are fractured families or multiple occupants in households. On the day of our visit, the health practitioner followed up four referrals. This involved tracing, reviewing and recording in 17 sets of records for all those linked to the referral. It is vital for the practitioner to maintain contemporaneous records but it is not the best use of resources for the practitioner to be undertaking additional administrative tasks such as scanning of documents into electronic health records. Furthermore, for the practitioner this reportedly this means they often exceed their hours in order to complete the work.
- 5.1.11 School nursing teams are not well engaged in the work of the early intervention hubs. As a consequence it is not clear how health information is shared for school aged children to go on and effectively inform multi-agency decisions and actions. The Calderdale continuum of need does see that universal services to include school nursing are a component to the delivery of early help to children and young people. It is not clear how health actions identified at panel meetings for school aged children are reported to the school nursing team to help meet children's needs and inform their ongoing care.

- 5.1.12 Frontline health staff are expected to be informed and aware of child protection protocols but this approach on its own does not give robust assurance that this is embedded in practice. We saw evidence of the CCG intending to disseminate a multi-agency safeguarding protocol on bruising, burns and scalding for non-mobile babies to GP surgeries. This is positive as it helps to ensure GPs can be aware and vigilant to identifying such safeguarding concerns. However, it is not evident how this will be shared with other health services across Calderdale to support practitioners in responding to and safeguarding those at risk of harm. Injuries to non-mobile babies and children have often been identified in serious case reviews and in many areas. (**Recommendation 4.2**)
- 5.1.13 There is evidence of a multi-agency response in Calderdale for female genital mutilation that is seeing the designated nurse working with the LSCB to produce the strategic response. The FGM guidance is clear with useful referral pathways to aid management. However, the enquiry and assessment of FGM in under 18s is not embedded in frontline health services such as the CASH service. As a consequence there is a risk that staff could miss the opportunity to effectively safeguard children and young people. (**Recommendation 1.4**)
- 5.1.14 The CCG have increased resources in the safeguarding team that has seen the recent appointment of a named nurse to work with the designated nurse in implementing the safeguarding agenda. Whilst the post is full time it will be shared with Kirklees CCG; it is positive that the CCG have made this investment that will benefit children and young people of Calderdale.
- 5.1.15 The designated children looked-after nurse is employed by, and placed within, the provider service rather than being aligned within the CCG. It is well documented that the purpose of the role is strategic and should be distinct from the operational delivery of health services to children looked-after. Such an approach can impair the ongoing ability to positively influence commissioning for effective services for children looked-after. As a consequence there is a missed opportunity to develop health services further for children looked-after. There appears to be an under-utilisation of the expertise and strategic knowledge that is brought by a designated team, therefore their ability to drive improvement for this vulnerable population is limited as demonstrated in the continued poor offer to care leavers in the provision of health passports. (**Recommendation 1.17**)
- 5.1.16 Existing resources in the children looked-after team are preventing the delivery of the full service specification. The looked-after children annual report (2014-15) indicates that the provider trust is aware of this and that it remains an ongoing unresolved issue. It is vital that commissioners and providers work to resolve this matter to ensure children looked-after have access to effective health services. (**Recommendation 1.19**)

- 5.1.17 The timely achievement of some RHAs was reported to have been hindered by an IT failure that prevented the allocation of this work to school nurses. As a consequence this delayed the opportunity to review children's health and identify early any other health needs that require actions and additional support to improve outcomes. (**Recommendation 1.25**)
- 5.1.18 The children looked-after team have led on a number of areas of innovative practice. The designated children looked-after nurse is engaged not only in the development of local services but is also involved in national work. For example, we learned that the designated nurse, together with a colleague in a nearby area, developed a benchmarking tool to support NHS England in monitoring the application of service commissioning for children looked-after. However, the findings of a recent benchmarking exercise using this tool have yet to be published at the time of our review.
- 5.1.19 The children looked-after service is responsible for the implementation of a flagging process within the trust's emergency department index system (EDIS) to aid the identification of vulnerable children and young people. This involves the placement of an alert on the system, accompanied by a narrative explanation for ED staff. This flagging system extends to children who are looked after by the neighbouring Kirklees local authority as well as children placed in Calderdale from elsewhere. This ensures that all children who present at ED can have their clinical presentation considered in the context of them being looked after and this supports good outcomes.
- 5.1.20 There is effective engagement from the CASH service in Calderdale's approach to supporting those children at risk of CSE identified on the matrix. This response is pro-actively facilitating the opportunity to safeguard these vulnerable children and young people further should they access the CASH service. However, we were less assured that the existing environment and culture provided strong professional challenge to develop and raise the standard of safeguarding practice further. For example; whilst practitioners appropriately focus on contraception and sexual health in their assessments of under 18s safeguarding risk assessments are under-developed and often do not extend beyond Fraser guidelines. (**Recommendation 1.4, 1.5**) *These concerns have been brought to the attention of the public health within Calderdale Metropolitan Borough Council, as the commissioner of this service.*

