

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

Children Looked After and Safeguarding

The role of health services in York

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Provider services included:	City of York Local Authority, Public Health Harrogate and District NHS Foundation Trust (HDFT) York Teaching Hospital NHS Foundation Trust (YTHFT) Tees Esk and Wear Valleys NHS Foundation Trust (TEWV) Lifeline York Integrated Recovery Service
CCGs included:	Vale of York
NHS England area:	North Region (Yorkshire and Humber)
CQC region:	North
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Summary of the review

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

Where the findings relate to children and families in local authority areas other than York, 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 2013.
- Where we found areas for improvement in services provided by NHS but commissioned by the local authority then we will bring these issues to the attention of the local public health team in a separate letter.

How we carried out the review

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

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

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

In total, we took into account the experiences of 64 children and young people.

Context of the review

The latest published information from the Child and Maternal Health Observatory (ChiMat) 2016 shows that children and young people under the age of 20 make up 21.6% of York's population. There are 10.1% of school aged children from a minority ethnic group. The proportion of children under 16 living in poverty is 11.2% which is less than the England average of 18.6% and the rate of family homelessness is better than the England average. The number of children in care is slightly less than the England average but not significantly.

The ChiMat data shows that on the whole, the health and wellbeing of children in York is generally better than or not significantly different to the England average for most of the attributes measured. For example children and young people in York have better than average levels of obesity. However, hospital admissions as a result of self-harm in the 10-24 year age group have increased in the last three years and are significantly worse than the England average, as are hospital admissions due to dental caries for one to four year olds.

The Department for Education (DfE) provides annual statistics of outcome measures for children continuously looked after for at least 12 months. As at March 2015, York had 145 looked after children that had been continuously looked after for at least 12 months (excluding those in respite care), 15 of whom were aged five or younger.

The DfE data indicates that a lower proportion of York's looked after children had received an annual health assessment, 69% compared to an England average of 89.7%. The national data also shows that 93.1% of looked after children in York are up to date with their immunisations however we have been told by the provider in York that currently this figure is closer to 61%. This compares to an England average of 87.8%. The percentage of looked after children who have had their teeth checked by a dentist is 75.9% which is lower than the England average of 85.8%.

The strengths and difficulties questionnaire (SDQ) is a brief behavioural screening tool that can be used to assess three to 16 year old children and young people. It exists in several versions to meet the needs of researchers, clinicians and educationalists. In York the average score has increased since 2013. The most recent average of 15.1 in 2015 is considered to be borderline cause for concern and is above the England average of 13.9.

Commissioning and planning of most health services for children are carried out by Vale of York CCG.

The Named Nurse for looked after children and the looked after children specialist nursing team are provided by Harrogate District Foundation Trust (HDFT)

Acute hospital services are provided by York Teaching Hospitals NHS Foundation Trust (YTHFT).

Community based services (health visiting and school nursing) are commissioned and provided by City of York local authority.

Child and adolescent mental health services (CAMHS) are provided by Tees, Esk and Wear Valleys NHS Foundation Trust.

Specialist facilities are provided by Leeds and York Partnership NHS Foundation Trust (CAMHS inpatient unit).

Contraception and sexual health services (CASH) are provided by YTHFT.

Child and adult substance misuse services are provided by Lifeline York Integrated Recovery Service.

The last inspection of safeguarding and looked after children's services for York took place in March 2012 as a joint inspection, with Ofsted. At that time, the contribution of health agencies to keeping children and young people safe was judged to be good as was the overall effectiveness of services for looked after children. Recommendations from that inspection were considered during this review.

Findings from CQC regulatory inspections of registered providers as they relate 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 the parent of a young child who had received care and support at York hospital's emergency department (ED). When asked about their wait to be seen they told us:

"It was OK but it took quite a while. We had to wait for a long time but luckily he (their child) was not seriously ill."

We asked them what they thought of the waiting area. They told us:

"It's what we have to do isn't it. It would be nice if we could have waited somewhere else but it wasn't a problem. I have been here before now on my own in the evening and it was really noisy, full of drunks. I wouldn't have wanted to bring my son here on a night like that."

They went on to tell us:

"The staff are lovely here. They all seem so busy but they take the time to reassure you and do their best for you. I don't know how they do it."

Some parents told us the following about their perinatal experiences:

"Health visitors have been brilliant. They have really supported me – couldn't fault them."

"The labour midwives were outstanding."

"I had to go to A&E a few times and they were very reassuring - that was a really good service."

A young person told us this about their experience as a child in care:

"Overall my last health review was pretty good. We nattered first and that made me feel more comfortable instead of just going in there with questions."

"I missed my HPV vaccine but I didn't get told until I was halfway through my maths lesson and someone came in to get us. We need to be given notice, at least 24 hours. I had to have it that way because I have moved around."

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 York Teaching Hospitals NHS Foundation Trust (YTHFT) have an established arrangement to notify GPs when children and young people attend the Emergency Department (ED); this consists of a letter generated from the electronic patient record keeping system. However, the notification arrangements to the 0-19 service are not robust; notification of attendances of children aged 0-5 at ED are routinely sent to Health Visitors. The same cannot currently be said of children aged 5-19. There is an overreliance on the professional judgement of individual practitioners to share concerning information such as repeated attendances to the ED. The absence of a dedicated paediatric liaison function prevents the review of care and actions taken by ED staff when children have attended.

[\(Recommendation 1.1\)](#)

1.2 Midwives within YTHFT use an *aide memoir* assessment tool to help them better consider risk in pregnant women. The assessment is aimed at both the mother and her partner and considers a range of factors. These include; previous children involved with social care or children looked after; whether there is a history of abuse, criminality or other safeguarding concerns; the vulnerabilities of parents under 16 years of age; relationships, domestic abuse and maternity care such as concealed pregnancy and substance misuse. This tool provides practitioners with clear guidelines to; assess risk, refer to support services and also includes contact details for YTHFT safeguarding professionals.

1.3 York community midwives have positive working relationships with health partners. York community midwives undertake joint assessment and handover visits with health visitors and, where possible, in the clients' home so that they can better assess the impact of the home environment. We were made aware that, on the whole, midwives have good working relationships with York GPs. The majority of midwives are invited to and attend practice meetings where the effectiveness of support offered to vulnerable clients can be discussed. This is a positive arrangement because it enables midwives and GPs to be fully sighted on additional needs that will influence their safeguarding risk assessments and subsequent referrals.

1.4 The health visiting service delivers the universal healthy child programme to children aged five years and under in York. This includes the mandatory ante-natal, new birth, six weeks, one year and two to two-and-a-half year visits as well as healthy child clinics at each of the city's children's centres every week. However, managers we spoke with acknowledge that the number of children receiving the two to two-and-a-half year checks is low; this may limit the opportunity to identify new or emerging health needs to support children's readiness for school.

Our review of the data supplied by the health visiting service further indicates that health visitors in York see fewer children for all milestone dates than the rest of England. For instance for the first quarter of 2016 to 2017, the percentage of newborn infants seen within 14 days is at 74% compared with an average of 88% for the rest of England. For the one year review and the two to two-and-a-half year reviews this rate is lower still with 24% and 22% respectively compared with the England averages of 74% and 76% for the same period. Although there is evidence that the trend is generally improving, these rates are nonetheless disappointing and indicate that any additional needs would not be identified as early as they should be and opportunities for early help are delayed. *We have brought this significant shortfall to the attention of public health at City of York local authority as commissioner and provider of the Healthy Child Service.*

1.5 The health visiting service provide support to vulnerable families under the category of universal plus which aids the timely identification and response to their additional needs. The co-location of the health visiting teams in York children's centres has resulted in more ready access to these local additional services and this facilitates the role of the health visitors as lead professionals under the family early help assessment (FEHA) processes. For example, in one of the cases we were tracking across services, we noted that the health visitor had arranged support for a family from the children's centre and the engagement of a child development worker; this secured good outcomes for the family prior to moving out of area. However, the FEHA documentation was not always used by the health visitor to assess the level of need and, in this particular case, would have helped the health visitor to rationalise the need to escalate the matter to social care as a potential child in need. *We have brought the inconsistent use of the FEHA form to the attention of public health at City of York local authority as the commissioner and provider of this service.*

1.6 The health visiting service advised us that they receive notifications of children's attendances at the ED at York hospital in the form of typed information taken directly from the ED clinical notes. We saw evidence in files examined that such notifications are sent to health visitors although the service was not assured if all attendances at the ED are notified to them or simply those where there are identified concerns. When notifications are received, health visitors review the information and follow-up as necessary, such as a home visit or telephone call to establish whether the family require any additional support following the episode of urgent care. We have commented above on the need to improve the consistency of notifications from the ED at the York Hospital. ([Recommendation 1.1](#))

1.7 At key points of transition, we have seen some examples of health services working together well. For example, joint visits between community midwives and health visitors in the family home and face-to-face health visitor to school nurse handovers when there is an identified need. This prevents drift during times of change in practitioners and allows opportunity for continued engagement with families.

1.8 The school nursing service is accessible for young people within mainstream education in the City of York through a variety of pathways including through 'drop-in' sessions at all secondary schools. This enables early identification of children and young people's emotional and physical needs such as low self-esteem, enuresis and contraception. It also provides opportunities for early help services to be considered.

1.9 School nurses are not informed by CAMHS about children and young people who are receiving support from that service. This means that school nurses cannot take full account of a young person's emotional needs during their interventions and this is a gap. The absence of information from CAMHS is also evident for looked after children. This carries more significance as the school nurse completes the looked after child health reviews. Missing information about a child's emotional and mental health can lead to an inaccurate and less meaningful assessment. ([Recommendation 2.1](#))

In one case examined, the school nurse had extensive knowledge of a child in care's history including not being brought to appointments. The young person had recently been placed with a member of the extended family. The CAMHS record showed that an appointment had been offered but not attended. The CAMHS service was not aware of the young person's status as a child in care. This means that they were unable to consider the impact of this on the young person's emotional health which limited effective and meaningful communication with professionals. When we looked at the case in the school nursing service, they were not aware of a CAMHS referral or and that recent appointments had been missed. This means that the school nurse was not able to fully understand the young person's emotional health needs and care at the health review and the emotional health needs of the young person are still not addressed.

