

Review of health services for Children Looked-after and Safeguarding in Kingston upon Hull

Children Looked-after and Safeguarding The role of health services in Kingston upon Hull

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| NHS England area: | NHS England North Region North Yorkshire and Humber office |
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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 Kingston upon Hull. It focuses on the experiences and outcomes for children within the geographical boundaries of the local authority area and reports on the performance of health providers serving the area including Clinical Commissioning Groups (CCGs) and NHS England Local Area Teams (LATs).

Where the findings relate to children and families in local authority areas other than Kingston upon Hull, 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. It also included some cases where children and families were not referred, but where they were assessed as needing early help that they received from health services. We also sampled a number of other such cases.

Our tracking and sampling also followed the experiences of looked-after children to explore the effectiveness of health services in promoting their well-being. In total, we took into account the experiences of 55 children and young people.

Context of the review

The latest published information from the Child and Mental Health Observatory (ChiMat) (2016 - but reporting data ranges from 2014 to 2016) shows that children and young people under the age of 20 years make up 24% of the population of Kingston upon Hull with 16% of school age children being from a minority ethnic group. Generally, data shows that children in Kingston upon Hull experience economic and health inequalities.

The proportion of children under 16 living in poverty is 31.7%, significantly worse than the regional average of 22.5% and the England average of 39.2%. Family homelessness is also worse at 3.1 per 1,000 as opposed to 0.8 regionally and 1.8 for England. The number of children in care is significantly greater than the regional and England average with 120, as opposed to 64 and 60 per 10,000 respectively.

The infant (aged 0 to 1 year) mortality rate is similar to the regional and England average with 4.1 per 1,000 live births. The child (aged 1 to 17 years) mortality rate is also similar to the region and the rest of England at 11.6 per 100,000.

The ChiMat data shows a generally poorer picture for the general health of children and young people in Kingston upon Hull with most of the attributes measured being worse than the rest of England. A minority of those attributes are similar to or slightly better than the England average. For example, immunisation coverage for all children is similar to or better than the national average with the coverage for children in care being similar to the rest of England.

The rates of hospital admissions for children aged 0 to 14 in the area due to injuries, or for those over 15 years due to substance misuse are worse than the regional and England averages. However, hospital admissions in young people aged up to 19 for asthma, for young people over 15 with injuries, for young people with mental health conditions and for young people over 10 years through self-harm are all similar to the regional and national averages.

The rate of under 18 conceptions and of teenage mothers, however, are among the worst in England. The rate of children with one or more decayed, missing or filled teeth is significantly worse than the region and the rest of England. Obesity in children aged 4 – 5 years and in children aged 10 – 11 years is also significantly worse than the region and England.

The Department for Education (DfE) provide annual statistics derived from outcomes for children continuously looked-after. As at March 2016, Kingston upon Hull had 485 children who had been continuously looked-after for more than 12 months (excluding those children in respite care), 75 of whom were aged five or younger.

The March 2016 DfE data indicates that a smaller proportion of Kingston upon Hull's looked-after children (79.4%) had received an annual health assessment than the average for England (90.0%).

The DfE data also shows that 87% of looked-after children were up-to-date with their immunisations, similar to the England average of 87.2%, whereas only 55.7% of looked after children had received a dental check compared with 84.1% in England as a whole. However, a greater number of looked-after children aged under five had an up-to-date development assessment with 86.7% as opposed to 83.2% for the rest of England.

The commissioning and provision of health care services for children and young people in Kingston upon Hull is as follows. Commissioning and planning of most health services for children are carried out by NHS Hull CCG. Health services for looked-after children are commissioned by the NHS Hull CCG and provided by City Health Care Partnership Community Interest Company (CHCP).

Acute hospital services, including emergency care and maternity, are commissioned by the CCG and provided by Hull and East Yorkshire NHS Trust (HEY).

Community health services for children and families (health visiting and school nursing), are commissioned by the Hull Public Health (Hull City Council) and provided by CHCP.

The child and adolescent mental health services (CAMHS) are commissioned by the CCG and provided by Humber NHS Foundation trust (HFT) as are the mental health services for adults.

Integrated Contraception and Sexual Health (CASH) and Genitourinary Medicine (GUM) services are commissioned jointly by the CCG and Hull Public Health and are provided by CHCP.

Substance misuse services are commissioned by Hull Public Health and are provided by two organisations, 'Lifeline' and Change, Grow, Live' through a partnership arrangement branded as 'ReNew'.

The last published inspection of safeguarding and looked-after children's services for Kingston upon Hull that involved the health services took place in June and July 2011. This was a joint inspection with Ofsted. At that time, the effectiveness of the arrangements for both safeguarding children and looked-after children were judged to be 'adequate'. Recommendations for the providers arising from our recommendations of that review were considered during this review.

Ofsted carried out a single agency inspection of the local authority and the local safeguarding children board in November 2014. . In addition, a pilot integrated inspection of safeguarding involving Ofsted, CQC, Her Majesty's Inspector of Constabulary and Her Majesty's Inspector of Probation took place in November and December 2014. We have taken account of the findings of both of these inspections during this review

All three of the principal providers identified above have been inspected by the CQC through the course of 2016. The findings of those inspections in relation to children and young people have been considered as part of this review.

The report

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

What people told us

We spoke with care leavers. They told us:

“It was pushed upon me to have contraceptive implant and I felt pressurised that it was because I was in care.”

“There are not enough mental health services for children, I was sometimes told that I was not in the right place or it was not the right time to be seen.”

“I wasn't given a choice about my health assessment and felt awkward because it happened in school and I was embarrassed.”

“I wasn't given a health passport when I left care.”

A young person who had just recently become looked after told us;

“The health check was alright. I felt part of it and it wasn't a problem.”

The young person went on to say:

“[My health assessment] arrived in the post. I don't know where it came from but it was OK. It was all fine with no mistakes on it. I'm pretty healthy but if I had any problems I'd know who to ask for advice. I've got a doctor and a dentist as well.”

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 Health services in Kingston upon Hull follow the Hull Safeguarding Children Board's (HSCB) procedures for making referrals for children and young people for additional services according to their level of need. Those levels are described by the HSCB guidance for determining thresholds of need as 'no additional needs', 'additional needs', 'complex needs' and 'risk of significant harm'. Referrals for children with complex needs or who are at risk of significant harm are made to the Access and Assessment Team (AAT) of Hull Children's Social Care using standardised referral documentation. The AAT screen all referrals and may choose to re-direct the referral to early help services.

1.2 All practitioners, including health service staff, can also directly refer children or families with additional needs to one of three, locality based early help hubs or to services that might best meet children's needs. The hubs are based at the children's centres and provide opportunities for direct liaison with other practitioners; for example, with health visitors who carry out child health drop-in clinics at the centres. The arrangement benefits practitioners because it means travelling time between locations is minimised and contact time with families is increased. It also benefits families because it means that a range of help and services is available in one place.

1.3 In the maternity department provided by Hull and East Yorkshire NHS Trust (HEYHT) at Hull Royal Infirmary we noted good liaison with other relevant services and agencies. We found evidence of effective information sharing, and joint work carried out with social workers to ensure that vulnerable women and teenagers are well supported. For example, the pathway for pregnant women who misuse substances describes links with drug and alcohol services and includes a vulnerability assessment and a specialist clinic for women. The service takes a flexible approach to meet those needs and this ensures vulnerable, pregnant women remain engaged. This ultimately secures better outcomes for women and their unborn children.

1.4 The public health community child health services provided by City Health Care Partnership (CHCP) are configured in a way that we have not commonly encountered during these reviews. Children aged from birth to 11 receive care and support from Hull's health visiting service, which enables the public health (school) nurses to focus more on the particular needs of adolescent young people aged between 11 and 19. In both services we saw evidence of a broad offer for families with additional needs and of joint, co-ordinated work with other services.

1.5 Health visitors carry out ante-natal visits from 20 weeks pregnancy, which is earlier than we have seen in many other areas. Records we looked at showed that this provides early opportunities to assess the home and environmental situations of women and their families. Further, the early visit facilitates health visitors' ability to identify additional needs and those families who would benefit from post-natal support, whether through additional resources delivered directly or on a more co-ordinated basis through the children's centres.

1.6 We have seen figures showing a high success rate for timely, mandated health visits carried out under the healthy child programme. This high success rate increases the opportunities for health visitors to identify additional needs. Each child, up to the age of five, whether they have additional needs or not, has a named health visitor and this, too, enables an informed and co-ordinated approach to any changing or evolving needs.

1.7 Opportunities to identify and support families with additional needs continues up to the age of 11 with health visitors carrying out hearing checks, immunisations and the national child measurement programme. As stated above, this is an uncommon approach and uses health visitors to support transition from early years to primary school. Our view is that this enables health visitors to take a longitudinal view of children they may already know and enhances their understanding of a child's needs over time.

1.8 Health visitors in Hull with special interests engage with hard to reach families. For example, a health visitor is supported to engage with traveller families whilst another practitioner works with women and children in Hull's homeless health hostel and women's aid refuge. These roles help to ensure the health needs of potentially vulnerable children are met and any additional needs recognised.

1.9 The same is true for public health nurses who also provide a broad service, either on request, by referral or through the weekly pop-in sessions in the city's secondary schools. Nurses also offer 15 minute appointments to individual young people during their pop-in sessions so that they can be seen at a time that is convenient and that fits in with their school day.

1.10 The public health nurse offer includes support with strategies to reduce harm from drugs, alcohol and tobacco; sexual health advice, screening and contraception; support to children and young people with additional physical, emotional, behavioural and learning difficulties; and immunisations. Nurses have begun to host pop-in sessions at Hull's young people's support service, known as Kenworthy House, for children and young people who might not be comfortable accessing the service at school.