5.2 Governance

- 5.2.1 The existing governance arrangements on maternity are not ensuring that record keeping systems and performance are effective. We saw variable standards of record keeping that affected the quality and the visibility of information in the record. As a consequence, it was difficult to navigate the Athena record system and see the information that maternity staff had recorded about those in their care. Furthermore it was not always clear that new information was fully informing ongoing service provision and case management. Record keeping and information sharing is further challenged by systems that do not interact. For example; Athena does not link in with Badgernet used on the neonatal unit. Clinicians are required to access information from both systems to inform their care planning. However, we are aware that the electronic record keeping systems are continuing to be developed and staff are being trained in their use. (**Recommendation 1.1, 1.6**)
- 5.2.2 The named midwife is not fully sighted on or informed of cases where there are emerging safeguarding concerns or cases that are not in the threshold of child protection but have other vulnerabilities. As a consequence, these cases are not visible to the named midwife hence she could not oversee the effectiveness of the midwives safeguarding practice. There is a lack of assurance that issues identified by maternity staff have been analysed and actions addressed with appropriate plans in place for mother and unborn. (**Recommendation 1.5**)
- 5.2.3 Health visitors and school nurses have variable access to complete records of children and young people as records are not shared. This means information held on the different units of SystmOne in respect of sibling groups is not readily available to all professionals involved. This prevents the practitioner from having an effective oversight of the family structure and from inputting into individual records should they have a contact to record relevant to a child in the family held on a different unit. As a consequence there is a reliance on practitioners to liaise and share this information verbally to inform ongoing practice. Lack of effective information sharing is a feature of serious case reviews. (**Recommendation 1.26, 6.3**)
- 5.2.4 The use of audit in health visiting and school nursing is helping to provide assurance to managers of the effectiveness of practice. In health visiting management and peer reviews have led to the initiation of developmental work with practitioners to improve practice. In school nursing audit has enabled the development of new ways of working. For example, audit of safeguarding supervision has seen that school nurses are required to discuss children subject to child in need or child protection plans for over a year; this aids the identification of drift that enables escalation to children's social care. These approaches benefit and help to safeguard the children and young people of Calderdale.