1.10 The issue of CAMHS assessing vulnerabilities for children who do not attend appointments is further compounded by historical records being stored off site and there being no child in care pathway in CAMHS. In the example provided, if CAMHS had communicated with the school nursing service, this would have provided an opportunity to give context to the case, understand the significance of the young person not attending the appointment and allow follow up by universal health services. ([Recommendation 2.2](#))

1.11 The CAMHS are in the process of making a number of service changes designed to improve the way children and young people access the service and the arrangements for assessing and meeting their emotional needs. The single point of access (SPA), due to be formally launched in January 2017, is being piloted and we saw how new referrals into the SPA are being quickly reviewed and allocated assessment appointments to practitioners who have expertise in their identified need. Care pathways are being introduced to support a structured approach to providing intervention, though it is too early to comment on the impact of this work. This approach is supported by the newly appointed emotional health and wellbeing workers operating out of York schools to try and make the service more accessible to children and young people and facilitate timely referrals to early help services. In both GP practices we visited, primary care staff identified challenges in knowing where to refer children and young people when the concern is not high risk which means that some referrals to support services are less timely for children and young people. ([Recommendation 5.1](#) and [2.14](#))

1.12 Contraception and sexual health services (CASH) as provided by YTHFT since July 2015 is an 'all ages' integrated service providing sexual health and genitourinary services to people across York with the aim of providing 'one service by one practitioner to clients in the area. Young people can access services at various locations such as GP surgeries, colleges, and universities across the area which means people will generally not have to travel far to obtain care and support. Young people can self-refer into the service which removes barriers to accessing support.

1.13 CASH services include a specialist clinical outreach team (SCOT) to provide clinical services from those locations and sites in York. The team engage with sex workers, clients who access sex via internet web sites and people who attend public areas for sex. This is good practice to engage and offer support to people of all ages who undertake risky sexual activities and particularly an opportunity for practitioners to identify vulnerable young people, support them with services from their own agency and refer for further support to social services and vulnerable, exploited, missing and trafficked (VEMT) processes.

1.14 The CASH 'SCOT' also provides a service to groups of the population based on geographically mapped need. For example, outreach work to public places where risk taking behaviour has been identified and 'teach and screen' educational and screening events delivered in York colleges. Young people over 16 years of age can access an initial service online. This provides opportunity for health promotion and risk assessments for some clients in the city who would otherwise not access such a service.

1.15 CASH services demonstrate use of user feedback to improve service provision. For example, starting in January 2017 a specific Monday service provides an opportunity for young people between the hours of 8am and 4pm to access emergency contraception and sexual health testing should they require it following the weekend.

1.16 York 'Lifeline' adult substance misuse service is accessible for clients in York. There are no barriers to referral into service. Most referrals come from GPs and clients can self-refer. Initial consultation is usually within a week which means that there are no delays in assessing risks to children and young people posed by the adult's substance misuse.

1.17 The adult substance misuse services provide care and support to clients aged 18 years and over. There is a young person's service for clients who are 18 years and below with no lower age limit. A prescribing team liaises closely with GPs and other health services to ensure holistic care packages are offered. This supports practitioners to think family when working with adults.

1.18 Adults who require support from the adult mental health service for the first time or who return to the service, are initially assessed by the TEWV single point of access or by the crisis team in urgent situations. Practitioners are supported to 'think family' during this initial, or 'access' assessment by the use of mandatory safeguarding questions embedded into the assessment template which is part of the electronic case management system. This template requires practitioners to ask whether the client is a parent or carer or has access to someone under 18; whether the mental health of the client has an impact on their parenting or family life; whether the family has an impact on their mental health and whether there are any safeguarding children concerns.

In one case examined that was managed by the crisis team these questions were considered in some depth through dialogue with the family's health visitor. This ensured that the child's needs were considered during the initial assessment process.

1.19 GPs we spoke with told us they are not routinely represented at multi-agency risk assessment conference (MARAC) meetings. Primary care leaders acknowledge that there is more work to do to involve GP's in the full MARAC cycle so that they receive relevant information and outcomes. The work of the primary care nurse consultant and named GP has resulted in all GP practices receiving information about cases discussed at MARAC that involve their patient as the victim or any associated children. This has helped the practices to make informed decisions relating to children who might witness domestic abuse. We saw one case example of a GP whose attendance at a MARAC conference was facilitated by the MARAC chair to co-ordinate with the break in surgery times. When GP's have contributed to a MARAC, sharing relevant action plans would support management of risk to the victim and family. ([Recommendation 3.1](#))

2. Children in need

2.1 On entering the ED at York hospital, children and young people's demographic details are taken at the reception desk alongside adult patients. Although there is a small younger children's gated play area to one side, children and young people await triage in the shared waiting area as there is no dedicated environmental paediatric provision. ED staff make efforts to see children as a priority over adult patients, however this is not always possible due to medical emergencies. During our visit we saw children waiting amongst adults who had also been assessed at triage as requiring care at the earliest opportunity. These arrangements are not consistent with the relevant standards for children in emergency care settings. This also means that children must wait to be seen in an environment that is potentially distressing. ([Recommendation 1.2](#))

2.2 The absence of bespoke paediatric facilities persists once children leave the waiting area. After triage, some children are directed to be seen by a GP working on the unit. Those who need to be seen by ED staff for further assessment and treatment are placed into generic, curtained cubicles that are also used by adult patients. We saw several adults in cubicles where the curtains were either fully or partly open in the same part of the ED used by children. If children are directed to other areas of the hospital, such as the x-ray department, we saw that they again have to wait in areas shared by adult patients. This means there is a risk that vulnerable children might witness or hear distressing situations. ([Recommendation as at 1.2 above](#)).

2.3 CAMHS provide an assessment service to the ED seven days each week between 1pm and 9pm. Outside of these hours telephone support is available from a CAMHS consultant. CAMHS are providing a 7 day follow-up after hospital attendance and admission which is in line with best practice guidelines and provides timely support for vulnerable young people. However, ED and paediatric ward staff told us that there can be delays in accessing out-of-hours CAMHS advice when the on call practitioner is off work due to sickness for example. This means there can be a delay in accessing appropriate CAMHS specific advice and care. ED practitioners advised us that they routinely seek advice from the on call adult mental health service for assessment before a young person is admitted to the paediatric ward. ([Recommendation 2.3](#))

2.4 Health visitors routinely enquire about the risks of domestic abuse with new mothers. These questions are asked at the antenatal and new birth visits and the response is noted in the child's record by way of a check box as part of the recording template together with any relevant explanatory text. This enables the health visitor to consider whether there is a risk to the mother and newborn infant and to take appropriate action by way of referral to social services if necessary. However, the template simply records that the question is asked and is left blank if, for example, the health visitor is unable to ask the question such as if it had not been safe to do so. This means that information about domestic abuse risks does not appear in the record and there is no other opportunity to consider those risks. *We have brought this to the attention to public health at City of York local authority as the commissioner and provider of the 0-19 healthy child service.*

2.5 In one case examined in health visiting, we saw that there had been clear documented risks about domestic abuse in earlier entries within the record, including an earlier antenatal joint visit by another health visitor in another part of the city in conjunction with the community midwife where these risks were evident. However, a subsequent antenatal visit when the mother-to-be had moved into another area of York and later new birth and six week visits had overlooked this earlier information. Therefore, an assessment of the risks to the newborn infant had not been properly identified or explored. Whilst we acknowledge that the electronic patient recording system is not configured to alert future readers of a record of any risks, a simple review of recent record entries would have identified these concerns. We asked the service to carry out a review of this case during the review. *We have brought this shortfall in records about routine enquiry regarding domestic abuse to the attention of public health at City of York local authority, as commissioner and provider of the Healthy Child Service.*

2.6 Children in York who need medical support in school, such as in the use of an Epipen for the emergency treatment of anaphylaxis, do not benefit from a whole school training approach to meeting their needs. There has been a recent change to how this service has been commissioned and the impact of the new accredited training session is not yet known.

2.7 Young people aged 16 years and over can access sexual health screening services online. Where appropriate, this leads to a telephone assessment prior to a screening test kit being sent to them. The telephone consultation follows the same format as a face-to-face consultation which includes the use of a 'spotting the signs' child sexual exploitation (CSE) assessment, and is strictly for young people aged 16 and over. Children aged under 16yrs who access the face to face service are routinely screened for CSE using the spotting the signs screening tool. A sexual health service may be the first service a young person accesses alone and so this is good practice to routinely identify vulnerabilities.

2.8 York adult substance misuse services includes a team called 'ATLAS' which works with children and young people affected by parental or carer substance misuse. With parental consent the team provide support to children, as well as carrying out some family work such as health promotion and signposting to the peer led recovery community. They also provide educational support in schools and colleges across York. For example they commissioned 'The Invisible Man' theatre company to provide a monologue production to educate children in why people abuse substances, how to recognise the signs and symptoms and what support is available for all those affected. In appropriate circumstances, this allows children and young people to be informed which supports them in accessing support as they need it.

2.9 In the adult mental health service, whilst the 'think family' approach is supported during initial or access assessments, there is some way to go to ensure that this approach is maintained throughout the service's intervention with clients. For example, in one case examined we noted that the child of a client who had presented to the crisis team with suicidal ideation featured prominently in the initial assessment although this was less prominent as the successive interventions progressed. This was a case which would ordinarily have merited some form of safeguarding advice and guidance in the early stages but this was not evident in the record. Towards the end of the short term period of treatment the child had virtually disappeared from the practitioner's on going assessment of their client.