1.11 The focus of the public health nurse service is for older children and young people. This means that practitioners are more attuned to the needs of this particular group and more readily able to identify risks and vulnerabilities and we saw evidence of this in the cases we looked at during the review.

1.12 Children and young people access emergency care in a bright and welcoming, dedicated paediatric emergency department (ED) at the Hull Royal Infirmary that has its own entrance. The area is open and children and their parents can easily be observed. This careful consideration of their pathway in ED means that contact with adult patients is minimised and a child-friendly culture maintained.

1.13 Young people over 16 and up to 18 are given the choice of whether they are seen in the paediatric ED or the adult ED next door and this is good. However, depending upon the time of admission, paediatric paperwork is not always used for older children. This does not support practitioners to ask appropriate questions of young people related to their particular vulnerabilities and this may lead to information being overlooked. [Recommendation 1.1.](#)

1.14 The frequency of children's attendances is identified in the electronic records system in ED but we did not see evidence of repeat attendances being explored in the records we examined. When frequency of attendance and reasons for attendance are not clarified, the history is not seen in context and it is difficult for staff to identify potential areas of concern or need at the earliest opportunity.

1.15 A 'think family' approach was also not evident in records we examined in the paediatric ED. For instance, the name and status of the person accompanying the child to the ED is frequently not recorded or simply described as 'mum' or 'carer'. This, too, indicates practitioners are not primed to fully explore information about a child's situation and could lead to uncertainty about who has accompanied the child and whether, for instance, they can lawfully provide consent. [Recommendation 1.2.](#)

1.16 The HEYHT safeguarding team screens the records of all children and young people who have attended ED and review any adult records where children are identified. This provides a second look to ensure information about children and young people's attendances are notified to other services for any follow up or early help opportunities. For example, any pregnancy related attendances at ED are shared with maternity so that midwives can consider this information as to the way it might affect the woman's plan of care.

1.17 Public health nurses are routinely notified of all children who attend the ED at Hull Royal Infirmary. ED notifications are triaged by the safeguarding team but are of variable quality and so are not always helpful. Where the quality of the notification has resulted from poor photocopying of the document, for example, the notification is returned for clarification. This can result in information not being received in a timely way for the sake of it being accurately transferred. [Recommendation 1.3.](#)

1.18 In the adult ED at Hull Royal Infirmary, important questions about children in the family or whether adult patients have caring responsibilities are not routinely asked even though the prompts to ask these questions exist on the templates. There is no evidence to suggest that thinking about families is embedded in practice and so risks to children or recognition of the need for early help and support may be missed. [Recommendation 1.4.](#)

1.19 Children and young people with emotional and mental health needs can access the CAMHS provided by Humber NHS Foundation trusts (HFT) through the 'Contact Point' single point of access where a safeguarding assessment is undertaken in every instance. This enables safeguarding risks to be looked at straightaway and feature in early decision making about a young person's pathway.

1.20 Although CAMHS practitioners do not act as lead professionals in early help processes, they participate in team around the family (TAF) meetings where these have been set up to provide early intervention and support to young people and their families. This ensures that young people's emotional health and wellbeing are considered in achieving good outcomes.

1.21 Currently the Kingston upon Hull early help action meetings (EHAM) process works well to identify and coordinate services for children who would benefit from early help and health providers are actively involved in this. We are also encouraged by the development of the new front door approach that is soon to be implemented across Hull that develops the current arrangements further. This will enable all referrals of young people who require additional services to be considered by a multi-agency team who will direct the most appropriate service for the most appropriate level of intervention.

1.22 We have seen specifications that show that health practitioners will play an active role in this Early Help and Safeguarding Hub (EHASH) and will contribute with information sharing and decision making at the point of referral. The new process, which arises out of an Ofsted inspection recommendation from 2014, will follow a multi-agency safeguarding hub (MASH) model that is effective in other areas and will improve the current arrangements.

1.23 The 'think family' model is not embedded in practice in adult mental health services. Records do not readily show that there are children in the household or if the adult has caring responsibilities for children. Children also do not feature as part of a client's intervention. For example, the triage and referral form used by the rapid response and community mental health teams (CMHT) asks for details of dependents and whether or not they are living in the same household as the adult client. This form has just been redesigned and the new, leaner version has these questions removed. We would suggest the old form ought to be reinstated. A vital part of 'think family' practices are the steps taken by children's, young people's and adults' services to identify child and wider family needs which extend beyond the individual they are supporting. Ensuring that such a 'think family' approach is adopted early can help avoid problems escalating to a more acute level and reduce the number of families and individuals who need intensive support in the future. The progress made by the provider in assessing the impact to children and young people of clients was seen as a strength in the previous Safeguarding and Looked After Children review of 2011 and so the current practice is a disappointing reversion.

[Recommendation 2.1.](#)

1.24 In the sexual health service, there is a strong outreach offer which includes a presence at public health nurse pop-in sessions. Notably, home visits are carried out for those young people who might be difficult to engage. This is a proactive means of ensuring young clients are seen by the service and of emphasising the importance of good sexual health. This level of engagement creates good opportunities to identify additional needs through observation or assessment in an environment that is less clinical and more relevant to the young person.

1.25 Both Change, Grow, Live (CGL) and Lifeline who form the 'ReNew' branded adult substance misuse service have dedicated family workers to support families of clients. This creates opportunities for signposting or referral for early help and, in the case of CGL, support is offered to families even when the adult who is misusing substances does not themselves access support from the service. However, the safeguarding risk assessment templates used when a client enters the service are limited in the extent of information they require practitioners to seek. In this respect the templates do not support or prompt practitioners to explore risks fully and the process relies on their professional curiosity. This creates the potential for some risks to be overlooked. [Recommendation 8.1](#). *We have brought this issue to the attention of Hull Public Health, the commissioners of the adult substance misuse service.*

1.26 Safeguarding practice and understanding of vulnerable families is variable in the GP practices we visited. In one practice the GP had a safeguarding lead and we saw and heard good evidence of a 'think family' approach to case recording and of information sharing with community teams together with a will to develop further.

1.27 This was not the case with another practice we visited where the approach to safeguarding is limited, with little understanding of safeguarding processes. The practice reported little involvement with safeguarding cases and could not demonstrate effective information sharing arrangements with health visitors. This means that the practice cannot be assured that they have full insight of all families on their patient list who are vulnerable or who require additional services or support. We are aware that the recently appointed named GP is embarking on a programme of work to improve and standardise several aspects of GP's safeguarding practice including establishing effective information sharing arrangements within primary care. We recommend that this latter aspect of the work is expedited as a priority. [Recommendation 4.1](#).

2. Child in need

2.1 Women who are identified with, or who develop, mental ill-health in pregnancy benefit from a peri-natal mental health pathway. There is currently no specialist peri-natal mental health midwife but the lead vulnerability midwife co-ordinates the woman's care with the hospital based peri-natal mental health team and the health visiting peri-natal mental health champions. This ensures vulnerable women with a higher level of need and their unborn or newborn babies receive co-ordinated support during their pregnancy and in the post-natal period from appropriately qualified clinicians.

2.2 Pre-birth and discharge plans are formulated with other agencies and this ensures continuity of information. However, maternity records could be strengthened by the routine use of chronologies and genograms, tools that enable practitioners to access key information quickly and enhance understanding of risks.

[Recommendation 1.5.](#)

Good practice example

Safeguarding practice in health visiting is well developed. In one case we were tracking across services we saw that the health visitor had begun her engagement with the expectant mother before the birth of her baby when she became aware that the child would be born with a life altering condition. There were older siblings in the family with whom the health visitor already had contact and additional vulnerability factors within the family dynamics, such as a history of domestic abuse perpetrated by the father.

The health visitor maintained regular contact with the expectant mother up to the point of birth and beyond. She also engaged extensively with multi-agency partners and shared information to ensure the safety of the child and mother in the period following the birth.

Over a longitudinal period since the baby's birth, the health visitor has remained involved with the family on a regular basis and facilitated the attendance of the mother and child at specialist appointments despite a sometimes chaotic family situation. This continued involvement has ensured the child received appropriate assessment, care and support.

Without the health visitor's continued interventions in this case it is likely that child protection measures would have been necessary. The child is now subject of an education, health and care plan to help manage additional needs and is on track to attend all health appointments as scheduled.

2.3 Public health nurses actively engage with education services to better identify those children and young people who are either educated at home or are currently missing from education but not subject to child protection or safeguarding procedures. All such children and young people from the age of five are offered an annual health needs assessment and this ensures their needs are not overlooked.

2.4 Public health nurses we spoke with told us of improving relationships with CAMHS, particularly in relation to understanding what CAMHS is able to offer and where additional, lower level intervention or support may be obtained. This is facilitated by the single point of access to the CAMHS, which supports the consistent use of safeguarding assessments and a broader understanding of the needs of a young person coming into the service for the first time. This clarity ensures that the right care is delivered to young people in a timely way and by the most appropriate professional. This general uplift in the offer of support to young people who don't meet the community CAMHS threshold will be improved further with the forthcoming implementation of the 'Headstart' programme. We have commented further on 'Headstart' below in 'Governance'.

2.5 Health and development practitioners within the public health nurse service provide additional support to children and young people with additional needs on a more longitudinal basis. They routinely attend looked after children health reviews, child in need meetings and core groups and work closely with young people to ensure they remain engaged in health services. This ongoing support helps young people to manage evolving or changing needs over time and promotes their transition to life as an adult.