- 5.2.5 Safeguarding is embedded into the governance processes of the CAMHS service from board to operational level. This also includes representation on the local safeguarding children board sub-groups. We saw that team managers were involved in a multi-agency emotional health and wellbeing task force whilst another manager was a key partner in the CSE operational sub-group. In this way, young people's mental health remains a feature of multi-agency planning and this is positive.
- 5.2.6 CAMHS and adult mental health practitioners have a fragmented oversight of child safeguarding information as the electronic record keeping system is not enabling them to upload these important documents into health records. This restricts access to a complete electronic record that is inclusive of essential documentation such as strategy meetings, child protection conference minutes, child protection plans and child in need plans. Additional documentation such as emails, copies of referrals into the service or discharge letters are copied and pasted into the log of the child or adult's record. Whilst this ensures the information is located somewhere in the record cases seen demonstrated that information was buried in records making it difficult and time consuming to retrieve. In a busy service, this inhibits practitioners from having an effective oversight of risks and vulnerabilities of children and young people with whom they are working. **(Recommendation 2.5)**
- 5.2.7 The standard of record keeping in cases seen in CASH was inconsistent. Of particular concern was in seven cases where the quality of the under 18's risk assessment was poor. We found that risk assessments had not consistently been reviewed when young people re-attended, were incomplete, did not trigger further enquiry by the practitioner or were illegible. This standard of practice will not robustly safeguard children and young people in Calderdale. **(Recommendation 1.5)** *These concerns have been brought to the attention of the public health within Calderdale Metropolitan Borough Council, as the commissioner of this service.*
- 5.2.8 We could not be assured of the effectiveness of child safeguarding practice provided by the CASH service as managers do not have a strong oversight of the performance of their frontline staff. In the absence of any robust monitoring of safeguarding practice there is a risk that poor practice is not being identified and addressed. A case we reviewed demonstrated that the service did not follow safeguarding procedures for a young person who had attended a number of times claiming their first sexual encounter was when they were under 13. Whilst the practitioner did identify concerns on the risk assessment they were not rigorous in their approach to ensure that this information was shared and robustly acted on to safeguard the young person. Whilst there was no evidence that suggested the young person continued to be at risk we brought this to the attention of the designated nurse. **(Recommendation 1.5)** *These concerns have been brought to the attention of the public health within Calderdale Metropolitan Borough Council, as the commissioner of this service.*

- 5.2.9 Adult mental health managers and the safeguarding team have a strong oversight of children and young people that staff refer to children's social care as these cases are brought to their attention through the completion of an incident referral form completed at the same time as the referral to children's social care. We could see that this is effective in enabling managers and the safeguarding team to monitor the numbers of referrals made by staff, the actions and outcomes for children and young people. This arrangement facilitates professional support and challenge to the practitioner regarding their management of the case that also benefits the child in ensuring they are adequately safeguarded. This approach does help to ensure that these children are visible to managers but its robustness relies on practitioners completing the incident referral form; it is not clear how well embedded this is in frontline practice.
- 5.2.10 In adult mental health, managers expected staff to 'think family' and considered this to be custom and practice within frontline staff. We reviewed cases in which practitioners considered risks to children and young people in the care of adults living with mental health issues and heard about their good practice approaches having been well supported by the safeguarding professionals. However, we could not be assured that this was well embedded as we were unable to review any child protection reports or minutes to assess their quality; and clarify if identified actions for the service were informing client care plans and risk assessments. We could not access this information as managers and the safeguarding team could not identify children linked to adults that were receiving early help or the subject of child safeguarding procedures in Calderdale. This prevents managers from having a strong oversight of the vulnerability in the caseloads of frontline staff. (**Recommendation 2.7, 2.10**)
- 5.2.11 The adult substance misuse service has safeguarding integrated within its key governance processes and is a standing agenda item at each level of its management meetings, from board level to operational management. In addition, safeguarding activity is supported by the appointment of a local lead staff member whose role is to support and guide staff in safeguarding processes and to carry out safeguarding supervision. The provider also holds fortnightly quality assurance panels where 20 cases are selected at random, including safeguarding cases.
- 5.2.12 The SystmOne record used by adult substance misuse is not compatible with the SystmOne records used by GPs. Records for the adult substance misuse service are discretely held providing no facility to interact across health services. For example, GPs cannot view entries made in the patient record by the adult substance misuse service and adult substance misuse practitioners cannot view information placed on the system by GPs. This restricts the opportunity for information sharing to flow with ease across services and inhibits access to a complete record that may contain essential social information and details of children which is vital given the potential for fractured families. Instead, separate requests are made between services for information when this is required.