[\(Recommendation 2.4\)](#)

2.10 Midwives we spoke with told us that relationships with mental health teams were continually improving. Advice and guidance can routinely be sought from mental health services for patients aged 16 years and above. Mental health practitioners visit the unit to assess women's mental health needs when required to do so to provide support and guidance to both clients and practitioners.

However, there is currently no specific commissioned service for perinatal mental health in York. Nor is there a formal pathway for pregnant women with mental ill-health to access specialist psychiatric support. Currently, women are referred to the mental health service through the single point of access and generally receive support through the community mental health teams and a psychiatrist with a special interest in this area. The service is currently exploring a number of different funding options and service delivery models but these are not likely to come to fruition in the short term. [\(Recommendation 6.1\)](#)

2.11 We have been encouraged to see that the adult mental health service have recently issued directions to introduce a tool known as the 'Procedure for Assessing and Responding to the Impact of Parental Mental Health on Children' (PAMIC) and have embedded this as a template on to the electronic system. The use of this tool is triggered when a practitioner opens a child safeguarding template on the client record. A practitioner checks boxes on the template to signify the type of risk, such as parental mental health, child protection plan, substance misuse, domestic abuse and others. The practitioner is then directed to open the PAMIC guidance and follow an algorithmic decision making template to arrive at a determination of the level of risk.

In two cases examined we saw that this tool had been effectively used to assess risk to children of clients although the rationale for arriving at this assessment was not strongly articulated in the record. At present, however, this is an optional tool and is not mandatory in every case when a client is identified as having access to a child. Safeguarding practice would be strengthened significantly if this were to be a mandatory tool. ([Recommendation 2.5](#))

3. Child protection

3.1 We cannot be assured that practitioners are applying a think family model to their consultations with adults attending the ED. If adults attend the ED for example following drug or alcohol misuse, staff are not prompted to ask about what access they might have to children. In one case examined we saw that an adult had attended the ED having abused alcohol but we could not ascertain if they had been asked about parental or carer responsibilities. ([Recommendation 1.3](#))

3.2 ED at York Hospital do not use separate documentation other than the addition of 'Under Eighteen'. Paediatric documentation contains some relevant information such as who the child has attended with, but is not specific enough to prompt practitioners to ask enough questions to establish safeguarding risks. This means that safeguarding assessments are reliant on professional curiosity. ([Recommendation 1.4](#))

3.3 Not all children accessing York ED have a child safeguarding risk assessment. ACHILD is an additional form to enable practitioners to be assured that they have completed a robust safeguarding assessment for every child that attends the ED. The form includes consideration of the number of attendances to ED over the last 12 months and if the child is known to social services. However, in records examined, we saw that both nursing staff and doctors do not always complete the documentation accurately and in some instances not at all. In the absence of dedicated paediatric records this arrangement does not support robust children's safeguarding practice. ([Recommendation 1.5](#))

In one case examined a young child was brought to the ED by their mother. The mother had been a victim of domestic abuse during which the child had been grabbed and possibly injured. The perpetrator of domestic abuse was the child's father, who as a consequence was in police custody.

The child was assessed and discharged from ED to be taken to a place of safety by the mother. The assessment led to an appropriate referral to children's social care with relevant risks documented with regards to the child. However, the examined casualty card and referral to children's social care did not document who the father was, whether this question had been asked or if there were any other children in the family who might be at risk.

3.4 At York hospital ED, we examined referrals to children's social care and most of them contained appropriate information about the child being referred. This supports social care and other partners in decision making processes and accurate referrals to children's social care allow timely intervention for vulnerable children, young people and their families.

3.5 In records examined we saw that when making a referral to children's social care, York hospital ED practitioners do not always record if consent to the referral is sought prior to the referral being made. It is important that consent is discussed and ideally obtained from the parent or carer of a child considered at risk unless this would put the child at further risk. Seeking consent will ensure parents are appraised of the reasons for the referral being made and able to secure good outcomes arising from the referral. Gaining consent for safeguarding referrals is supported locally by a recommendation from a recent and local learning lessons review in order to facilitate robust statutory interventions or step downs to early help. ([Recommendation 1.7](#))

3.6 Vulnerable children and young people who are admitted to the paediatric ward at York Hospital in mental health distress are safeguarded well. Environmental risk assessments have been undertaken on the paediatric wards to reduce the risk of vulnerable children and young people in mental health distress being able to self-harm or attempt suicide. The risk is further reduced by the provision of one-to-one support during their time on the ward.

3.7 Once a child or young person in mental health distress is admitted to the paediatric ward at York hospital to await a CAMHS assessment, they are provided with one-to-one supervision from the allocated paediatric nursing resource for that shift or a member of staff from the wider organisation. If the patient is currently a CAMHS inpatient, a member of that team provides the one to one supervision. We were advised that there can be more than one child or young person admitted to the ward to await a CAMHS assessment at any one time and the timeliness of the CAMHS assessment on the ward can be limited by CAMHS staff availability. This places an increased demand on staff and reduces capacity to meet the needs of all patients on the ward. ([Recommendation 2.6](#))

3.8 In records examined in maternity services, we saw that practitioners seek consent from clients when a referral is made to children's social care. Where it is thought that consent might not be given by the parents, we saw that practitioners engage in discussions with the YTHFT safeguarding team to further explore the safeguarding risks. We also saw records that documented clinical decision making when consent was not given. This facilitates client engagement in interventions and provides clarity in regards to application of thresholds by maternity services.

3.9 Practitioners on maternity wards at York hospital are supported to involve security staff when they consider it necessary, such as when a visitor to the unit becomes verbally aggressive. Recent and appropriate improvements have been made to the entrance and exit mechanisms to the maternity ward when it was discovered that they could be bypassed by visitors which ensures that the physical environment is safe for new mothers and babies.

3.10 Electronic tracking tags are available to use on all babies on the maternity ward. However, practitioners we spoke to were not aware of guidance that supports their use and whether consent is needed. This means that safeguarding risks may not always be considered or discussed with parents and carers and rationale for decision making may not always be clear. ([Recommendation 1.8](#))

3.11 Multi-agency pre-discharge plans are routinely used within York midwifery services to assure vulnerabilities are considered and acted on prior to a mother and child being discharged from the unit. Plans examined were detailed and clearly set out roles and responsibilities prior to any discharge decisions being made. This ensures that vulnerable children and families are better protected where risk is identified.

3.12 Community midwives prioritise attendance at all child protection and core group meetings and provide written reports. Invitations to, attendance at and outcomes from child protection conferences are monitored by senior managers on a spreadsheet to ensure appropriate midwifery input into safeguarding processes is maintained. This good practice ensures consistency in child safeguarding practice and secures the expertise of midwives in multi-agency decision making and planning for those in their care.

3.13 Midwives at York Teaching hospital demonstrate that they are aware of increased vulnerabilities during pregnancy. Pregnant women booked at York teaching hospital are asked at least twice during their pregnancy whether they have experienced domestic abuse. When risk is identified a discussion takes place with the YTHFT safeguarding team and a referral is made to the Independent Domestic Abuse Service (IDAS) in York and children's social care in the case of the unborn child. This practice is reflective of NICE best practice guidelines and offers vulnerable women and children timely support.

3.14 Across York, most services prioritise attendance at strategy meetings, child protection conferences and core group meetings. A report is provided by the practitioner for the appropriate meeting. This is good practice to better inform the decision making process. However, in some services, the voice of the child was not reflected by the practitioners report. For example the reports seen in the school nursing service did not evidence that the school nurse had seen the child or attempted to appropriately obtain the views and opinions of the child or young person. This means that the child or young person is not at the centre of the care planning. *This has been brought to the attention of public health at City of York local authority as the commissioner and provider of the 0-19 healthy child service.*

3.15 Health visitors are actively and routinely engaged in child protection processes such as child protection conferences and core groups and we saw evidence of this in the files examined. Health visitors also provide written reports for conferences setting out the information they will share and these reports are shared with parents prior to the conference commencing. We saw evidence of good quality reporting for conferences containing robust analysis and recommendations of the practitioner concerning the desired outcome.

3.16 Although health visitors are actively engaged in child protection processes, not all engagement with those processes is noted on children's records. For example, in one case seen we saw that no written documentation relating to an initial child protection conference had been uploaded to the child's record, including the invitation to the conference or the report submitted by the health visitor. This means there was no accountable record of the contribution of the health visitor to the decisions made by conference. *This shortfall has been brought to the attention of public health at City of York local authority as the provider of the 0-19 healthy child service.*

3.17 Minutes from child protection conferences are mostly received by health service providers in a timely manner. Where the facility is available, the minutes become part of a single patient record. This means they can be used to inform patient care and safeguarding supervision processes which increases the opportunity to identify drift.

3.18 Information sharing between health visitors and GPs is sporadic across York even though each GP practice has a dedicated link health visitor. Vulnerable families meeting arrangements are underdeveloped in some practices but well developed in others. Where formal arrangements exist, meetings between health visitors and GPs take place generally every six weeks. The health visitor service manager and the primary care nurse consultant for York are in the process of developing a revised specification for information sharing arrangements, including scheduled multi-disciplinary vulnerable families meetings. It is hoped that this will standardise practice across the city, ensure that effective planning can take place for each child for whom there are safeguarding concerns and increase multi-agency role awareness. ([Recommendation 3.2](#))

3.19 Health visitors do not always demonstrate professional curiosity in relation to safeguarding risks. In one case seen we noted that parents of a child denied the drug misuse they had been suspected of and told the health visitor that children's social care had closed their case. The practitioner relied upon this assertion and did not check the veracity of the claim with the social worker. Therefore, it could not be ascertained if previously reported risks were still relevant. *This has been brought to the attention of public health at City of York local authority as the commissioner and provider of the 0-19 healthy child service.*

3.20 Referrals made by health visitors to children's social care are generally of a good standard. In one referral made by a newly qualified member of the health visiting, team we noted that key risk features had been well described and analysed alongside the practitioner's observations about protective factors. The health visitor also followed up the referral the following week to ascertain the outcome of the referral; this is diligent practice and ensures the health visitor has a full insight into the case before carrying out the next visit.