Good practice example

In one case we examined we saw that a young woman was about to leave care having been looked after since the age of 11. She had been particularly difficult to engage with by health practitioners in, for example, completing health assessments during her time in care. Over time however, the health and development practitioner persisted in attempts to engage with the young person, especially when she entered into a relationship where domestic abuse was prevalent. The young person became pregnant and, following a parenting assessment, she moved into a mother and baby unit in Kingston upon Hull.

During this critical time of acute need, work undertaken by the health and development practitioner included facilitating appointments with a clinical psychologist and ongoing work relating to her understanding of attachment. By continuing to engage with the young person we saw that the health and development practitioner helped the woman to reach a point where she is now successfully caring for her child, is no longer in an abusive relationship and is fully engaged in an apprenticeship programme. Public health nurse interventions have reduced over time and plans for her to leave care are well underway.

2.6 CHCP provide a family nurse partnership (FNP) service in Kingston upon Hull. This service, provided by nurses with additional training in meeting the needs of vulnerable young mothers and their babies, is aimed at ensuring a healthy pregnancy and improving the health opportunities for their children up to the age of two. In Kingston upon Hull the FNP is well established with practitioners holding an agreed number of manageable cases; this enables enhanced contact time and greater understanding of the particular needs of this vulnerable group of women and their infants. This service is effective in supporting young people in Hull, especially as the rate of teenage pregnancies and conception in people under 18 is among the highest in England.

2.7 HFT provide some specialist functions to support the delivery of care to people who are already receiving health services. Of particular interest to us is the mental health liaison team based within the Hull Royal Infirmary to support people with mental ill-health who attend the emergency department in acute need including children and young people. This leads us to one of the main issues of concern we have identified during our week in Kingston upon Hull.

2.8 During our visit to the hospital paediatric ward we were advised by staff that HFT do not routinely provide CAMHS staff to assess and advise on young people who are admitted having harmed themselves. Paediatric ward staff were unclear about the role of the hospital based mental health liaison team. They reported feeling unsupported to manage the care of these vulnerable young people whilst they remain on the ward. Risk assessments or care plans undertaken by the HFT mental health liaison team were generally not shared to inform a joint approach to meeting young people's needs.

2.9 This was illustrated in one of the cases we sampled in the paediatric ward of a 14 year old young person who had been admitted following an overdose and with a risk of absconding from the ward without treatment. Staff advised us they had not seen any care plan relating to this young person to support them in delivering care for the time they remained with them. The young person in question had originally been seen by the crisis team in the ED and then again by the mental health liaison team in the paediatric ward. At the time of our visit there was no risk assessment or care plan evident within the young person's paper health record.

2.10 By contrast, our interviews with CAMHS managers indicate that the mental health liaison team is resourced with practitioners who are skilled and knowledgeable in the management of young people who self-harm and that they carry out comprehensive assessments. This was borne out in our review of the records of the previously mentioned young person which we gained access to through the electronic patient records system used in the CAMHS team. This record showed a detailed, comprehensive mental health assessment, risk assessment and care management plan, which was appropriately young-person focused. Although the assessment had been uploaded by HFT staff onto the electronic system used by both trusts, it was not shared with, and therefore, not available to the HEYHT paediatric staff.

2.11 In summary, we are satisfied that the mental health liaison team are appropriately skilled in carrying out assessments of children and young people who are admitted. However, there is clearly some work to do by both trusts to ensure that paediatric ward staff are clear about the role of the mental health liaison team and that they have sufficient information available to them, in the form of risk assessments and care plans, to ensure they can deliver appropriate care to vulnerable young patients. [Recommendation 5.1.](#)

2.12 During our visit to the CAMHS we reviewed another record of one young person who frequently attends the ED with a range of issues relating to their emotional health. We noted that the CAMHS had prepared an action plan for the benefit of all health practitioners to support them in their initial management of the care of this young person. This care plan was uploaded on to the electronic patient records system used by both HEYHT and HFT but as we have set out above, we cannot be assured that this care plan will have been seen or used by relevant staff in Hull Royal Infirmary. We have commented further on the use of this system under 'Leadership and Management' below.

2.13 Further, we learned of the use of a protocol known as 'patient watch' which provides the mechanism for young people to receive one-to-one supervision by members of the hospital security team. Relevant guidance requires this role to be undertaken by suitably qualified, trained and experienced health staff. Such staff should be capable of establishing a rapport with the child or young person and of responding appropriately to an emerging situation based on a risk assessment and their care plan, the purpose of which is to minimise harm and promote their care. The 'patient watch' protocol suggests that this arrangement should be rare and only used in extreme situations. Our interviews with paediatric ward staff, however, suggested that this arrangement is used more often

2.14 We saw that the protocol calls for reviews of security to be undertaken daily by the adult safeguarding team and then stepped down as soon as applicable. We acknowledge that there is a plan to implement an enhanced care team who will be specially trained in one-to-one supervision but this is not yet in place. We are not satisfied that there is currently sufficient understanding of the relevant guidelines about the supervision of young people in these situations and are concerned that young people may be receiving inappropriate supervision that does not meet their needs. We have asked the CCG to work with HEYHT to urgently audit the use of this protocol against the needs of young patients and to ensure that steps are taken immediately to rectify any inappropriate practices. [Recommendation 6.1.](#)

3. Child protection

3.1 We have seen good evidence of a robust approach to the screening for domestic abuse in maternity services. For example, the practice of making a routine enquiry at every opportunity during a woman's episode of care is well evidenced as is the noting of police domestic abuse incidents. The trust's oversight and monitoring of this area of work through monthly sampling ensures that staff practice remains effective and that information is shared across agencies to help protect women and their babies at a time when the risk of abuse is known to increase significantly.

3.2 The female genital mutilation (FGM) policy at HEYHT has recently been updated as a result of a learning lessons review and staff have received mandatory training. We noted that there is a good level of knowledge about FGM and its incidence among maternity staff. All women are routinely asked about whether they have experienced FGM at the point at which they book their maternity care. The understanding of midwives about FGM and the processes in use in maternity ensure that women and children at risk of FGM can be identified at the earliest opportunity.

3.3 All requests for attendance of a midwife at child protection meetings are sent to the safeguarding team in the first instance and then on to practitioners. Midwives are expected to attend all child in need and child protection meetings where possible. Reports for child protection conferences are copied to the named midwife for monitoring to ensure the quality of information remains of a good standard. However, copies of minutes from child protection meetings, including core group and strategy meetings, were not evidenced in the maternity records we looked at. This gap in record-keeping means that some key information may be overlooked by practitioners whom the woman or her baby might encounter during her episode of care. [Recommendation 1.6](#).

3.4 In maternity records we looked at, referrals made to social care did not always explain risk or contain sufficient details that would enable the receiving social care staff to make an informed decision about action required. Staff told us that outcomes from referrals to children's social care are not routinely received and are reliant upon individual practitioners to pursue. Evidence of outcomes following a referral to children's social care was not seen on records and this, too, is a gap in information. [Recommendation 1.6](#) and [1.7](#).

3.5 Record keeping in the health visiting service is strong and supports effective information sharing for safeguarding purposes. For example, contact logs are detailed and easy to read and understand, reports to inform child protection conferences are detailed and articulate risk well and referrals made to social care contain an appropriate quality of information to inform decision making.

3.6 Records we looked at showed that health visitors routinely assess the risk of domestic abuse by making routine enquiry of new mothers alone and away from other family members at the ante-natal and new birth visits. This helps the identification of risks of harm to infants and young children from domestic abuse.

3.7 As with the health visiting service, safeguarding record keeping in public health nursing is strong. Records we looked at showed a good approach to the exploration of risks and the recording of this in detail.

Good practice example

In one of the cases we were tracking across services, we noted that advice and guidance was sought from the safeguarding team and was acted upon straightaway. A verbal referral was made immediately to children's social care and followed up in writing. The analysis of risk in the referral records was strong with a clear statement of the nature of the risk.

As the case evolved, continued liaison and discussion with the social worker was described clearly and a report for the initial child protection conference set out the findings for a home visit undertaken by the practitioner.

This high standard of record keeping describes effective safeguarding work and supports accurate, accountable decision making at each stage of the process.

3.8 Both health visitors and public health nurses are actively engaged in child protection processes including attendance at all initial child protection conferences, review conferences and core groups. Mandatory attendance at all initial and review conferences as well as at core groups where there is involvement with the child or family is strong practice. This supports good decision making and it is encouraging to see that CHCP have reinforced this. However, the attendance at all other meetings where the contribution of public health nurses and health visitors might be limited has highlighted a capacity issue and this has an impact on their core function. For example, we learned that safeguarding case-loads are high with cases being held even when there is little or no involvement with the family concerned. We also learned that sometimes public health nurses or health visitors have had to cancel face-to-face meetings with clients in order to attend core group meetings where they have no information to share. This detracts from client contact time and could adversely affect practitioners' ability to identify any new concerns. *We have brought this to the attention of Hull Public Health as commissioners of the public health nursing and health visiting service.*

3.9 By contrast the multi-agency child exploitation (MACE) meetings that manage child sexual exploitation (CSE) cases and the MARAC meetings for domestic abuse are attended by practitioners from the CHCP safeguarding team. Outcomes from those meetings are cascaded back to individual practitioners to better inform their working relationships with vulnerable children and young people. This means that health visitors and public health nurses have more capacity to undertake routine health work but with additional information to help them to consider risks. We have commented further on the approach to domestic abuse under 'Leadership and Management' below.

3.10 We looked at safeguarding referrals made by ED staff at Hull Royal Infirmary and found that they generally describe risk adequately, although sometimes the information is not always as detailed as it might be to support accurate assessments. As with the other services, staff report that they do not routinely receive outcomes from children's social care for the referrals made.