- 5.2.13 There is further progress to be made in embedding the function of the named GP into primary care practice. Positive progress is underway, with the distribution of briefings sent to practices by the named GP and the offer of safeguarding leads meetings with designated professionals. This platform could provide a good opportunity to engage primary care services further in promoting and ensuring best practice around child safeguarding and children looked-after. We have seen these forums being used to very good effect in other areas where they are well established.
- 5.2.14 Existing governance arrangements and monitoring in the ED have not identified that ED practitioners are not consistently recording the details of adults who accompany children. As a consequence practitioners have not established who the responsible adult is accompanying the child or the appropriateness of this, and who has parental responsibility for issues of consent. (**Recommendation 1.3, 1.5**)
- 5.2.15 LSCB performance data indicates that there are significant gaps around the sharing of data between the ED and Locala school nurses. Locala reported that for quarter three of 2015-16, they received information regarding 10 children and young people attending following deliberate self-harm which they then followed up. However a further 32 cases had not been shared with the school nurse team hence they had not been followed up. As a consequence of weak data sharing arrangements there is a risk that there are children and young people with ongoing health needs that are not benefiting from the support of the school nurse. (**Recommendation 1.16**)
- 5.2.16 CHFT have demonstrated commitment to drive improvement through audit. Staff undertook an audit of the effectiveness and impact of cause for concern forms initiated by the paediatric liaison nurse on the actions taken by health staff. This identified variability in the practice of health visitors from record keeping to delayed actions. Clear learning and actions for staff were recorded. However further testing through audit will demonstrate progress with this.

5.3 Training and supervision

- 5.3.1 Training data supplied by SWYFT and CHFT does not give enough detail about the number of hours practitioners have undertaken for child safeguarding training at level two or three; what training was delivered or the format. Access to more robust data that captures this detail will help providers to evidence staff compliance with training and intercollegiate guidance. As a consequence we could not be assured that frontline staff had received sufficient child safeguarding training commensurate with their role. The provision of a range of child safeguarding training at the appropriate level, delivered in a range of formats, including multi-agency not only helps to maintain expertise in the workforce but supports the application of best child safeguarding practice. (**Recommendation 1.13, 2.8**)
- 5.3.2 We established that midwives in Calderdale have completed the appropriate number of hours of child safeguarding training at the required level; however, they are not benefitting from learning opportunities that are appropriate for their speciality. For example the trust offer a vulnerable women's study day as part of level three training but this is not mandatory for midwives to attend. This is a missed opportunity to ensure midwifery specific training is accessed by all.
- 5.3.3 There are gaps in the child safeguarding training health visitors have received which may impact on their ability to effectively safeguard those in their care from CSE and FGM. It is positive that health visitors have received training for CSE yet; this has not equipped them sufficiently to embed the use of the toolkit in their frontline practice. They have also not received training to help raise their awareness of FGM. This could affect the responsiveness of the service to identify those at risk and as a consequence delay access to protection. Access to training ensures continuous professional development and that child safeguarding practice is underpinned by sound evidence base. (**Recommendation 1.13**) *These concerns have been brought to the attention of the public health within Calderdale Metropolitan Borough Council, as the commissioner of this service.*
- 5.3.4 Newly qualified health visitors working in Calderdale are well supported through a preceptorship period with access to a mentor for additional support that continues beyond the preceptorship period. Embedding a strong preceptorship process in line with institute of health visiting (iHV) demonstrates that the organisation values the process and ensures that newly qualified health visitors have the appropriate skills to equip them for role.

- 5.3.5 CAMHS practitioners receive multi-disciplinary safeguarding training commensurate to their role but individual practitioner uptake of LSCB multi-agency training is limited. Access to multi-agency training provides candidates with opportunities to interact in discussion with other services to understand their role and how the partnership can effectively collaborate to safeguard children. Internally the trust safeguarding team proactively share learning with the workforce to aid practice and provide occasional bespoke events for all staff.
- 5.3.6 Staff awareness of the unique needs of asylum seeking children is limited which could impact on the early identification of any emerging needs and affect the responsiveness of services. This is of particular relevance to staff undertaking children looked-after health assessments to ensure needs identified as asylum seeking children enter care and throughout their care journey. Positively this has been identified by the trust and training is planned for relevant staff in the near future.
- 5.3.7 The children looked-after team ensure that their professional development reflects the roles they perform. For instance, the named nurse received training for CSE to support her role as operational CSE lead for the trust. The team also contribute to the development of other health professionals. The team support the trust's named safeguarding team to deliver safeguarding training at level three of the intercollegiate guidance to trust staff requiring this knowledge. The positive impact of the training they have delivered to health visitors and school nurses was evident in the standard and quality of health assessments they had completed. This helps to ensure that the health needs of children looked-after are understood and effectively managed.
- 5.3.8 We are not assured that frontline CASH staff met fully with intercollegiate requirements for child safeguarding training. As a consequence this may impact on the effectiveness and performance of child safeguarding practice with case evidence demonstrating areas for development with regard to this. We saw a trust flyer that was circulated to staff advertising level two and three child safeguarding training; however, this provision alone is neither sufficient nor compliant with the intercollegiate guidance.
(Recommendation 1.13) These concerns have been brought to the attention of the public health within Calderdale Metropolitan Borough Council, as the commissioner of this service.
- 5.3.9 The adult mental health practitioners are trained to level two for child safeguarding which the trust have acknowledged does not meet intercollegiate guidance requirements. The trust has developed a plan that will see this start to be addressed from May 2016 to ensure compliance. Furthermore, frontline staff in adult mental health have good access to the trust safeguarding team where they can discuss children of concern and receive safeguarding advice. We saw case evidence demonstrating the positive influence of the safeguarding team in supporting the child safeguarding practice of adult mental health staff. *(Recommendation 2.8)*