3.21 In another examined case we noted that risks to a young mother and her infant arising from the mental ill-health of maternal grandmother were well set out, fully explaining the rationale for the referral by the health visitor to children's social care. A later referral was made by the health visitor in relation to these risks continuing and also in respect of additional risks arising from potential exploitation on the part of a much older male relative. However, the referral was subsequently declined by children's social care. In this instance we noted that there was no use of a CSE screening tool to underpin concerns and enable the health visitor to escalate the concerns appropriately and strengthen the case for social care involvement. **(Recommendation 3.3)** *This has also been brought to the attention of public health at City of York local authority as the commissioner and provider of the 0-19 healthy child service.*

3.22 Robust arrangements are in place to support CAMHS practitioners in attending initial child protection conferences and providing written reports. Sometimes, however, CAMHS practitioners are not being notified by children's social care of conferences that are cancelled or re-arranged. This impacts on service provision and does not allow the CAMHS service to utilise their resources and effectively contribute to child safeguarding processes. **(Recommendation 2.7)**

3.23 Not all CAMHS practitioners fully understand and consistently apply the escalation process to address professional disagreement with children's social care following a referral. There were isolated good practice examples of practitioners seeking safeguarding advice that informed practice. However, in 2 cases when safeguarding advice had been sought, new information would have warranted further discussion with safeguarding or a line manager to escalate the practitioners concerns. This did not happen which means that the records indicated that the risks to the young person remained. This means that children and young people continue to be at risk and it limits the opportunity for appropriate professional challenge, support and application of safeguarding thresholds. In one case examined a decision was made to refer the case back to the service for further review. **(Recommendation 2.8)**

3.24 CAMHS practitioners are provided with copies of child protection plans and minutes. However, records examined did not demonstrate how practitioners are using child protection plans to inform care or what their responsibilities are as part of the core group. This is compounded because the CAMHS practitioner cannot upload documents to a single patient record on the electronic record keeping system. This practice does not allow practitioners to evaluate the effectiveness of a child protection plan. It means that's as a consequence there can be drift or 'start over' because previous plans and interventions to safeguard are not clearly documented. **(Recommendation 2.9)**

3.25 The 'think family' model is embedded within Lifeline adult substance misuse services. For example, using national learning to recognise the risks posed to children who have contact with adults using a safe storage box for prescribed medication. As a result, all clients with access to children aged ten years and under have a home assessment to ensure appropriate use of the safe storage box. This reduces the risk of harm to children and young people as a result of accidental ingestion. Regular audit of the safe storage box use, including where the box is kept, whether it is large enough to store all the doses, has provided the service with an opportunity to benchmark practice and be assured of their continued safe use.

3.26 In adult substance misuse services, the electronic client record system prompts practitioners to ask important safeguarding questions at all stages of the assessment process. These questions identify children and young people to whom the clients have parental/carer responsibility or access. When a practitioner is made aware that a client has entered into a new relationship a further risk assessment is completed and questions are asked about any new children to which they might have access. This promotes identification of the hidden child.

3.27 The electronic patient records used in adult substance misuse service is an easily navigated IT system which flags safeguarding and child protection concerns and also manages safeguarding tasks, for example, contribution to child protection conference. Local managers have used the system to quality assure practitioners contribution to safeguarding work.

3.28 There are three core teams to which clients can be referred within adult substance misuse services. The 'Inspire' team works with people on a short term basis for up to three months who require lower levels of care and support. The 'Change' team works with clients for up to a year who require more intensive support and the 'Empower' team works with 'long term' clients with more chaotic lifestyles who may be difficult to engage with and require more intensive support.

3.29 The adult substance misuse service offer information to clients that reflects national legislation. For example a co-sleeping leaflet is offered to all clients during their assessment that details changes in co-sleeping legislation when adults are under the influence of alcohol or drugs. This ensures that clients are aware of the reasonable considerations that they need to make to safeguard their child's wellbeing and the impact of not being able to do so.

3.30 There are effective working relationships between Lifeline adult substance misuse services and York hospitals maternity services. This is supported by the Lifeline maternity services pathway which details information sharing between the organisations to ensure the safety of an unborn child. For example, pre-birth reports from Lifeline are provided to paediatricians to better inform their interactions with vulnerable women during their pregnancies. A newborn baby and mother who has been accessing Lifeline, benefit from a home visit from a Lifeline practitioner at 14 days. This visit allows an additional support mechanism for women who may be more vulnerable in the postnatal period and ensures that the child safeguarding assessment can be reviewed.

3.31 In the adult mental health service, whilst the electronic system alerts can trigger practitioners to adopt safeguarding thinking in their approach to their work with their clients, there are systemic failings in the database that hinder or limit the effectiveness of their practice. For example, the system does not have the capability to upload key documents as attachments. As a result practitioner reports regarding child protection conferences, child protection meeting minutes and child protection plans are contained elsewhere in hard copy files. In one case we noted that the record of a child protection conference had been copy-pasted into a facility on the system known as 'letters' but this had resulted in a hard to read account making retrieval of key information difficult and impractical. Otherwise there was no record in the case or activity notes in the system of the child protection plan or of actions arising from the conference.

Paper records are held in a document store in the location we visited and we were therefore able to examine the record of this particular case. We saw that the child protection conference minutes were located in this file but there was no evidence of the practitioner's contribution to the conference within the file or on the electronic system. In addition, we learned that the document store was not readily accessible to every practitioner from different locations across the city and so the effectiveness of the hard copy files is limited. This demonstrates that there is no single and complete client record held centrally or electronically. This is a concern as managers and new practitioners accessing the client record may not be fully informed of their child protection responsibilities and there is risk that key activity will not be carried out. ([Recommendation 2.10](#))

3.32 A similar problem arises in adult mental health services in relation to safeguarding referrals. In one case examined we saw that the electronic records system had no record in case or activity notes to show that a referral relating to domestic abuse had been made to the local authority. In this case, the referral record itself had been copied to the trust's safeguarding team and we were able to see that it contained enough detail to enable the recipient of the information to understand the nature of the risks; in this respect the quality of the information in the referral was good. The only reference to the referral within the client record appeared some days later when the client called to remonstrate with the practitioner for making a referral without her knowledge and therefore consent. The absence of documentation of a referral in the client record means that managers or other practitioners are unsighted on current risks and this inhibits their capacity to make informed decisions about ongoing care or planning. ([Recommendation 2.11 and 2.12](#)).

3.33 The electronic client management system in the adult mental health service uses alerts to ensure practitioners are aware of ongoing concerns. This includes an alert to signify whether a child that a client has access to is subject of a child protection plan. This makes risks to children highly visible to practitioners using the adult record and helps them to assess any risks.

3.34 GP's are not consistently notified of safeguarding concerns. In one case tracked across services we were informed by the GP that the first notice they had of domestic abuse in the family home was when they were asked to provide information to this review. A second case example showed that the GP's had not been made aware that a young person was in care. This limits primary care's ability to ensure that particular vulnerabilities are considered should the child attend the practice for treatment and prevents their contribution to multi-agency partnerships to safeguard children. ([Recommendation 3.5](#))

3.35 GP's in York contribute to child protection processes however they are not always receiving timely invitations to contribute. GP attendance at child protection conferences is not routine, they use templates on the electronic patient record to facilitate their contribution and reports seen were comprehensive. The invitations are received in appropriate timescales when they are sent by secure email, there was less confidence when an invitation is sent in the post. ([Recommendation 3.6](#))

4. Looked after children

4.1 Children who are in the care of City of York have their health needs assessed by a range of health professionals. We found some variability in the quality and timeliness of health assessments. The looked after children health team provided by Harrogate and District NHS Foundation Trust (HDFT) carry out a co-ordination role for all health assessments for all children in care and complete some review health assessments. All initial health assessments (IHA) for children who are new to care are carried out by paediatricians from YTHFT.

4.2 The specialist nurses from the looked after children team undertake high quality review health assessments (RHA) for those children with complex needs, for those children aged 16 to 18 or those who are accommodated in a residential setting. Health visitors (for children under five) and school nurses (for children aged five to 15) undertake RHAs for all other children.

4.3 We learned that both IHAs and RHAs are often not completed within statutory timescales. For example, figures produced by HDFT indicate that, for the first two quarters of the financial year 2016 to 2017, only 24% of IHAs requested by the local authority were completed within the 20 working day timeframe. This means that 76% of children who were new to care experienced a delay in having their health needs assessed. ([Recommendation 4.1](#))

4.4 Further analysis of those figures show that 86% of those late assessments were overdue because of a delay in the relevant documentation being received from the local authority. In some cases the intervals between being notified of a child coming into care and receiving the request documentation were themselves beyond the statutory timeframe. We have noted, however, that in a significant number of cases, the delay in completing IHAs was not simply due to lateness in receiving documentation. In five of the 14 IHAs that had been completed in that period, the time between receiving the request and completing the assessment also fell outside a further 20 day period. Although the organisation have oversight of the reasons for these delays and the partnership have done work to reduce the variability in uptake of health assessments, some children wait for too long to have their health needs assessed. ([Recommendation 4.2](#))

4.5 We are aware that the issue of delayed health assessments has been escalated and discussed at a strategic level between health and local authority leaders and that it remains an ongoing issue of concern. We are also aware that there have been systemic issues relating to the implementation of a new electronic client management database. The administrators in the looked after children health team have all received some training in the use of the new client management system and will begin to use this from January 2017. It is hoped that this will enable them to retrieve request documentation in a timely way and reduce the time taken to allocate the health assessments to a practitioner although the impact of this cannot be assessed at this time. Nonetheless, these delays have prevailed for more than half a year without resolution and have led to too many looked after children having to wait for their health needs to be assessed and met.