[Recommendation 1.6.](#)

3.11 Referrals made by CAMHS practitioners are detailed and contain suitable analysis of the risks. This means that information about young people who are referred by the CAMHS is meaningful and relevant and supports good decision making by the children's social care assessment team.

3.12 CAMHS practitioners attend child protection conferences and contribute to decisions made by conference. Reports made by CAMHS practitioners are held on the client's file in line with good practice and they set out an appropriate analysis of current work by CAMHS with the child or young person. As before though, we learned that the records of conference were not always received by the CAMHS team and so client records were incomplete and missing key information.

[Recommendation 2.2.](#)

3.13 Community mental health practitioners are routinely invited to attend and inform both pre-birth and post-birth discharge planning meetings. This is good practice as adult mental health practitioners are often able to provide important information to assist in the protection of vulnerable infants.

3.14 Mental health service managers expect practitioners to attend child protection conferences and participate in core groups. They are also clear that practitioners must submit written reports in advance of conferences although we did not review any of these and cannot comment on their quality. As with other services, records of conferences were absent from files we reviewed. [Recommendation 2.2.](#)

3.15 Anyone under 16 who visits the sexual health service is routinely subject of a 'Spotting the Signs' risk assessment for potential CSE and this is good practice. This is also the case for anyone aged between 16 and 18 who is identified as vulnerable (through referrals into the service or cues picked up during discussion) and this recognises that young people may still be exploited despite reaching the age of consent. In the cases we looked at we saw that the quality of the records of the assessments was acceptable. However, the level of detail did not reflect the extent of the dialogue between the client and the practitioner at the time the assessment was carried out and this creates a gap in key information.

[Recommendation 3.1.](#)

3.16 The safeguarding team at CHCP attend all MACE meetings. Practitioners contribute information through the safeguarding team although they do not attend in person. The electronic patient records system carries alerts for children and young people known to the outreach workers or known to MACE to ensure staff are aware of risks when they attend for consultations. However, this is only for young people who are already known to the service. The sexual health service is in a unique position to consider risk to vulnerable, potentially exploited young people and so the process could be strengthened to include a means of alerting staff to all young people subject of the MACE. This will prepare staff to consider this if such a young person attends the service for the first time. [Recommendation 3.2.](#)

3.17 Referrals made by sexual health practitioners are monitored by the CHCP safeguarding team although they are not routinely uploaded into the electronic patient records system. Those we looked at, however, were of a good quality with sufficient detail and analysis of risks to support assessment by children's social care. [Recommendation 3.3.](#)

3.18 Sexual health staff do not attend child protection conferences and the electronic patient records system used by the service is not routinely searched by the trust safeguarding team when preparing information for conference. This is a missed opportunity to provide any additional information for the conference that might not be available through the public health nursing or health visiting systems. [Recommendation 3.4.](#)

3.19 *We have brought the foregoing issues in the integrated sexual health service to the attention of Hull Public Health as co-commissioners.*

3.20 In the adult substance misuse service we learned of a robust process for checking medicine storage boxes in the homes of clients with children. As part of the 'think family' approach, consideration is given to alternative, safer prescribing options to reduce the risk of toxic ingestion by children and this is good practice.

3.21 Adult substance misuse staff make referrals to social care where appropriate. However, in one case we looked at in the Change, Grow, Live part of the service, the referral was not followed up so the opportunity to factor evolving child protection information into ongoing work was lost. [Recommendation 9.1.](#) The quality of referrals made by this part of the service is acceptable but the depth of the analysis of the impact of substance misuse could be strengthened to ensure social workers are clear about the extent of risk. [Recommendation 9.2.](#)

3.22 The focus on the children of clients in the Lifeline part of the adult substance misuse service requires strengthening to ensure the impact on children from parental substance misuse is clearly identified by adult practitioners. Currently the emphasis is narrowly focused on the adult client. For example, one report for a child protection conference was submitted with information about the client's substance use and their recovery programme but accompanied by a comment that stated 'we are an adult service and so cannot comment on the child'. This approach does not assist the conference, or any safeguarding forum to make a judgement about parental capacity and the impact of drug use on children and families. [Recommendation 10.1.](#)

3.23 *We have brought these issues in relation to the substance misuse service to the attention of Hull Public Health as commissioners of the service.*

3.24 As we have set out above under 'Early Help', the approach to safeguarding is variable in the two GP practices we visited. In one practice we saw that reports for child protection meetings are always made *in lieu* of attendance. The reports we looked at were of an acceptable standard and provided adequate information to support decision making at conference. In this practice, patient records are flagged with a child protection alert to enable the GP or health practitioner to consider risks during consultations.

3.25 In another GP practice child protection has a limited focus. The practice does not have a clear picture of the number of children and young people on the practice list who are subject of a child protection plan. Many records are out of date by a considerable timescale, with some young adults over the age of 18 still being flagged on the electronic patient records system as vulnerable. We are not clear how common this issue is in GPs in Hull; some data cleansing work to establish an accurate picture of vulnerable children and families in GP patient lists is required as a priority. [Recommendation 7.1](#).

4. Looked after children

4.1 Looked after children in Kingston upon Hull have their health needs assessed by, and in most cases provided by, City Health Care Partnership. Initial health assessments are undertaken by consultant community paediatricians or paediatric registrars; review health assessments are undertaken by specialist looked after children health visitors and by public health (school) nurses according to age. The model sees children up to age 11 seen and assessed by the health visitor who is familiar with them, and for older children over 11 by adolescent public health nurses who may also provide follow-on services for them. This is a strong model as it supports accuracy in assessments and continuity of care.

4.2 Most children and young people placed outside Kingston upon Hull live in the East Riding area and their health needs continue to be provided by Hull staff. Again, this is effective as it promotes continuity of care. Those placed further afield are assessed and have their needs met by staff in those areas by agreement.

4.3 The CHCP children's safeguarding team is co-located with children's social care at the local authority offices. Discussions about looked after children take place face-to-face. We saw evidence of good professional working relationships between health services and social care. We have commented further on the configuration of the management of the looked after children health service in 'Governance' below.

4.4 There is good liaison between the public health nurses and health visitors and other parts of the health sector, such as midwifery outreach teams. Our case sampling showed a number of examples where information exchange was good and had led to effective health interventions.

4.5 The looked after children health visitor teams, public health nurses and the majority of GPs across Kingston upon Hull use the same electronic patient records system. There are many reasons why this is beneficial. For instance, administration staff and practitioners across disciplines can more easily keep each other informed of their responsibilities in providing care and support to this vulnerable client group. In addition, we saw that GPs contribute to health assessments as a result of being tasked on the electronic system. Likewise, looked after children health nurses have a greater awareness of interactions with young people by other practitioners using the same system and supervisors can better monitor quality.

4.6 Of the cases we sampled during our review, on the whole, both initial and review health assessments are undertaken within statutory timescales. However, we are aware that over the last year, the timeliness of initial health assessments has deteriorated somewhat with a significant number falling outside the statutory timeframe. This means that some young people have to wait too long to have their health needs taken care of. We are advised that this is due to many notifications being received late or without the necessary consent in place. This is exacerbated by the capacity of the paediatrician team to meet occasional spikes in demand due to vacancies within the team that the trust has been unable to fill.

4.7 Nonetheless, we are assured that additional recruitment options are being considered to meet the shortfall in suitably qualified staff. We are also satisfied that the issue of late notification has been properly escalated with the local authority although we are concerned that the issue still persists. We have elaborated on this further in 'Governance' below. [Recommendation 4.2](#). Positively, though, we have seen evidence of the looked after children health team's proactivity in scheduling priority appointments to see children earlier when late notifications are received. For example, if a notification is received later than five days of the child coming into care the appointment will be brought forward so that the child is seen within 21 days.

4.8 Initial health assessments are carried out at various clinic locations in Kingston upon Hull and the East Riding of Yorkshire which means children and young people don't have to travel too far to be assessed. Review health assessments up to age 11 are routinely undertaken in the home even though the child ultimately has a choice of where to be seen.

4.9 Assessment documents used for children and young people aged nine and over are designed with a different emphasis and support practitioners to ask more age appropriate questions of the child or young person. This differentiation is a small change but it means that older children have a greater opportunity to express their wishes and thoughts. The practical effect of this is to promote the interaction between the young person and practitioners and to help children to understand the relevance and value of the process to their own health as they get older. For example, a practitioner was able to explore fully a child's anxieties about being overweight and to discuss how those concerns would be communicated to the foster carer. This had a positive impact on the willingness of the child to engage with the fostering processes where there had previously been difficulties.

4.10 The looked after children health team ensure that strengths and difficulties questionnaires (SDQ) are delivered to children and young people. These are completed and returned to children's social care. Social workers use the SDQ scores to inform their work with looked after children although we saw evidence that they are also used, in some cases, to inform health assessments. Our discussions with practitioners indicate that the emphasis is on SDQs being a social care tool, despite a clear commitment by the local authority to make these available to health staff. Our view is that these are also a key health assessment tool as they enable health staff to better understand and consider emotional health and wellbeing and can be used to tailor health interventions. A more proactive approach to securing SDQs from the local authority in every case, as opposed to them simply being available, would strengthen their routine use in assessments. [Recommendation 3.5](#).

4.11 The legibility of initial health assessments we looked at during our review is variable where they have been hand-written with some of the sections being very difficult to read. However, we also saw that all health action planning sections (part C) of the assessments are typed and provide clear information about the assessment. The part C sections effectively describe the child or young person's health needs, including those historical needs that are still relevant, and action plans are SMART with clear objectives. The assessments are age appropriate and show that the child's wishes and feelings have been taken account of.

4.12 Review health assessments undertaken by health visitors and public health nurses are also generally of a good quality, taking account of the child's views. Health action plans arising from those assessments are sometimes relatively simple but they are generally SMART, clear and readily understandable, providing appropriate direction and accountability.