- 5.3.10 The arrangements for planned external child safeguarding training for adult substance misuse staff give no indication if this meets the required intercollegiate standard. Whilst access to training is vital to aid the ongoing professional development of frontline staff it should also be sufficient to equip them in their practice. Adult workers have an important role in child safeguarding in helping to determine if issues affecting the adult's they support impact on children and young people they have contact with. Staff have received the appropriate level of safeguarding training in early 2015 as the service was undergoing re-commissioning to the current provider
- 5.3.11 As set out in the intercollegiate document registered nurses and medical staff working in the ED are required to be trained to level three for child safeguarding. Whilst all clinical staff in the ED are trained to level two, senior staff (band six nurse and middle grade doctor level and above) are trained to level three through the multi-disciplinary training programme offered by the trust's safeguarding team. Hence, band five nurses and junior doctors have not received level three child safeguarding training. This approach does not comply with intercollegiate guidance.
(Recommendation 1.13)
- 5.3.12 The ED at Calderdale Royal Hospital has two full-time trained sick children's nurses and paediatric nurse consultant as part of the workforce. Whilst this does not provide sufficient paediatric trained coverage for every shift in the ED, trained nursing staff from the paediatric ward is accessible for advice or assistance when necessary. In addition, all band six and seven registered nurses employed in the ED are trained in advanced paediatric life support and this goes some way to mitigate this resource gap.
- 5.3.13 In the MAST health staff access safeguarding supervision monthly. Whilst the staff are not the key record holder for the children and young people this enables them to challenge and reflect on their role in these highly complex cases where they have taken the lead for health in multi-agency decision making at strategy discussions. This also ensures staff are well supported and resilient to aid undertake this essential role.
- 5.3.14 The existing arrangements for safeguarding supervision in midwifery are not well defined or embedded with provision following an as required approach. This informal arrangement inhibits regular analysis of case work and sensitive professional challenge that can increase learning and strengthen competence in safeguarding practice. This gap is acknowledged by the named midwife who intends to increase her oversight and scrutiny of practice and formalise arrangements for safeguarding supervision.
(Recommendation 1.14)

- 5.3.15 There is good trust oversight in place to monitor health visitors safeguarding supervision that has identified a lag in performance with 57 outstanding health visitor cases that required discussion. That aside, the existing safeguarding supervision arrangements provide the health visitor team with group and one to one supervision that we could see well evidenced in children's health records. The one to one approach is focussed on children that are the subject of child protection plans enabling discussion and analysis of the report, minutes and the plan. This ensures there is good oversight of actions and interventions for the health visitor to benefit the child, family and multi-agency working. Health visitors can discuss children with vulnerabilities below level five of the continuum of need this relies on them accessing the safeguarding team as required.
- 5.3.16 In school nursing, band six school nurses have good access to both formal and ad hoc one to one safeguarding supervision. We saw case evidence of supervision notes within the child's records that evidence discussions and actions identified for the school nurse to complete. However, this model could be strengthened to include more random sampling of caseloads to provide a broader supervisory oversight and scrutiny of practice, rather than a reliance on practitioners identifying individual cases for discussion.
- 5.3.17 In the CAMHS staff are well supported with safeguarding supervision delivered through a variety of approaches. This includes quarterly, group safeguarding supervision, facilitated by the trust's safeguarding team which is comprised of the named nurse and a team of safeguarding nurse advisers. Staff identify cases for discussion to learn from, and support each other to benefit their ongoing practice and care of the child. Additionally staff receive dedicated one-to-one supervision sessions where safeguarding is a standing agenda item and particular cases are reviewed to reflect or guide decision making and offer pastoral support. The safeguarding team also provide case specific supervision to practitioners or teams for particularly difficult cases. In our review of case records we saw that supervision was clearly documented in the client's electronic records to evidence discussion and any actions identified for the practitioner to implement.