4.6 There is a similar picture in respect of RHAs. Figures produced by HDFT show that only 18% of RHAs were completed within the statutory timeframe for the four months July to October 2016. We noted that 64% of those that were delayed were due to late documentation being received from the local authority and that 9% were due to a slow response from the practitioner allocated to carry out the assessment. As with the late IHAs, this means that the majority of looked after children in York are not having a timely review of their health needs. *This shortfall has been brought to the attention of public health at City of York local authority as the commissioner and provider of the 0-19 service who complete the review health assessments. ([Recommendation 4.2](#))*

4.7 The named nurse for looked after children in York has taken steps to address the delay in receiving completed review health assessments by introducing additional quality monitoring criteria on the health assessment quality checklist (known as 'Annex H'). The checklist now asks whether the assessment fell outside the statutory timeframe and requires the practitioner to provide a reason for any delay. This is a recent initiative and so its impact on timeliness of RHAs cannot yet be assessed.

4.8 It is encouraging to note that HDFT have responded to emerging findings from a CLAS review in a nearby area and have directed practitioners to schedule RHAs up to two months in advance where they know that a RHA is due. This will ensure that any delay in receiving the request documentation is minimised.

4.9 IHAs we examined were generally of a good quality with the assessor making use of information from a variety of sources. We noted that parental and sibling health history was ascertained and well documented. This is important as it enables many underlying health risks to be identified and planned for. Furthermore, IHAs contained good information obtained directly from the child or young person, often from seeing the child alone, and conveyed a good sense of the child as a person. This ensures that any plans made keep the child at the centre and acknowledge their wishes and feelings.

4.10 RHAs we examined were of a variable quality. Those completed by the specialist looked after children nurses generally contained a good level of detail, took account of a range of sources of information and conveyed a clear sense of the child. Those completed by health visitors and school nurses were less detailed and the voice of the child was less evident. This is discouraging since we have been advised that they have received training from the looked after children team in carrying out effective assessments. For example, one assessment of a four year old child showed that all of the conversation was conducted exclusively with the carer and not the child even though it was clear that the child was present at the time. *This shortfall has been brought to the attention of public health at City of York local authority, as the commissioner and provider of the 0-19 service who complete the review health assessments.* ([Recommendation 4.3](#))

4.11 Health action plans within IHAs were generally SMART with clear, achievable health objectives, realistic timescales and the identification of a person who is accountable for ensuring actions are completed. This was not the case for RHA's however, where timescales were frequently vague with a lack of a clear direction as to what was intended to be achieved. For example, one plan seen described a young person's smoking as a health issue with a corresponding action for health staff to discuss the risks with them on an 'ongoing' basis. Clear objectives to reduce smoking and a timescale for eventual cessation would have helped the young person, their carer and any identified health professionals to focus on a clear measurable and positive outcome.

4.12 Furthermore, not all information arising during the assessment was taken account of in the health action plan. In the assessment of one young person it was clear that he was having regular unprotected sex with his partner and there was reference, in the assessment, to the need to ensure he was aware of the risks of this. However, the health action plan did not mention this behaviour at all and contained no clear plan to manage any health risks. For instance, there was no time bound action to arrange any chlamydia or STI screening or for him to be given the opportunity to obtain condoms, action which would have both reassured him and supported him to prevent any infection or unplanned pregnancy. ([Recommendation 4.4 and 4.5](#))

4.13 Strength and Difficulties Questionnaires (SDQs) are not routinely used in either IHAs or RHAs although we have been advised that the request documentation is to be re-designed to include the SDQ score and that there are challenges in routinely receiving completed SDQs. This limits the opportunity to consider information taken directly from the child or young person to help them assess and track their emotional and mental health. ([Recommendation 4.6](#))

4.14 Practitioners undertaking IHAs and RHAs are required by the children in care team to complete a quality checklist, Annex H. This is designed to prompt the practitioner to consider key activity such as, for example, ensuring the child has an opportunity to contribute and that emotional and behavioural needs have been assessed. These are then reviewed by the named nurse or a member of the children in care nursing team against the checklist. However, as we have previously noted, the quality of RHAs was variable with a number of shortfalls. There was no evidence on the file or on the electronic patient records system that feedback had been provided to practitioners where those shortfalls were identified. The absence of a formal process for quality assuring health assessments and providing feedback does not support an improvement in practice standards and can lead to drift.
[\(Recommendation 4.7\)](#)

4.15 The looked after children's health service carried out an IHA audit on a small sample of cases in the last half year. This audit was based on the headings from Annex H and had identified a number of areas of practice that required improvement. These include the capture of the voice of the child, the record of the results of mother's screening for blood borne viruses and the identification of a person responsible for parts of the health action plan. In the IHAs we looked at we noted evidence of these improvements being made, evidence of the effectiveness of the audit in ensuring better outcomes. We are aware that this audit is to be repeated in the coming year and that there are plans to carry out a similar audit for RHAs.
[\(Recommendation 4.8\)](#)

4.16 Record keeping within the children in care service is disjointed. The service uses a multi-functional electronic patient records system designed to log all clinical contacts as well as correspondence and communications with clients and others. In the cases we looked at where the timeliness of assessments was an issue, none of the communications with the local authority to chase documentation or with health practitioners to chase the outcome of health assessments were recorded on the system. Instead, a paper based tracking system was used and this was filed elsewhere. This means that there is no central, accountable record of key contacts and there is a risk that important information could be overlooked.
[\(Recommendation 4.9\)](#)

4.17 The HDFT looked after children's team and Vale of York CCG take steps to ensure the 'voice of the child' is prevalent in service design. For example, a consultation exercise organised by the provider with the group of young people in care and care leavers known as 'Show Me That I Matter'. The purpose of this exercise was to ascertain the thoughts and ideas of young people to support improvements in the service. One such improvement was the production of a video aimed at young people in primary school and the first years of secondary school and using toy figures. The purpose of the video is to reassure young people about, and to ensure they understand the benefits of, participating in health assessments.

4.18 Health summaries have recently been introduced in the looked after children's service based on a passport model produced by the Coram Foundation. These have initially been issued to all children who are new to care and all those under five. There are plans in place to introduce these for children and young people over five, and particularly those aged 16 and above in the coming year although this has not yet begun. Such health histories are important as they provide a strong basis for young people to plan for their own health needs as they approach adulthood and leave care. ([Recommendation 4.10](#))

4.19 York hospital ED electronic patient record identifies children who are in care. This is managed and kept up to date by the safeguarding team at YTHFT. This allows frontline practitioners to be alerted to a more vulnerable cohort of young people who may present to the ED alone.

4.20 There is currently no bespoke specialist community CAMHS provision for looked after children in York. We are advised that a decision was made to decommission this specialist and dedicated service. Instead, children in care have access to the range of emotional health and wellbeing services offered in the area by a number of different providers in the same way as other children who are not in care. This means that the very particular emotional and mental health needs of this vulnerable cohort of young people are not prioritised and the current service offer is not compliant with NICE guidance.

4.21 We have seen a confusing and fragmented approach to the co-ordination and provision of CAMHS to looked after children. Records seen during the review indicate that the increased vulnerability of children in care is not considered or informing decisions regarding access to pathways. In addition, no health service had oversight of children in care who are waiting for or receiving a CAMHS service. The recent decision not to recommission a specialist CAMHS service has meant that there is now no care pathway for looked after children and the new contract for core CAMHS does not acknowledge the vulnerabilities within this cohort of children. Prior to this review the designated nurse had identified these concerns and work was underway with the provider to identify all children in care who were on a CAMHS waiting list in addition to ensuring that children in care are identified by the professional when referring into the new Single Point of Access (SPA). It was too soon to see the impact of this as the SPA was not yet fully operational during our review. However, the designated nurse has appropriately escalated concerns via the CCG and strategic partnership for children in care so that these issues are identified strategically and actions agreed to adequately address them moving forward.

4.22 Through record reviews this week, we have seen evidence of poor communication by CAMHS with the responsible case holder for looked after children. This means that some records do not holistically reflect the provision of health services, for example at review health assessments. This therefore limits the opportunity to review health needs and discuss and offer alternative support to the child or young person. ([Recommendation 2.2](#))

4.23 GPs are routinely asked to contribute to all IHAs. Engagement with GPs is reportedly very good with the majority of requests for information being responded to positively. However, in records examined we saw that responses were not routinely recorded in the electronic patient records system used in the looked after children service and so we could not be assured that GPs provided good quality information to support assessments. In addition, GP's we spoke with reported that communication between them and the HDFT looked after children's team could be refined to ensure that it was always benefiting the child. For example, ensuring all GP reports are uploaded to the electronic patient record in HDFT and that GP's ensure they understand the impact of a looked after children's health assessment in regards to flagging on records and when a subsequent review may be requested. *This shortfall has been brought to the attention of public health at City of York local authority as the commissioner and provider of the 0-19 healthy child service who complete the review health assessments. ([Recommendation 4.11 and 4.12](#))*

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 Senior leaders and designated nursing staff are active participants and contributors at the City of York Safeguarding children's board. The designated nurse for safeguarding children is a member of a number of the LSCB sub-groups, including CSE and neglect and in addition, is the chair of the case review sub group. There is good representation on the board sub-groups from nurse consultant for primary care and named professionals and leaders from provider organisations.

5.1.2 The development of a safeguarding children application is an example of innovative work as a collaborative project between the CCG, the commissioning support unit technical staff and the designated nurses for safeguarding children and children in care. An initial project launch to GP's was facilitated through the established safeguarding leads forum. Accessing the application means that practitioners in York can easily resource up to date contact details, national and local guidance and links to safeguarding boards in the area which can support timely intervention for vulnerable children, young people and their families.

5.1.3 The designated nurses for safeguarding and looked after children are visible to service users and staff. We saw examples of this through; attendance at the Children in Care Council (Show Me That I Matter) to develop health passports and work to encourage engagement by young people in their health assessments, development of training based on learning from serious case reviews from supporting practitioners to develop skills in challenging to development of innovative safeguarding children training 'simulation in safeguarding'. This ensures there is a clear thread between strategy and frontline delivery of safeguarding services.