4.13 In both initial and review health assessments we saw that parental and sibling relationships, health backgrounds and lifestyle choices are examined in depth and used to inform health assessment and care planning. For example, in one case we looked at we saw that the impact of the child's birth parent's substance misuse was a prominent feature of the assessment. This is evidence of an holistic approach to assessment, making use of historical as well as current information.

4.14 Whilst the involvement of children and young people in assessments is a positive feature, part C conclusions and health action plans are not routinely shared with carers or the children and young people to whom they relate. This could be strengthened as it will enable young people to check to the action plan accurately reflects their needs and will support them to take some ownership of their health care; a more complete co-production. [Recommendation 3.6](#).

4.15 There is currently no specific looked after children CAMHS team in Hull. However, practitioners we spoke with advised us of improved relationships with the CAMHS team. Direct contact is made with the looked after children team whenever a referral is not accepted into the CAMHS so as to provide a clear explanation and signposting the child to other services that might be in a better position to provide suitable care and support. In any event, all young people who are looked after and who need CAMHS are assessed, and treatment begun, within 12 weeks from initial referral, although we are advised that this is often as early as four weeks. This ensures quicker and more meaningful interventions to meet the needs of this particularly vulnerable cohort.

4.16 Children and young people, including care leavers, are involved in the looked after children service design. For example, care leavers are involved when interviews are held to appoint new members of staff. Care leavers are consulted on, and involved in, the design of the soon to be released 'leaving care passport'. As a result the new, soon to be issued health passport includes more specific birth details such as the time of their birth and their birth weight, their past and present health profile and professional and other useful contacts for them to use as they move towards managing their own health care.

5. 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 CCG are active and visible leaders in safeguarding practice across health services in Kingston upon Hull. Quarterly monitoring of safeguarding performance in each of the providers has been incorporated into the contract monitoring arrangements and so the CCG has a clear understanding of strengths and areas for development. For example, we noted that both HEYHT and HFT have been required to make improvements in the take-up of safeguarding training where shortfalls became evident through this process.

5.1.2 Further, during our review we have seen evidence of responsive leadership by the CCG's safeguarding team following inspections, serious case reviews, and lessons learned reviews and, more importantly, quarterly reports by providers. The previous safeguarding and looked after children inspection of 2011 and a pilot (unpublished) joint inspection of 2014 resulted in extensive actions plans that have helped to make improvements in safeguarding practice in the city that we have seen plentiful evidence of during the inspection.

5.1.3 We recognise that providers are also active and responsive to audits and reviews and we have noted some of the initiatives and activity in this report. On the whole, we have found a positive safeguarding culture among health services leaders during our week in Hull with a desire to understand where challenges are and where improvements can be made.

5.1.4 Health services are instrumental or feature as key collaborators in safeguarding developments across the multi-agency partnership. For example, we would highlight the NHS England commissioned Child Sexual Assault and Assessment Service (CSAAS) that is provided by HEYHT for the Humberside Police area which includes Kingston upon Hull. This service operates from the dedicated child protection medical suite (see below) in Hull Royal Infirmary and provides sexual abuse forensic medical examinations together with a pathway for access to additional health support and follow-on care. We learned that there are links with the CAMHS (for emotional wellbeing) and sexual health services (for screening) who typically provide such follow-on services. This enables evidence to be gathered in the most appropriate way from children and young people who have been sexually abused and for them to receive the right health after-care to meet their needs arising from their traumatic experience.

5.1.5 There is a dedicated child protection medical suite, the Anlaby suite, at Hull Royal Infirmary under the management of the HEYHT safeguarding team. The suite provides tailor-made facilities for all examinations of children who have or are likely to suffer significant harm. It is equipped with a police interview area and is also available out-of-hours. Such, 'one-stop' facilities are not common and its availability here means that children and young people in Hull who have been abused do not have to visit different locations to undergo child protection assessments.

5.1.6 We would also highlight the work of health practitioners as part of the HSCB and alongside police counterparts to embed good information sharing as part of the MARAC arrangements. A member of the CHCP safeguarding team is a permanent member of the MARAC and ensures that information is shared with key health practitioners about cases where there is heightened risk from domestic abuse. A particular strength is that all domestic abuse incidents attended by the police are routinely notified, through the CHCP practitioner, to maternity, health visiting and public health nursing teams as well as to the GP. This helps to alert health practitioners to any risks to children in such households.

5.1.7 Significantly, this also illustrates that there is a recognition by multi-agency partners of the important role played by health partners in Kingston upon Hull to managing these particular risks; evidence of a strong health contribution in the HSCB and of positive learning from a serious case review. CHCP continue to monitor the effectiveness of this arrangement and we have seen evidence of robust audit, together with ongoing actions to improve the strength and clarity of information received still further.

5.1.8 The impact of health visitors on the effectiveness of safeguarding work in the health partnership is well understood by CHCP and their deployment reflects this. For example, there is a liaison health visitor nominated as a link for every nursery in Hull. This enables nursery nurses to routinely liaise with health visitors and share concerns that might arise from their work with very young children. Likewise, there is a liaison health visitor attached to each GP practice in Hull. Health visitors can undertake regular visits to those surgeries so that information can be shared in relation to vulnerable children and young people. However, as we have referred to earlier, the management processes that support this are not yet properly developed, with varying levels of engagement in primary care.

5.1.9 Managers within public health commissioned services in Hull maintain effective oversight of practitioner caseloads through a quality monitoring regime. This includes monthly safeguarding audits on particular themes such as record keeping, safeguarding processes and information governance. This is enhanced by auditing of 'live' cases supported by personal discussion with practitioners. This creates a culture of improvement and we are satisfied with its effectiveness given the generally good quality of safeguarding and looked after children work in the CHCP services.

5.1.10 The transformation of the public health commissioned community children's services has led to a diverse skill and banding mix among health visiting and public health nursing teams. Our observations during the week are that this works well and supports effective safeguarding practice. For example, there is an appropriate mix of band five, six and seven nurses and health visitors who carry out a variety of case-holding and management functions. The public health nursing team are supported by band four health and development practitioners who carry out longer term and less acute work with children and young people and we have emphasised some good work from this group in one of our box examples above.

5.1.11 Of note, however, are the capacity issues in the public health nursing service where four specialist nurses hold in excess of 170 safeguarding cases each at any given time. Practitioners we spoke with told us that this has an adverse impact on their ability to proactively engage with children and young people by having to spend most of their time on case file management duties. There is a risk, therefore, that important opportunities to identify safeguarding risks might be missed as a result of not being able to routinely meet with clients on their caseload. We have brought this to the attention of Hull Public Health as commissioners of this service.

5.1.12 The HFT safeguarding team are in the process of developing an extensive safeguarding audit programme with the purpose of improving and assuring safeguarding performance across the trust. Of note is the audit planned to look at 'think family' practice in the adult mental health service and we are encouraged that this is acknowledged by the trust as an area for improvement.

5.1.13 We would emphasise at this point, however, that there are acknowledged capacity issues in the adult mental health service. The staff team of 35 practitioners currently work with six clinicians less due to sickness and vacancies. The recent reconfiguration of the service has dispersed the waiting lists across East and West teams and resulted in a list of 90 cases to reallocate with a waiting list of 90 (figures cited are a snapshot in time at the point of inspection). Recruitment is problematic and capacity and resource shortfall results in extended waiting times. As we have reported above 'think family' is not well embedded in practice and this is compounded by the stretched capacity. This means that children may be left in vulnerable situations without any evidence of planning for their needs or involvement of other professionals.

5.1.14 The adult mental health service holds daily multi-disciplinary team meetings and these include discussion of any identified safeguarding issues. This leads to the production of a safety consideration report log to inform risk management where issues involving children in families of clients are set out. This would ordinarily mean that other team members are aware of any current risks in families that might impact upon children. However, we noted that there are gaps in entries where information is incomplete and this does not support practitioners to properly consider risks. Managers recognise that there is more work to do to ensure such risks are consistently captured and disseminated. [Recommendation 2.3](#).

5.1.15 There is more work to be done to effectively support young people who transition from CAMHS to adult mental health services. The referral point for young people to transfer to adult mental health services is when the young person approaches their 18th birthday with planning work taking place six months prior to this. However, we were told that there are few, if any, children that transition from CAMHS to adult mental health services. This is unusual given the numbers of children accessing CAMHS services and that the needs of young people are becoming more complex.

5.1.16 There is a currently a draft transition protocol being developed for joint working between CAMHS and the adult service. The new protocol calls for a flexible approach and the exploration of whether there are important clinical reasons why therapeutic work would be required instead of transition to an adult team. However, there are no clear safeguards built into the process to ensure that this option is not over-used. Given the low numbers of young people who transition we would suggest that clear guidance should be developed about how the therapeutic option is considered and how its effectiveness will be measured. [Recommendation 2.4.](#)

5.1.17 The named GP is relatively new to post and has a work plan aimed at improving safeguarding practice and processes for GPs. One of these aspects likely to be challenging will be the development of multi-disciplinary liaison between GPs and other health services; this process is under-developed at present and we have suggested above that this piece of work should be expedited. For example, although we know that each GP practice has a liaison health visitor, the arrangements for regularly and formally sharing information about vulnerable families are not consistent across the Kingston upon Hull practices. We should note that one of the practices we visited was unaware of the identity or the responsibilities of the named GP and so we would assert that there is some work to do to raise the profile of the role and ensure practices are aware of this layer of support. [Recommendation 7.2.](#)

5.1.18 There is currently no system for monitoring the quality of 'Spotting the Signs' CSE risk assessments carried out in the sexual health service. As outlined above this is an area for development where some records do not fully reflect the dialogue with the client or the practitioner's thinking. The quality of these risks assessments, and thereby the effectiveness in identifying young people at risk would be strengthened through the use of an audit as part of CHCP's, already robust, quality monitoring programme. [Recommendation 3.1.](#)

5.1.19 There are challenges to health services in the way that information is logged and shared with other disciplines, mainly due to differences between the systems in use. The functionality of the electronic patient records system used in Hull Royal Infirmary and in HFT services is under-developed and does not support effective safeguarding practice. This has been evident in three key areas; safeguarding alerts, consistency in the logged narrative and attachment of key documents.