- 5.3.18 Safeguarding supervision arrangements are not well defined or undertaken formally in the CASH service and as a consequence this is not well embedded in practice. However, managers in the CASH service have good links with the named nurse; accessing support if required to aid case management with this link also facilitating the dissemination of safeguarding updates and information to staff. We were told that where case discussions about clients have taken place during team clinical meetings no record of any actions or outcomes are added to the health record. This conflicts with professional record keeping standards and does not evidence how this discussion has benefitted the future care of the child or young person or the practitioners learning. Serious case reviews commonly cite the value of supervision in developing the expertise of practitioners that can go on and inform their future child safeguarding practice. **(Recommendation 1.14)** *These concerns have been brought to the attention of the Public Health within Calderdale Metropolitan Borough Council as the commissioner of this service.*
- 5.3.19 In adult mental health we were told that safeguarding supervision would form part of clinical supervision or team discussions. The trust expectation is that adult workers should access safeguarding supervision for those families with children subject to child protection plans, CiN or common assessment framework (CAF). However, we were not able to analyse the impact or effectiveness of any cases discussed as managers could not identify who the children were. This prevents the opportunity to maintain any oversight that ensures staff are not only implementing actions identified but that their involvement remains dynamic and child centred. Case records seen indicated that staff make good use of their ad hoc access to the safeguarding team which benefits outcomes for the children discussed. We saw evidence of these discussions recorded in client records with plans and actions that were on the whole SMART. Case notes contained very detailed recording by the safeguarding professionals that provided practitioners with a step by step approach of actions they were required to undertake to safeguard the child or young person. In one case we saw that the safeguarding advisor even completed a child protection risk assessment template that staff had not updated. When accessed by practitioners this level of support triggers a strong response by the safeguarding team but it is not clear if the impact of this episodic approach becomes embedded in frontline practice. **(Recommendation 2.9)**

5.3.20 In the adult substance misuse service practitioners are offered safeguarding supervision during bi-monthly group sessions where staff are invited to bring cases of concern for discussion and review. Furthermore, staff are offered eight to 12 weekly supervision sessions where safeguarding is a standing agenda item. Similarly, cases are discussed, decisions are reviewed and pastoral support is offered at these sessions. However, we could not review the impact of this as safeguarding supervision is not recorded in client records. This not only falls short of professional record keeping standards but prevents access to any actions identified to benefit the child that would go on to inform ongoing care planning. (**Recommendation 8.1**) *These concerns have been brought to the attention of the Public Health within Calderdale Metropolitan Borough Council as the commissioner of this service.*