5.1.4 The Designated Nurses have worked with colleagues in the CCGs and Partnership Commissioning Unit (PCU) to develop, negotiate and agree Safeguarding Children Local Quality Requirements (LQRs) for all the NHS Providers across North Yorkshire and York, together with a number of private providers.

5.1.5 Embedding the reporting against these LQRs via relevant Sub Contract Monitoring Boards (CMB) is a key priority for the Designated Professionals during 2016-17. As part of this extended role, the Designated Nurses are now attending relevant Sub CMBs in order to offer expert advice and challenge when provider safeguarding children LQR reports are presented.

5.1.6 The child sexual exploitation meetings do not yet fully support a multi-agency approach to supporting vulnerable young people. Primary care is not yet engaged and local area intelligence is not used to break down offender behaviours and contribute to health professionals understanding of risk. We have seen that this has already been identified as a piece of ongoing work by partners across the City of York. ([Recommendation 3.4](#))

5.1.7 Lessons learned from local and national case reviews are being used to inform policy and practice. Guidance for 'managing injuries to non-independently mobile children' has been fully ratified by the LSCB and a 'was not brought' policy is being developed. These practices and policies are not yet fully embedded so the impact is not clear. Commissioners provided assurance that although there may be changes to service models and providers, lessons learned locally and nationally, would continue to inform developments in service provision.

5.1.8 The primary care nurse consultant for safeguarding adults and children and the named GP have effectively developed some processes that support safeguarding children. Recent work includes the development of named GP and safeguarding practice lead forums, providing training on 'hot topics' and encouraging practices to complete the NHS England safeguarding practice self-assessment tool. GPs we spoke with told us that they consider the safeguarding lead forum a valuable resource to remain abreast of both local and national issues that might better inform practice and safeguard vulnerable people. It is also an information sharing forum for them to discuss practice with peers which can then be shared at individual surgeries. These processes optimise opportunities to share learning and improve practice.

5.1.9 The primary care nurse consultant for adults and children's safeguarding and the named GP for York have been effective in benchmarking, improving and communicating good practice in safeguarding children across York. For example, using the electronic records to support safeguarding work and developing agreed coding guidance for electronic recording systems. They are aware of the areas that need further development, such as; primary care representation at the monthly CSE meetings, consistent contribution to child protection conferences, development of regular defined liaison with community health professionals and full involvement in MARAC processes.

5.1.10 Health leaders participate in the bi-monthly 'City of York children in care strategic partnership' meetings with colleagues from the local authority. This provides the basis for developing joint policy and practice for children in care in York. Whilst this is a positive arrangement, the group is relatively new and has yet to make a significant impact on practice. For example, this group is currently steering the initiatives designed to mitigate the delayed health assessments and as stated previously, this issue has not yet been resolved.

5.1.11 There are effective reporting and governance structures to ensure the CCG are aware of safeguarding practice across York, including risks within provider organisations. The designated nurse presents a quarterly report to the CCG quality structures and meets bi-monthly with the chief nurse. We were assured that the designated nurses are involved in the scrutiny of tenders for NHS provision across York and through the quality meetings. As highlighted previously, the designated nurses can demonstrate how they have worked with provider organisations to improve the quality and compliance with safeguarding key performance indicators including safeguarding children training.

5.1.12 The York and North Yorkshire safeguarding children health professionals' network provides a forum for designated nurses to share national and local safeguarding developments. There is good representation from named staff in provider organisations. The networks cover new guidance, national, local and regional learning including serious case reviews and thematic inspection findings. This allows opportunities for safeguarding leads to be fully appraised of developments and supports critical thinking in their professional roles.

5.1.13 At the time of the review, frontline practitioners shared their anxieties about the changes in the configuration of the 0-19 healthy child service and how this could impact on vulnerable children and their families. Although staff were nervous about the future, we saw evidence of a committed workforce delivering services to families across the City of York. *This has been brought to the attention of public health at City of York Local Authority, as the commissioner and provider of the 0-19 healthy child service.*

5.1.14 Children and young people are starting to benefit from recent initiatives to identify and support their emotional health and wellbeing. The CAMHS executive group have recently reviewed their membership and terms of reference to pull together the CAMHS transformation plan and provide oversight on its implementation. This means that one multi-agency group has oversight of this work with sufficient capacity for challenge to improve service delivery.

5.1.15 The arrangements to safeguard children and young people within adult and child mental health services across York are developing and improving. Since the transfer of service to the new provider, work continues to introduce and embed improved safeguarding practice. We have seen examples of how the IT system used by TEWV has very recently been adapted to support identification and management of vulnerability, though it is too early to comment on the uptake of this by practitioners.

5.1.16 Practitioners across all services have told us that safeguarding teams are accessible and have proved to be an effective means of first line support to help to develop their practice and their thinking in safeguarding children. In most cases, this was reflected by documentation in records of practitioner's communication with the appropriate professional.

5.1.17 Access to services to meet the needs of minority groups is proportionate in York. For example, although York is recognised as not being ethnically diverse, midwifery practitioners at York hospital have access to 'The Big Word' language line to assist communication with families whose first language is not English.

5.1.18 The electronic client records system, is used effectively by CASH practitioners to record interactions, risk assessments and care plans pertaining to young people in their care. It is also used as an effective quality assurance and auditing tool by managers with a full audit trail available on all documents on the system. This allows opportunities to identify areas of practice that would benefit from development.

5.1.19 The CASH service complete safeguarding audits of client records that include reviewing whether there is a clear safeguarding plan in place, checking if social worker details are clearly recorded, emails are clear and that there is clear evidence of multi-agency communication. The nature of these audits allows senior manager oversight and opportunity to identify strengths and areas for development in service provision to vulnerable young people accessing the service.

5.1.20 There is good oversight of children's safeguarding caseloads in the adult substance misuse service. A weekly safeguarding report informs senior managers of all current safeguarding cases that practitioners hold. The report includes cases where risk is identified but the children are not subject to child protection measures. Client cases can only be closed by adult substance misuse managers who review the records to ensure every opportunity has been taken to ensure children to whom service users have access are well protected and that when appropriate other support services, are in place. This practice ensures senior managers maintain good oversight of cases where there is risk to children and young people.

5.1.21 The TEWV NHS foundation trust safeguarding team have a good central safeguarding structure that enables the trust to fulfil its safeguarding obligations across its large geographical footprint. An associate director of nursing (safeguarding) provides the accountable link to the trust board via the Executive Director of Nursing and this accountability is threaded into operational safeguarding practice through two regional teams, each lead by a named nurse. This provides the trust with the mechanism to develop and implement policy and improve practice.

5.1.22 The York TEWV safeguarding team is appropriately resourced with specialist safeguarding expertise available to adult mental health services and CAMHS. The York TEWV safeguarding team has a base in York for the named nurse, senior nurse and support from a safeguarding trainer. The named nurse position for the York locality is an additional resource since the change in provider. Staff we spoke with during our visit told us that the safeguarding team are accessible and have proved to be an effective means of first line support to help to develop their practice and their thinking around safeguarding children. Moreover, this level of safeguarding support, the extent of the safeguarding expertise and the emphasis on the 'think family' approach has been keenly noted by managers and staff to be significantly uplifted since TEWV were commissioned to provide the service at the end of 2015.

As we have noted elsewhere in this report, and as acknowledged by managers, there are still areas where further improvements are required to ensure the 'think family' approach is fully embedded into practice.

5.1.23 During our visit to adult mental health services, we noted that there are gaps in the operational oversight of safeguarding children practice. This means that there is a disconnect between the supervision arrangements provided by the trust's safeguarding team and front line practice. This was highlighted in two cases where a clear intention was noted in the records to seek safeguarding supervision but there was no supervision template completed and no other record in the case or activity notes that supervision had been sought or provided. Generally, managers are unaware of the extent of the safeguarding context of their team's case load. ([Recommendation 2.13](#)).

5.1.24 GP's we spoke with reported that they are well supported in the safeguarding children work, by designated professionals, the nurse consultant safeguarding children and vulnerable adults (primary care) and the named GP. This includes a safeguarding GP lead meeting chaired by the named GP and updates via the LSCB representatives on a monthly basis of local and national safeguarding information that might influence practice GPs. This reflects the robust arrangements to support Primary Care to improve safeguarding children in York.

5.1.25 In GP practices visited we saw that the use of codes on the electronic records is robust and well led. Safeguarding, child protection, child in need and child in care codes and alerts are used appropriately when the information is available to the GP practice. Achieving consistency across practices has been a significant piece of work undertaken by the nurse consultant safeguarding adults and children primary care, supported by the named GP. Local coding guidance has been developed and is supporting administration teams and health professionals that use the electronic records to identify and improve identification of vulnerabilities for children, young people and their families. In all cases examined we saw that it would be difficult for a user of electronic record not to be made aware of specific risks that had been shared with the GP.

5.2 Governance

5.2.1 In York hospital ED there is a lack of quality assurance of child safeguarding practice. The electronic patient record system does not aid managers to routinely review the quality of assessments undertaken for looked after children or those subject to child protection plans. ([Recommendation 1.6](#))

5.2.2 Safeguarding alerts are managed by the Safeguarding Children Team upon receiving notification that a child has become subject to a Child Protection Plan or if they have become Looked After. The alert is removed upon receipt of the relevant notification which is received via monthly updates from the local authority. This means that practitioners and managers can be assured that these alerts are the most relevant and up to date.