5.1.20 For the first of these, the system has the capacity to alert staff to a range of safeguarding issues by the use of flags and children on a child protection plan are currently flagged in this way. Further flags for other areas of risk, such as domestic abuse or CSE, or for children in need or looked after, would support practitioners in their approach in consultations but these flags are not used on the system.

[Recommendation 5.2.](#)

5.1.21 Secondly, contact logs, particularly those used in HFT services often lack detail and there is an over reliance on paper records. In one case we looked at in the adult mental health service, staff told us they had referred an issue to children's social care but this was not evident from viewing the case record. In another case, however, we noted that a copy of case notes had been scanned into the system to demonstrate why it had been closed. This inconsistency means practitioners cannot be assured they are viewing a complete record of information, there is no audit trail and, in the case of the referral, details of the risk are missing. This does not enable staff to have a clear picture of risks and means that some may even be overlooked.

[Recommendation 2.3.](#)

5.1.22 Lastly, as is illustrated in the example set out earlier under 'Child in Need' in relation to management of the care of a young person on the paediatric ward, clear understanding of documentary plans held on the system would have led to much greater understanding of the young person's needs. This case highlights the need to ensure staff from both trusts attach and signpost key documents that assist in the care and support offered to young people. **[Recommendation 5.1.](#)**

5.1.23 Although the community maternity services currently use a well organised paper records system with the capacity to isolate safeguarding information, we learned that the service are soon to revert to the same electronic system. Provided improvements are made in the way it is used, as we have set out above, this will improve the capacity to properly share safeguarding information across acute and mental health services.

5.1.24 There are clear, joint governance and management arrangements for the adult substance misuse service through the Drugs and Alcohol Partnership Group. However, there are challenges to its ability to secure consistent safeguarding performance. This is due to the service being provided by two different providers (Change, Grow, Live and Lifeline) with different approaches to safeguarding and incompatible electronic records systems. For example, the superficial safeguarding risk assessment templates on both systems could be enhanced through some collaborative work between the safeguarding teams of both organisations to ensure that safeguarding risks are better understood when a client enters the service. We have brought this to the attention of Hull Public Health as commissioners of the adult substance misuse service.

5.1.25 The variability in the way multi-agency safeguarding documents (child protection conference minutes, core groups records and records of strategy discussions) are received from social care or captured on patient or client records has been a feature throughout our visits to services during the week. Incomplete records limit practitioners' ability to properly understand risks. The same is true of outcomes to referrals made. We have heard throughout the week that practitioners often have to chase-up outcomes to referrals made to social care. Receiving feedback adds value to the referrer and helps to keep practice strong. Some work could be done by commissioners, the CCG and Hull Public Health, to strengthen the reciprocal information flow between agencies. [Recommendation 7.3](#).

5.2 Governance

5.2.1 Throughout our review we have found evidence of a generally strong safeguarding culture within the CCG and at all of the providers we visited. We also noted a will to improve, develop practice and assure quality both as separate organisations and collaboratively with each other and with commissioners. Other than those few instances where we have reported and made recommendations upon, safeguarding practice is generally well established with each provider having a safeguarding team and clear processes for quality monitoring, reporting and supervision. We have found examples of good practice that we have commented on in this report.

5.2.2 There are integrated governance arrangements for safeguarding children and for looked after children in Kingston upon Hull between the CCG, the providers, the HSCB and in some cases the local authority. We have seen evidence in annual reports that demonstrate this integration to be an effective means of governance. It enables key decisions to be made at scheduled meetings and for candid discussion and escalation of issues. Some of these arrangements are described below.

5.2.3 The Director of Quality and Clinical Governance at the CCG has executive responsibility for safeguarding in Kingston upon Hull. Overall strategic work is carried out by the designated nurse for safeguarding children who provides quarterly reports to the Quality and Performance Committee. Service level agreements are in place with HEYHT for the part-time deployment of a designated doctor for safeguarding children and designated paediatrician for unexpected death in childhood. The designated nurse represents the CCG on the safeguarding committees of HEYHT and HFT and also has direct liaison with the CHCP safeguarding executive lead.

5.2.4 The key safeguarding personnel at the CCG are also strongly represented, either singly or severally, on the HSCB and its sub-groups and play an active role in progressing the board's business. For example, the Child Death Overview Panel has a significant clinical presence in addition to the designated paediatrician for unexpected child deaths with the designated doctor, designated nurse and named GP all in attendance. This reflects the importance of the health role in this facet of safeguarding work.

5.2.5 The most recent CCG annual report states that they have a high level of confidence in both safeguarding processes and safeguarding performance. The responsiveness of the integrated governance arrangements have contributed significantly to the CCG being able to assert this level of confidence; they are clear as to where there has been success and where their challenges are. The principal vehicle for holding providers to account for safeguarding performance is through the Contract Monitoring Board. As we have commented earlier, we have seen evidence to illustrate that this is an effective medium for improving practice, particularly in relation to compliance with safeguarding children training requirements and the evolution of safeguarding supervision in HEYHT and HFT.

5.2.6 The Named GP for safeguarding children has recently been appointed with two half-day sessions each week allocated to the role. In our discussion with the named GP we learned of an extensive planned work programme to improve safeguarding practice across primary care. The work plan includes developing standardised formal processes for information sharing with community teams (which we have commented on above) and with child protection processes. For example, a new template document is being developed for sharing information with other professional agencies to support child protection conferences. The aim of this is to enable GPs to provide greater analysis of impact as opposed to the overly clinical format previously in use. This will then be implemented in practices.. The named GP intends to support the use of this template through a planned scenario based training event as one of the priority pieces of work.

5.2.7 It is acknowledged by the named GP that, at the time of the inspection, there is still work to do to ensure GPs are following safeguarding practice and processes consistently. For instance, the named GP has recognised that the standard of referrals made by GPs to children's social care is variable with often limited analysis of family dynamics. It is felt by the named GP that this could be due, in part to the high number of locum GPs employed in practices who might have less personal knowledge of families and so feel unable to comment. Our visits to GP practices demonstrate that child safeguarding practices are still inconsistent and require standardisation although there are three clear priority areas to be addressed as we have outlined in this report. To summarise, these are; data management on electronic patient records systems to ensure practices have a clear understanding of the vulnerable families within their patient list; formal information sharing arrangements with community child health teams; and consistency of the quality of information shared with children's social care for safeguarding processes.

[Recommendation 4.1](#), [7.1](#) and [7.4](#).

5.2.8 We have had some discussion during the inspection with CHCP and the CCG about the role of the designated nurse in the looked after children team. The management of the looked after children health service within CHCP lies with the health visiting and adolescent nursing teams with operational oversight being provided by the named nurse for safeguarding children who also holds the post of designated nurse for looked after children. This role is provided to the CCG through a service level agreement.

5.2.9 Specialist safeguarding support for looked after children is provided by the CHCP safeguarding team who are co-located with the looked after children service. The designated nurse, however, carries out a role that would ordinarily be carried out by a named nurse for looked after children, a role that is not separately provided in Kingston upon Hull. The CCG and CHCP have recognised this, mainly as a result of a recommendation from the unpublished joint agency pilot inspection in 2014 and through the benchmarking exercise recently undertaken by NHS England. At the time of this inspection a new designated nurse role had been described and was about to be recruited to, separated from the line management of the looked after children service. However, the role is still located in the provider and not the CCG.

5.2.10 As the designated nurse for looked after children role should be held independently of the provider we would ordinarily see this as potentially leading to a conflict of interest. Our experience has been that this has often led to a corresponding drop in the quality of assessments. This has not been the case during this week where the quality has been generally good. However, the potential still exists for this arrangement to have an adverse impact on performance due to a lack of clarity about lines of accountability. Our position remains that we recommend the CCG take steps to ensure that such oversight is independent of the provider.

[Recommendation 4.3.](#)

5.2.11 The designated nurse and designated doctor for looked after children are key members of the monthly Integrated Looked After Children (ILAC) meetings with the local authority. This is a joint social care and health governance arrangement responsible for the strategic direction of partnership work for looked after children and we have seen evidence of the effectiveness of this forum in ensuring practices evolve. For example, the process for the issue and use of SDQs has been modified so that the emphasis is on the use of these by the local authority although we have commented earlier on the availability of these for health staff.

5.2.12 We have also seen evidence of the way that issues within the partnership are escalated beyond the ILAC, such as the dialogue between the local authority and the CCG in relation to the timeliness of notifications for looked after children that we have mentioned above. We are aware that the undertakings made by the local authority that were intended to improve this issue have yet to be realised. We also know that the dialogue is still ongoing and we cite this here as an example of the robust and persistent position taken by CHCP to resolve this. Our principal issue, however, is the fact that these concerns are currently being addressed with the local authority by the designated nurse employed by CHCP, the provider of the looked after children health service and by the organisation's chief executive. Our view is that this is an issue that should be more appropriately escalated by the CCG who commission the service and independently of the provider. We consider that this is evidence of the need for greater clarity in the lines of accountability for the looked after children service. **[Recommendation 4.2](#)** and **[4.3](#)**.