Recommendations

1. **Calderdale CCG and Calderdale & Huddersfield Foundation Trust should:**
 - 1.1 Ensure that record keeping systems in maternity and neo-natal enable staff to access a complete record and create and view documents such as birth plans, and child protection documents to inform their ongoing contact with those in their care.
 - 1.2 Ensure that adult ED documentation sets out appropriate prompts and trigger questions to support practitioners in the identification and exclusion of hidden harm to children linked to adults that present as a result of risk taking behaviours or mental health issues
 - 1.3 Ensure ED practitioners record in the child's record the name and relationship of the accompanying adult and parental details confirming who has parental responsibility.
 - 1.4 Improve the robustness of risk assessment to identify vulnerability in ED, maternity, health visiting and CASH to inform ongoing care, flag, reflect escalating or de-escalating concerns so that effective action is initiated at the earliest opportunity to safeguard and protect those in their care. This will aid the early identification of safeguarding concerns to include CSE and FGM.
 - 1.5 Improve child safeguarding governance arrangements to ensure effective safeguarding practice is provided by frontline staff across the continuum of need including referrals to children's social care.
 - 1.6 Ensure the standard of record keeping in the maternity service is in line with trust and best professional standards and is subject to effective governance and monitoring arrangements
 - 1.7 Work with partners to develop timely multi-agency plans for expectant women that are visible in records and prevent avoidable hospital stays for well mothers and babies.
 - 1.8 Work with the partnership to improve the timeliness of review health assessments to align with statutory requirements. This will ensure children looked-after have their health needs assessed in a timely manner to support the achievement of improved health outcomes.
 - 1.9 Review and resolve access and visibility of Part A of children looked-after health assessments in children's electronic health records to ensure that the important information contained in this section is available to practitioners to help inform health assessments.

- 1.10 Ensure health action plans for children looked after are reflective of health needs and that actions are monitored effectively to inform future review health assessments and health interventions.
- 1.11 Work with the local authority to improve the sharing of SDQs for children looked-after; to help inform health assessments, aid the child or young person to track their emotional and mental health and enable practitioners to identify emerging health concerns for referral to appropriate services.
- 1.12 Ensure that care leavers receive timely health passports and information to help them prepare for adulthood and are well supported in line with the service specification.
- 1.13 Ensure staff receive child safeguarding and children looked after training commensurate with their roles and this is monitored and compliant with the intercollegiate guidance (2014).
- 1.14 Develop and formalise arrangements to embed safeguarding supervision for frontline practitioners that have contact with the unborn, children, young people and families and ensure that individuals discussed have this recorded clearly in health records to inform ongoing care.
- 1.15 Develop procedures that promote the effective engagement of GPs in health assessments for children looked-after in order that the health assessment is comprehensive.
- 1.16 Ensure data sharing agreements between health providers are robust to facilitate effective and timely information sharing for example between the ED and school nursing. This will facilitate further oversight of the needs of children and young people in the community.
- 1.17 Utilise the expertise of the designated children looked after professionals in commissioning and strategic decisions to develop and improve health services for children looked-after.
- 1.18 Bring performance reporting of child safeguarding practice in line with adult safeguarding reporting in order to ensure effectiveness of child safeguarding practice is highlighted, monitored and improved.
- 1.19 Review the staffing in the children looked-after team to ensure resources are in place to deliver the commissioned service that should be afforded to all children looked-after placed in Calderdale.
- 1.20 Ensure practitioners providing care to those aged under 18 routinely record the name and relationship of adults that accompany them to access health services. This will help practitioners to consider the appropriateness of the adult and child relationship and ensure appropriate consent.

- 1.21 Ensure emergency department facilities provide a clear view and good oversight of children waiting to be seen to ensure effective early identification of children with deteriorating medical conditions and parent-child interactions.
- 1.22 Ensure that practitioners in the ED have access to and use age appropriate paediatric documentation for those aged under 18 attending the department.
- 1.23 Ensure documentation and assessment templates in the ED are robust and support practitioners to undertake effective safeguarding triage and assessment to include routine consideration for previous attendances.
- 1.24 Ensure midwives consistently complete routine enquiries about domestic abuse to women throughout their episode of care and record this to aid ongoing care planning and the identification of safeguarding concerns.
- 1.25 Ensure robust arrangements and IT are established to prevent unnecessary delays in completing review health assessments. This will help to ensure children looked-after have their health needs reviewed within statutory timescales.
- 1.26 Ensure health visitors and school nurse records are linked to enable an effective oversight of linked children and the family to support effective joined up working.

2. Calderdale CCG and South & West Yorkshire Partnerships Foundation Trust should:

- 2.1 Ensure that adult mental health practitioners are supported by systems which enable them to easily identify, place appropriate flags and consistently record all children and young people linked to adult service users, not just those subject to CP or CiN plans.
- 2.2 Ensure there is effective information sharing by adult mental health to notify health visitors and school nurses of the service's involvement with adults where there are potentially vulnerable children
- 2.3 Ensure that adult mental health relapse indicators and crisis plans are routinely shared with other professionals to enable early recognition of, and response to, deteriorating parental mental health thereby safeguarding children and young people effectively.
- 2.4 Improve access to CAMHS and develop arrangements to oversee and offer interim support to those children, young people and families waiting for CAMHS support.