5.2.3 The electronic patient database in the ED does not contain mandatory children's safeguarding fields which means that children are not always discharged with the appropriate risk assessment documented. For example, the admissions form asks the clinician to consider whether the presenting injury could be non-accidental and we did not see an example of this having been completed in the records we examined. This means that children and young people may be discharged from the ED with incomplete risk assessments. ([Recommendation 1.9](#))

5.2.4 There is no paediatric liaison at York hospital ED. Practitioners notify school nurses of children's attendance when there are concerns however this limits the ability to identify repeat attendances. Health visitors believe they are notified of ED attendances however there is no assurance that they are notified of all attendances. The records we examined did not provide assurance that the processes within the ED are assessing for or identifying these presenting concerns and there is no audit of communication from ED to community health so it is not possible to be assured of what is being communicated. ([Recommendation 1.10](#))

5.2.5 YTHFT have undertaken a limited number of audits, spot checks and monitoring of child safeguarding practice or record keeping in the ED at York. This limits the opportunity to benchmark their effectiveness by identifying good practice and exposing weaknesses that require further development to improve standards. ([Recommendation 1.6](#))

5.2.6 YTHFT maternity services record keeping arrangements do not ensure that child safeguarding information is highly visible to practitioners using the record. Important information such as risk assessments and key safeguarding contacts are within the main body of the record and so are not easily identified or retrievable. This inhibits practitioners' from having clear, overt insight into safeguarding risks and increases the chance that the risks are overlooked. The record could be strengthened by the use of an index sheet that alerts practitioners to safeguarding risks and key contacts ([Recommendation 1.11](#))

5.2.7 Designated Nurses are supporting work between NHS England Project Leads for Child Protection Information Sharing project (CP-IS) and local provider organisations. However, limited progress has been made, so far, with regard to YTHFT. ([Recommendation 1.17](#))

5.2.8 Case discussions with maternity services and York teaching hospitals safeguarding teams are clearly recorded on a template. The form captures a detailed discussion and an action plan. However, the assessment and action plan is printed out by a member of the safeguarding team and brought to the unit to be included in the clinical record. This means there is a risk of a delay in action plans and assessments being documented in the patient record. ([Recommendation 1.12](#))

5.2.9 Maternity services in YTHFT use an electronic record system to manage appointments and scan documents. Risks posed to unborn children are not recorded on this system. This limits the ability of all staff to safeguard children, for example administrative staff who may primarily use only one of the forms of client record. ([Recommendation 1.13](#))

5.2.10 The 0-19 children's community health services (health visiting and school nursing) are undergoing transformation. The new 0-19 Healthy Child service is now provided wholly by the City of York local authority. The transfer of safeguarding leadership and governance arrangements is still work in progress with interim arrangements being in place at the time of our review. The interim arrangements for providing guidance, supervision and support are described in training and supervision below.

5.2.11 A newly appointed health visiting lead nurse for safeguarding will take up post in early 2017 to support the 0-19 service, undertaking the responsibilities of a named nurse as described in Working Together 2015 and the intercollegiate guidance. Importantly the role will also incorporate some of the functions of a health representative within the local authority's safeguarding single point of access. However, this will be confined to the management of information emanating from just the healthy child service and not the rest of the health economy as we have seen work well in other areas. This is a missed opportunity for local health providers to work together to ensure that information from all relevant health teams is available to the single point of access.

5.2.12 We are advised that capacity of the new 0-19 Healthy Child service is stretched, many health visitors are holding complex cases and we were unable to identify any clear mechanisms for monitoring case loads. *This has been brought to the attention of public health at City of York local authority, as the commissioner and provider of this service.*

5.2.13 The electronic records system used in the health visiting service is not used to its full effect with the standard of safeguarding record keeping being variable. We noted a number of instances where records were vague or not clear such as not detailing risk based information exchanges with children's social care. *This shortfall has been brought to the attention of public health at City of York local authority, as the commissioner and provider of the 0-19 healthy child service.*

5.2.14 The school nursing service will not have access at their base, to all records for children and young people on their caseload. This means that their ability to contribute to risk based discussions, such as strategy meetings, might be limited and could mean there is a 'start again' syndrome or drift in some cases, for example those cases that are not active at the time of base transfer, will not be summarised onto the electronic record. We have seen the negative impact of this method of record storage and access in the CAMHS and adult mental health services. *This shortfall has been brought to the attention of public health at City of York local authority, as the commissioner and provider of the healthy child service.*

5.2.15 Practitioners in the 0-19 healthy child service are not clear how they escalate concerns regarding safeguarding children practice within and outside of the City of York council. They are now commissioned and provided by the City of York council and so the governance structures that they previously accessed in NHS providers are not known to the frontline staff. *This has been brought to the attention of public health, City of York Local Authority, as the commissioner and provider of this service. ([Recommendation 3.7](#))*

5.2.16 TEWV's IT system continues to hinder the creation of a single patient record as identified in the recent Durham CLAS. The situation in York is compounded by a complicated approach to the transfer of CAMHS and Adult Mental Health records from the previous provider. This means that practitioners do not have ready access to any care record prior to the transfer. Instead, printed copies of electronic records are held off site and have to be requested which delays practitioners being sighted of safeguarding concerns. ([Recommendation 2.15](#))

5.2.17 Staff retention in the TEWV York CAMHS service is reported to be good. This means that despite a change in provider and the way that clients access the service, there is continuity for children and young people and a good organisational memory to support developments in practice. For example, it is reported that since the separation of the tier 4 CAMHS provider, there has been a change in relationships, that has affected sharing of soft intelligence and preparation of what the next steps might look like for a child, young person and family. Staff awareness of the structures in York mean that these issues can be addressed within an appropriate setting.

5.2.18 York adult substance misuse services respond to client feedback for example removing the logo 'Lifeline' from appointment cards making it more anonymous. This respects client confidentiality and promotes partnership working.

5.2.19 Service user feedback is well developed in the substance misuse service. A parenting programme has recently been put in place within adult substance misuse services which focuses on the impact of substance misuse on families. Feedback has been positive and there is evidence of a demand for the programme to continue to run. Service plans for the next year include an intention to run community events for clients, their families and stakeholders. Service user feedback and engagement, allows the provider to continue to consider their views in determining service provision.

5.3 Training and supervision

5.3.1 There are currently insufficient levels of paediatric trained staff at York hospitals ED. We were advised that there are four paediatric nurses and this means there are frequent occasions when there is no paediatric nurse on duty. There is a risk that children and young people do not have consultations with nursing staff trained to assess and meet their needs. It also means the opportunities for adult trained staff to develop their skills are limited because there are so few occasions when a paediatric nurse is on shift. ([Recommendation 1.14](#))

5.3.2 York ED relies on agency staff and locum doctors to maintain staffing levels. This poses a challenge to ensure that all staff are appropriately trained in the use of York hospitals systems to assess risk and safeguard vulnerable children and young people. ([Recommendation 1.15](#))

5.3.3 At York hospitals ED, staff compliance with intercollegiate guidance for safeguarding children training is approximately 85% which is an increase over the last two years from around 54%. This has been achieved despite a high turnover of staff.

Safeguarding training is provided using a 'modular' approach which staff can attend, particularly if the modules are relevant to their current role. This includes training to recognise and report domestic abuse, child sexual exploitation and neglect. There is an emphasis on reflective supervision taking place within the ED using case examples to better aid the supervision process.

5.3.4 Some YTHFT staff have benefited from 'simulation in safeguarding' training. This initiative has been led by the designated nurses for safeguarding and children in care. The training involves development of four key skills; observation, interpretation, documentation and communication through the use of life-size models which are 'made up' to represent a child that might be the subject of abuse and/or neglect. Practitioners interpret and record what they see and complete a handover of the risks. This skills-based learning takes place in groups and aids shared learning and it's impact was reported positively by staff.

5.3.5 Midwifery and other frontline YTHFT staff access mandatory reflective safeguarding supervision three times per year with two group sessions lasting for an hour and a half and a third lasting for two hours. Practitioners are offered a selection of supervision dates throughout the year which they can attend without having to pre-book. They are encouraged to bring cases to supervision for discussion and peer support.

Actions arising from supervision and any other relevant detail of discussions undertaken are recorded in client records and on a separate register maintained by the safeguarding team. Maintaining supervisory oversight ensures there is no drift or 'start again' cultures that may impact on practitioner response to a child or young person. When practitioners request one-to-one support in midwifery services then this is provided by the safeguarding team as and when required. Practitioners we spoke with advised us of the ease of accessing safeguarding support from the team. Midwives are accessing group supervision however the absence of a minimum number of 1-1 supervision session means that safeguarding leaders cannot be assured that individual cases are scrutinised and practitioners appropriately challenged. ([Recommendation 1.16](#))

5.3.6 The transfer of the functions of the new 0-19 healthy child service took place in April 2016. Safeguarding support has been provided by the previous NHS trusts (YTHFT and HDFT) until October 2016 but this has now ceased. Until the lead safeguarding nurse takes up post in January 2017, the local authority have interim arrangements in place for providing safeguarding guidance and supervision to staff. These arrangements incorporate a week-day office-hours telephone point of access and advice, staffed by a temporary post-holder. A supervision and advice pro-forma has been developed to assist this process and to guide the discussion and this is uploaded to the child's electronic record. However, the template does not fully support the exploration of complex safeguarding issues.

We have been assured by the new lead nurse for safeguarding that this process will be re-designed as part of the service's new approach to supervision so that such discussions can follow a more structured format and explore the different aspects of a child's development, family life, risks and protective factors. *We have brought this to the attention of public health at City of York local authority, as the commissioner and provider of 0-19 healthy child service.*

5.3.7 In addition to advice and guidance provided on request, safeguarding peer supervision takes place within health visiting and school nursing services every three months. Some staff members have received additional training in safeguarding supervision and facilitate the group sessions. Practitioners are obliged to attend three of the four sessions annually to ensure they have access to peer support, guidance and learning from cases that they bring for discussion during the sessions.

Risk factors, protective factors and a summary of the analysis by the group are recorded on a supervision template, along with any actions arising from the discussion and uploaded to the child's record. These actions are followed up at the next peer supervision meeting to check whether the practitioner had carried out the actions and to assess the impact on the family. We saw evidence of this process in the cases we examined in the health visiting service.