5.2.13 There are accountable governance arrangements in place for safeguarding in CHCP. The bi-monthly Quality and Safety forum, chaired by the Operational Director for the Paediatric Services Section (care group 2) of the organisation, has oversight of all safeguarding activity. Major risks are escalated to the organisation's board. Safeguarding activity is supported by a comprehensive annual audit plan delivered by the safeguarding team. The audit plan has driven improvement activity in a number of areas such as safeguarding supervision and information sharing in relation to domestic abuse incidents.

5.2.14 HEYHT modified its safeguarding governance arrangements in 2016 so that executive accountability now lies with the Assistant Chief Nurse, aligned with the trust's safeguarding adults function in the Chief Nurse portfolio. Safeguarding activity is managed by the trust's monthly Safeguarding Committee that reports to the Operational Quality Committee. The trust is aware of its challenges in relation to safeguarding children, and has used these to direct its actions for this current financial year; for example, actions taken that resulted in improved compliance with level three training.

5.2.15 The effectiveness of the trust's safeguarding work is measured through audit activity. For example, along with CHCP, the trust carried out an audit of information sharing within the maternity service and with the health visiting service in relation to domestic abuse. The audit found that performance in this area was strong and this is borne out by our own findings during the inspection and reported earlier.

5.2.16 The trust has also reported a number of key successes during 2016 and we highlight the role of the Safeguarding Champion as an example of its proactivity. The trust states that there are around 50 safeguarding champions operating in the two hospital sites in Kingston upon Hull. The role of these champions is to help staff with simple safeguarding queries or to signpost them to other sources of support. Champions are given additional safeguarding training on key topical issues and participate in regular scheduled peer support meetings to maintain their knowledge and understanding. At the time of the inspection the initiative had not been formally evaluated but we consider this to be an example of a positive approach by the trust to uplift safeguarding awareness amongst its workforce.

5.2.17 In HFT, the Director of Nursing and Patient Experience has executive accountability for safeguarding and represents the trust at the Safeguarding Children Boards in the trust footprint. The Director of Nursing chairs the six-weekly Safeguarding Group which maintains oversight of safeguarding activity and reports to the trust's Quality and Patient Safety Committee.

5.2.18 The trust safeguarding team currently has an interim named nurse for safeguarding children and a further children's specialist practitioner. The trust reports that one of its biggest challenges is the capacity of the safeguarding team to deliver an improvement agenda. For example, the trust has reported that it has been unable to carry out its scheduled safeguarding audit plan for the previous financial year due to the capacity of the team. We are also aware that there is a considerable burden on the team to deliver increased safeguarding training sessions to improve the compliance rates for staff eligible for level three training, particularly in the adult service. We have seen the new safeguarding audit and monitoring plan for 2016 to 2019 which forms part of the trust's strategic objectives; this is an ambitious piece of work as many of the audit tools have yet to be developed. It is not clear at this time whether that plan can be achieved within timescales alongside the training and operational commitment due to the capacity of the safeguarding team.

[Recommendation 2.5.](#)

5.2.19 The CCG and the health providers proactively engage young people in the development of services for children and young people. For example, CHCP has recently begun a project to explore how young people can be better engaged and their access to health care improved through the use of technology, such as social media. The first part of this project was a focus group of 16 and 17 year old young people at the end of 2016 which, at the time of the inspection had only just reported its findings. We understand that this work will continue to be developed as the project progresses based on the views of the focus group.

5.2.20 The CCG and HFT have undertaken a considerable amount of work over the course of the last 18 months to improve the responsiveness of the emotional wellbeing and young person's mental health offer. These, too, have been developed with a strong emphasis on hearing the voice of young service users. We highlight two of these initiatives for further comment.

Headstart

The soon to be implemented 'Headstart' programme is a collaboration with 'Mind' and a local youth project known as 'The Warren' and is funded through the National Lottery. It is aimed at improving access to lower level interventions for young people with emotional wellbeing concerns where they would not ordinarily meet the threshold for support by the community CAMHS. The programme has undergone a successful pilot and is scheduled for full implementation shortly after the conclusion of our review. Together with the single point of access for CAMHS, this will lead to a much more accessible service where there is appropriate support and treatment available across the emotional and mental ill-health spectrum.

How are you feeling?

We have been encouraged by the development of the 'How are you feeling' online resource for young people arising from the Kingston upon Hull Children and Young People's Transformation Plan. This website was designed with the help of children and young people from a range of different age groups. Its purpose is to provide an accessible, young person focused source of advice and guidance on a whole range of emotional wellbeing and mental health issues. The website was launched at the end of 2016 through local news media and with the support of a small group of specifically recruited young people known as 'emotional wellbeing champions'. The success of the project has yet to be determined but our view is that this is an outstanding example of co-production between health services and young people.

5.3 Training and supervision

5.3.1 The health training steering group, chaired by the designated nurse, ensures that initial level three training for practitioners is provided on a multi-agency basis through the HSCB. Thereafter, health single agency based training is delivered by way of refresher or update events. The health training steering group enables all three of the trusts to carry out joint, level three safeguarding training for multi-disciplinary groups across the health services and to collaborate in training design. This enhances the effectiveness of safeguarding training as it enriches learning and enables practitioners to take a wider, cross-sector perspective during the discussions.

5.3.2 All midwives undertake level three safeguarding training and have had additional training in respect of the use of the vulnerability checklist, CSE and FGM. Midwives are given opportunities to access training for special interest and disseminate learning to their peers. As well as meeting the additional mandatory requirement of national guidance, it also ensures the workforce remain skilled in supporting vulnerable women and children.

5.3.3 Newly qualified midwives are subject to a 12 month preceptorship, a competency based programme to ensure that they are able to work to the appropriate level upon completion. As part of that preceptorship programme the named midwife and the lead midwife for vulnerability provide extra training sessions in respect of safeguarding and the vulnerability pathway to newly qualified midwives. This enables safeguarding to be highlighted at an appropriately early stage with new staff and means they are better equipped to identify and respond to concerns once signed off for independent work.

5.3.4 Supervision is provided by the named safeguarding midwife, the safeguarding team and by a cohort of midwives who have attended additional training in respect of safeguarding supervision. The target is to have one-to-one supervision three times yearly but this is a relatively new process and a challenge due to current capacity which is outstripping resources with no identified protected time for supervision. Group supervision and advice and guidance when required is also provided on a case by case basis. Supervision outcomes and actions are recorded in the patient record and this supports professional practice to develop. However, the current system is not formally structured and more work is required to ensure all relevant staff can benefit from the developing supervision system.

[Recommendation 1.8.](#)

5.3.5 Public health nurses and health visitors receive level three multi-disciplinary safeguarding training from the CHCP safeguarding team with good compliance reported. Both local and national issues form part of the training which includes learning taken from serious case reviews. CSE, FGM, trafficking and neglect are also included and the training continues to evolve according to need.

5.3.6 We have also seen evidence of good supervision processes at work in CHCP services. Practitioners receive routine, scheduled safeguarding supervision at least every three months and, according to caseload, as often as every six weeks; a process that has undergone some improvement as a result of a serious case review. Outcomes from those meetings are recorded in the client records on the children's record with dates for review, roles and responsibilities and specific timescales also being recorded.

5.3.7 We note that compliance with level three training for relevant staff groups in HEYHT has recently improved. Lower attendance rates were identified as a result of a re-evaluation of the staff groups deemed to be eligible for level three training but this has improved over the course of the second half of 2016 due to an increase in the number of training places available. Managers advised us that the figure for relevant staff in ED has risen considerably and now stands at 100%.

5.3.8 One-to-one supervision sessions are offered by the safeguarding team across Hull Royal Infirmary but there is a reportedly lower uptake by ED staff due to staffing and pressures of work in the department. Safeguarding advice and guidance is available for non-case holding staff and accessed on a case by case basis as well as support for simple queries provided by the previously mentioned safeguarding champions.

5.3.9 In the period prior to our review the take up of level three training by HFT staff was significantly low and had been subject of additional performance requirements by the CCG. We are advised by the trust safeguarding team that this shortfall is due to a re-evaluation of training needs of relevant staff groups, bringing adult mental health staff into the workforce requiring training at level three. HFT have advised that they are on trajectory to train 70% of their staff by the end of March 2017 although this will still not meet the CCGs required target of 80%. Given that only two of the staff in the community mental health team we visited had received such training and the capacity issues in the safeguarding team we mentioned earlier, we consider this target is optimistic in respect of the adult mental health service.

[Recommendation 2.6.](#)

5.3.10 The HFT safeguarding team have tried to enhance the understanding of a wider range of staff in relation to 'think family' by running a roadshow initiative at a number of different locations. This is encouraging, but is only a temporary measure capable of doing no more than raising awareness among staff in the adult mental health services. Our visit to the adult service, however, shows that this has had limited impact on practice or culture with managers having little or no knowledge of the roadshow programme.

5.3.11 Despite the capacity issues we reported above, the safeguarding team at HFT are accessible and supportive and we saw good examples of robust and supportive advice and guidance provided in cases we looked at in the CAMHS. This included good records of advice given and decisions reached.

5.3.12 Safeguarding supervision is delivered to CAMHS staff in various ways including advice and guidance. Our review of cases in the CAMHS shows that the advice and guidance supplied by the trust safeguarding team is key to ensuring safeguarding cases are progressed appropriately and that practitioners are supported. For example, in one of the cases we were tracking across services we saw that a practitioner who had made a safeguarding referral was at odds with the decisions made by the social worker about the progress of the case. The practitioner sought supervision and the record and outcomes of the supervision session were noted on the young client's record. The supervision record contained a good description of the practitioner's concerns, a note of the key points discussed and a set of actions arising from the discussion that were SMART. This case resulted in the effective use of escalation processes to ensure that the practitioner was supported appropriately by the trust, their concerns were addressed properly and the young person's situation was properly looked into.