- 2.5 Ensure practitioners have access to complete health records whereby essential information relating to children and safeguarding is secured and easily identifiable by using recognisable naming conventions to help inform their ongoing care and planning.
 - 2.6 Ensure a consistent approach to record keeping that will help practitioners identify children in the family or household of clients of the adult mental health service including information on whether they are subject to CiN or child protection plans, so that their needs and any risks are assessed effectively.
 - 2.7 Ensure that adult mental health managers are aware of the cohort of children and young people within the service's caseload and that operational governance of safeguarding practice is robust to include oversight of those subject to early help, child in need and child protection..
 - 2.8 Ensure staff receive child safeguarding and children looked after training commensurate with their roles and this is monitored and compliant with the intercollegiate guidance.
 - 2.9 Develop and formalise arrangements to embed safeguarding supervision in frontline services that have contact with the unborn, children, young people and families and ensure that individuals discussed have this recorded clearly in health records to inform ongoing care.
 - 2.10 Ensure that a Think Family model of service delivery is clearly demonstrated in adult mental health through care planning, practice and case recording
 - 2.11 Ensure practitioners complete written reports for child safeguarding meetings to underpin their professional view and analysis of risks and protective factors. This will ensure that the record is complete and reflective of the role and professional judgement of the practitioners involved.
- 3. Calderdale CCG and NHS England should:**
- 3.1 Ensure primary care practitioners develop their understanding of think family to embed this in frontline practice.
 - 3.2 Improve GP record sharing arrangements to enable the children looked-after, health visiting and school nursing service to access a complete health record of a child who is looked-after.
- 4. Calderdale CCG, NHS England, South & West Yorkshire Partnerships Foundation Trust, Calderdale & Huddersfield Foundation Trust should:**

- 4.1 Ensure health staff in MAST and Hub teams has access to complete health records to facilitate the review, inputting and sharing of information with relevant health services to alert practitioners to escalating or de-escalating child protection concerns.
 - 4.2 Ensure that developments in safeguarding practice such as the multi-agency bruising, burns and scalding protocol for non-mobile babies are shared with health staff across services and embedded into frontline practice to ensure that practitioners are aware of how to respond effectively.
 - 4.3 Develop an effective multi-disciplinary perinatal mental health pathway that is compliant with NICE guidance and reflects all services that are available to support women with perinatal mental health needs.
 - 4.4 Improve children and young people's access to local tier four mental health beds to reduce the risk of prolonged admissions on the paediatric ward.
- 5. Calderdale CCG should:**
- 5.1 Ensure the JSNA reflects the needs of children looked-after placed in Calderdale to help go on and inform the commissioning of services.
- 6. Locala Community Partnerships should:**
- 6.1 Improve the robustness of universal risk assessment to pro-actively identify or exclude child sexual exploitation and female genital mutilation by utilising tools and guidance to support practice decisions.
 - 6.2 Improve the engagement of the school nursing service at the early intervention hub.
 - 6.3 Ensure health visitors and school nurse records are linked to enable an effective oversight of linked children and the family to support effective joined up working.
- 7. Calderdale and Huddersfield Foundation Trust should:**
- 7.1 Ensure that the CASH service has effective policy and guidance to support the robust follow up of those under 18 year olds who miss appointments at the CASH service.
- 8. Developing Initiatives for Support in the Community:**

- 8.1 Develop and formalise arrangements to embed safeguarding supervision in frontline services that have contact with the unborn, children, young people and families and ensure that individuals discussed have this recorded clearly in health records to inform ongoing care.
- 8.2 Improve child safeguarding governance arrangements to ensure effective safeguarding practice is provided by frontline staff across the continuum of need to ensure record keeping and practice are consistent.

Next steps

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

Please submit your action plan to CQC through childrens-services-inspection@cqc.org.uk. The plan will be considered by the inspection team and progress will be followed up through CQC's regional compliance team.