5.3.13 As well as advice and guidance, group supervision, by way of drop-in sessions facilitated by supervisors who have received additional training is the predominating method in CAMHS. This runs alongside unscheduled supervision sessions that are delivered as and when required. In addition the named nurse visits the locations of some teams, such as the crisis team or the community teams, to deliver group sessions. This method can be an effective means of enhancing learning from local cases under discussion but it does not support in depth scrutiny of complex safeguarding issues in the same way that one-to-one supervision does. The case holding staff in the CAMHS do not yet have access to such regular, formal, mandatory and scheduled one-to-one safeguarding supervision that is in accordance with the trust policy although we understand that there is a programme in development to strengthen this. [Recommendation 2.7.](#)

5.3.14 In the adult mental health service, the lead clinicians in the community mental health team provide clinical supervision with a safeguarding component. Although we were told that a record of safeguarding supervision and actions were recorded in the patient case notes this was not evident in records seen. [Recommendation 2.8.](#)

5.3.15 As with the safeguarding champions at Hull Royal Infirmary, each mental health and CAMHS team also has a link safeguarding practitioner. Link practitioners have received additional training and can signpost staff to sources of support or guidance and this is a positive initiative.

5.3.16 At the sexual health service we learned that HSCB training is often difficult to access but that level three training is provided by the CHCP as part of organisation's training programme. Attendance is monitored and compliance rates are high. During our discussions with staff we found that overall knowledge of CSE, for example, was strong and that this led to effective discussions with clients to assess risk even if the recording of those discussions was limited (see above in 'Child Protection').

5.3.17 Sexual health staff receive three monthly small-group supervision. They also have access to advice and guidance as and when it is needed and pre-referral advice from the CHCP safeguarding team. Safeguarding supervision is not always documented on client records however and this should be strengthened.

Recommendation 3.7. *We have brought this to the attention of Hull Public Health as co-commissioners of the sexual health service.*

5.3.18 In the adult substance misuse service we have been advised that all practitioners have received and are currently up to date with level two training from the HSCB. This is insufficient for adult substance misuse practitioners who work with clients with families as they should all have been trained to level three. However, our discussions with the service and with commissioners indicate that there is some disparity in the way that HSCB training is categorised. HSCB training at level two is said to be equivalent to level three training as described by the relevant intercollegiate guidance although our discussions indicated some uncertainty about this. We are advised that this is a long standing issue that is still not yet resolved and practitioners in all providers would benefit from clarity in this area.

Recommendation 7.5.

5.3.19 The newly appointed named GP has responsibility for jointly leading the training programme for GPs. GP training is designed by a training group comprised of the named GP, the designated nurses for both Hull and the East Riding of Yorkshire, along with the designated doctor and the CHCP safeguarding trainer who also leads the delivery of the sessions. Training includes scenario based sessions on thresholds and processes. There are plans in place to provide forthcoming based training sessions on CSE, FGM, child trafficking and report writing for conferences. The current three-hour sessions run three times each year within the Hull and East Riding areas. GPs are encouraged to attend one of these sessions every three years as well as completing a further three hours of self-directed safeguarding children continuing professional development within this period.

5.3.20 The CCG take a lead role in directing health related action plans from serious case reviews and learning lessons reviews. The integrated governance arrangements described above lend themselves to effective implementation of actions derived from this learning. We have highlighted a number of initiatives and strong areas of practice in the report that have arisen as a direct of such reviews. For example, the specification and forthcoming implementation of the EHASH arrangements; the strengthened supervision processes in CHCP community services; the updated FGM policy and mandatory training in HEYHT; the strengthened information sharing arrangements relating to domestic abuse. This demonstrates that the CCG and all health providers have an effective culture of continuous learning and improvement as required by Working Together.

Recommendations

1. Hull and East Yorkshire Hospital NHS Trust should:

- 1.1 Ensure paediatric documentation is used for all attendances to the emergency department of children and young people up the age of 18.
- 1.2 Develop the understanding of ED staff of the purpose and use of paediatric documentation for older young people so that they are supported to make relevant, young person focused enquiries during booking in, triage and assessment.
- 1.3 Improve the quality of information about ED attendances that is routinely shared with primary care public health nursing teams so that it is legible and relevant.
- 1.4 Develop the understanding of ED staff of the purpose and use of templates on the documentation for adult patients that require questions to be asked about their children and families so that risks or additional needs relating to their presentation can be properly explored.
- 1.5 Develop the use of chronologies and genograms in maternity records so that key information about children and families can be accessed efficiently and enhance the understanding of needs.
- 1.6 Ensure all records of child in need and child protection meetings and records of the outcomes of referrals made by maternity and other acute services are recovered from children's social care and attached to the client or patient record.
- 1.7 Develop the ability of maternity staff to fully explain risks in sufficient detail when making written referrals to support good decision making by children's social care.
- 1.8 Review the current structure and resource commitment to safeguarding supervision in the maternity service so that relevant staff can benefit from the developing supervision system.

2. Humber NHS Foundation Trust should:

- 2.1 Develop the understanding of adult mental service staff of the 'think family' approach to identifying and assessing the needs of or risks to children and young people that their clients have access to.

- 2.2 Ensure all records of child in need and child protection meetings and records of the outcomes of referrals made are recovered from children's social care and attached to the client or patient record.
- 2.3 Improve and standardise the system for identifying and communicating risks relating to children and young people in the adult mental health service client records.
- 2.4 As part of the new transition protocol, develop clear guidance that sets out how and when a therapeutic option is considered for young people *in lieu* of formal transition to the adult service and how its effectiveness will be measured.
- 2.5 Review the capacity of the trust's safeguarding team to ensure it is able to meet its operational, training and audit commitments.
- 2.6 Significantly improve the offer and take up of level three safeguarding training in the adult mental health service.
- 2.7 Strengthen the formal one-to-one safeguarding supervision arrangements for case holding staff in the CAMHS to ensure they meet with trust policy.
- 2.8 Ensure records of safeguarding supervision or advice and guidance are made in the client record.

3. City Health Care Partnership Community Interest Company should:

- 3.1 Improve the level of detail in the record of the 'Spotting the Signs' risk assessments so that the record reflects the discussion with the client and the level of analysis.
- 3.2 Develop a system that enables all children and young people known to the MACE process to be flagged on the electronic patient records system of the sexual health service, whether they are already known to the service or not.
- 3.3 Ensure all referrals made by sexual health service staff are uploaded to the patient record.
- 3.4 Ensure client records in the sexual health service are included in the general search for information prior to child protection conferences.
- 3.5 Strengthen the arrangements for using SDQs in health assessments of looked after children.
- 3.6 Ensure part C health action plans are routinely shared with looked after children and their foster carers.
- 3.7 Ensure records of safeguarding supervision or advice and guidance are made in the client record.

4. NHS Hull CCG and City Health Care Partnership Community Interest Company should:

- 4.1 Work with the named GP to develop formal information sharing arrangements between GP practices and community child health services and to standardise the approach to this across Kingston upon Hull.
- 4.2 Ensure that the impetus is maintained in the discussion with the local authority to resolve the shortfall in the timeliness of looked after children initial health assessments
- 4.3 Ensure the role of designated nurse for looked after children is resourced independently of the provider.

5. Hull and East Yorkshire Hospital NHS Trust and Humber NHS Foundation Trust should:

- 5.1 Work together to ensure that paediatric ward staff are clear on the role of the mental health liaison team and that they have sufficient information available to them, in the form of risk assessments and care plans, to ensure they can deliver appropriate care to vulnerable young patients for the duration of their stay on the ward.
- 5.2 Develop the use of flags on the electronic patient records system used in both trusts so that key risks are alerted that would support practitioners in their approach during consultations.

6. NHS Hull CCG and Hull and East Yorkshire Hospital NHS Trust should:

- 6.1 Work together to audit the use of the patient watch protocol to ensure it is only used in exceptional circumstances and that there are proper arrangements in place for the one-to-one supervision of children and young people with mental ill-health on the paediatric ward.

7. NHS Hull CCG should:

- 7.1 Develop a process for data cleansing in GP practices as the first step towards establishing a clear picture, in every practice, of the numbers and extent of vulnerable children and families on patient lists.
- 7.2 Ensure GP practices are aware of the additional layer of safeguarding support offered by the named GP.
- 7.3 Work with Hull Public Health and with the local authority children's social care to assure the effectiveness of arrangements to share records of safeguarding processes and outcomes from referrals with providers.

- 7.4 Work with GPs to standardise the format for information sharing with the local authority for safeguarding purposes.
 - 7.5 Ensure the levels of training offered by the HSCB are clearly understood and communicated to providers in terms of content and duration so that providers can map this into training needs analysis and systems for recording compliance with guidance.
- 8. Change, Grow, Live and Lifeline, operating together as Renew, should:**
- 8.1 Develop standardised risk assessment templates for use when a client enters the service so that the practitioners from both parts of the organisation are prompted to explore risks to children and young people in a consistent way and to ensure those risks are not overlooked.
- 9. Change, Grow, Live should:**
- 9.1 Ensure all referrals made to children's social care are followed up so that progress in child protection processes can feature in ongoing assessments and work with clients.
 - 9.2 Ensure staff record an analysis of the impact of substance misuse within the body of referrals made to children's social care so that social workers have a clear understanding of this impact in individual cases.
- 10. Lifeline should:**
- 10.1 Develop the understanding of 'Think Family' among staff to enable them to consider fully the impact of substance misuse on children of clients

Next steps

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