Whilst we acknowledge the benefits of this process to improving practice through peer learning it is not sufficient of itself to ensure individual safeguarding performance is challenged and improves as a result. The interim arrangements for providing advice and guidance on request has limitations as we have set out above and so the current absence of scheduled, formal, one-to-one safeguarding supervision means that complex cases held by staff do not currently receive an appropriate level of supervisory oversight and there is a risk that decisions are not properly tested. We saw examples of how child safeguarding supervision was recorded in the child's notes in the school nursing service. The standard was variable and was dependent on individual practitioners. In some records, it was difficult to illicit how the supervision was informing practice. This is particularly significant given the impending change in the way that the service is delivered and with that a likely change in personnel that are currently allocated to work with children and young people. *This concern has been brought to the attention of public health at City of York local authority, as the commissioner and provider of the 0-19 healthy child service.*

5.3.8 Health visitors and school nurses have received safeguarding children training that meets the requirements of level three intercollegiate guidance. We are assured that all practitioners were up to date with safeguarding training at the time the service was transferred to the local authority and that they will participate in a rolling programme of training from January 2017. In the interim, and as part of a recommendation from a recent learning lessons review, the local authority have been providing additional multi-agency training to health visitors, school nurses and social workers in in the use of the graded care profile; to date around half of the 0-19 workforce have received this training. Managers acknowledge that training in relation to CSE and FGM is underdeveloped and that this will form part of the new training programme from January. *The training needs of staff have been brought to the attention of public health at City of York local authority, as the commissioner and provider of the 0-19 healthy child service.*

5.3.9 Child safeguarding supervision for TEWV caseholding practitioners (adult mental health and CAMHS) is only mandatory for those who are working with a child who is protected through a plan. Records seen demonstrate that not all supervision is being recorded on the electronic patient record and this has the potential to limit the effectiveness of supervision and in implementing any agreed actions. The trust's amendments to the IT system will incorporate the supervision template. [\(Recommendation 2.16\)](#)

5.3.10 All adult substance misuse clinical practitioners, including qualified nurse practitioners, are trained to level three safeguarding children. Non-clinical staff are not restricted in their access to training and can also access level 3 training as it is seen this will support them with their work with families.

Adult substance misuse services have protected time when clinics are closed two hours every Thursday morning to allow for additional staff training. Training topics have included CSE and recognising the signs and symptoms of abuse which can continue to support their work and their ability to contribute to the wider priorities for safeguarding children and young people in York.

5.3.11 Safeguarding supervision is mandatory within adult substance misuse services. New members of staff receive supervision every week for the first six weeks, every two weeks for the first six months and every month thereafter. Supervision has recently been extended to allow for case file analysis and cases are further routinely audited by 'dip sample' to analyse if safeguarding opportunities have been missed. This indicates that new staff members are well supported in their role and practices can continue to improve through case learning,

5.3.12 All adult mental health service staff who carry out clinical or therapeutic work with clients receive safeguarding training at level three, whilst those who are not in client facing roles receive levels one and two training according to their role. Level three training is delivered as part of a rolling training programme delivered by the trust's (TEWV) dedicated safeguarding trainer, supported by band seven nurse specialists. This training incorporates core safeguarding skills and knowledge and is delivered in a multi-disciplinary classroom setting. Staff are further encouraged to access training provided by the city of York safeguarding children board. In-house training has recently incorporated the trust's new approach to understanding the impact of parental mental health on children and this is considered a strength.

Training compliance within adult mental health and CAMHS is monitored by the trust through managers using a risk rated matrix generated by the trust's training department and by the trust's safeguarding department. The data we have been shown by the trust indicates that attendance rates for those staff who require levels one and two training are relatively high. However, the latest data for those staff who require level three training is currently at 67%. We have been advised that this data reflects the change in training requirement since TEWV were commissioned to provide the mental health service in October 2015; in essence, staff are now required to access training annually instead of triennially as was required in the precursor organisation. We have been assured that the rolling programme is continuing and that those staff who have received training less recently are being prioritised. We are advised that the trajectory is for 95% of staff to be compliant with safeguarding training. ([Recommendation 2.17](#))

5.3.13 Safeguarding supervision in the adult mental health service and CAMHS takes a variety of formats. Staff can access the trust's safeguarding team for advice and guidance as and when this is needed for complex cases or situations in their cases. Staff we spoke with told that this support has been invaluable since TEWV began to provide the service at the end of 2015.

5.3.14 Formal safeguarding supervision takes place in CAMHS and adult mental health services every three months for those staff who are currently working with clients who have access to children subject of a child protection plan. This supervision is carried out on a one-to-one basis by the band seven safeguarding specialist nurses and is mandatory. This is good practice as it ensures specialist oversight, facilitates effective risk assessment and decision making and provides an appropriate level of professional challenge aimed at improving practice.

5.3.15 In adult mental health, Both formal supervision and occasional advice and guidance is documented on a supervision template on the electronic records system which requires a member of the safeguarding team to 'sign off' the record to ensure actions identified during the supervision have been taken. Again, this is good practice as it enables an effective audit trail of decisions to be kept although as we have noted below, this did not always happen.

5.3.16 For practitioners who are working with clients who have children subject of a lower level intervention, such as a child in need plan or FEHA arrangements, case discussion is expected to take place during clinical supervision sessions with a facility to escalate this to formal safeguarding supervision if concerns are identified or if the local intervention itself is stepped up.

5.3.17 Team managers are present during daily 'huddle' team meetings within adult mental health services during which staff discuss concerning features from their current caseloads or from their previous day's work with their clients. This enables managers to identify any safeguarding concerns and either provide, or direct staff members to obtain, additional support or guidance where necessary.

5.3.18 During our visit to adult mental health services we noted that there are gaps in the operational oversight of safeguarding children practice. Safeguarding referrals are not routinely copied or notified to team managers and so they are not always apprised of current or ongoing issues. There is no mechanism for managers to quality check any reports submitted for child protection conferences and there is no clear understanding of the extent of such cases in their teams. ([Recommendation 2.18](#))

Generally, managers are unaware of the extent of the safeguarding context of their team's case load, such as which clients have children who are subject of a child protection plan, child in need plan, early help arrangements or where there are other identified concerns. This means that there is a disconnect between the supervision arrangements provided by the trust's safeguarding team and front line practice. This was highlighted in two cases examined where a clear intention was noted in the records to seek safeguarding supervision but there was no supervision template completed and no other record in the case or activity notes that that supervision had been sought or provided.

Recommendations

1. York Teaching Hospitals NHS Foundation Trust should:

- 1.1 Work with the City of York Local Authority to develop effective communication pathways to universal health services to better support identification of needs, risks and follow up actions required for children and young people who attend the ED. When developed frontline practitioners across all agencies should be made aware of this new identified process.
- 1.2 Ensure the building, facilities and assessment and treatment arrangements at the emergency department at York hospital meet the needs of children as well as the Royal College of Paediatrics and Child Health (RCPCH) standards for children and young people in emergency settings.
- 1.3 Develop prompts within the adult casualty cards to support practitioners in consistently identifying and safeguarding the hidden child.
- 1.4 Ensure the casualty cards for children and adults are specific enough to support practitioners to consistently consider child safeguarding risks during a presentation to the ED.
- 1.5 Ensure all ED practitioners are aware of the ACHILD form and expectations for its use. Regular audit of its use will provide assurance that children and young people attending the ED have robust safeguarding assessments.
- 1.6 Undertake regular audit and monitoring of safeguarding practice in the ED to inform frontline practice and assure leaders of quality standards. For example, audit of safeguarding aide memoirs and referrals to children's social care.
- 1.7 Ensure practitioners in the ED obtain and record parental consent to refer to children's social care unless this could increase the risk of harm to the child. This is in order to support engagement with subsequent interventions.
- 1.8 Ensure that professionals are aware of the policy and national learning that supports the use and reasons for using electronic tags on babies on the maternity ward.
- 1.9 Ensure that regular audit captures staff training need to identify whether practitioners are consistently assessing, recording and appropriately communicating risks to children and young people.
- 1.10 Complete an audit of communication from ED to universal health services to provide assurance as to when these services are being notified of children and young people's attendances at the ED.

- 1.11 Ensure safeguarding information is highly visible in maternity records. This will aid practitioners timely understanding of client specific risk and key safeguarding contacts.
- 1.12 Ensure that safeguarding discussions and plans are recorded and added to maternal records contemporaneously so that all maternity staff are aware of the most up to date information to safeguard a child.
- 1.13 Implement a standard in maternity services so that practitioners are immediately aware of which records contain the context of the risk to the child or young person. This is so that it is clear which record contains the information pertaining to the most recent management of risk for the child or young person.
- 1.14 Ensure that in the absence of being able to recruit permanent paediatric nurses, adult trained nurses have access to paediatric specific courses so that they can confidently contribute to work with children and young people.
- 1.15 Ensure agency staff receive an appropriate introduction to safeguarding systems at York hospital.
- 1.16 Ensure that midwives have 1-1 supervision to allow opportunity for case scrutiny and challenge.
- 1.17 Ensure progress to link the organisation with the CP-IS project in accordance with national NHS contract, including accessing support from designated nurses to ensure the project moves forward.

2. Tees Esk and Wear Valley NHS Trust should:

- 2.1 Ensure that with appropriate client consent, the CAMHS service consistently shares information with the school nursing service regarding children and young people that are accessing the service including those children who are in care. This will help to inform children's ongoing care, assessments and plans.
- 2.2 Ensure that CAMHS identify children who are in care as part of the referral to the service. This is so that primary record holders and children in care caseload holders can be advised of outcomes of interventions or young people not brought to appointments.
- 2.3 Ensure that there is capacity in CAMHS to cover 'on-call duties' for ED and the paediatric ward at York Hospital at expected times of 1pm-9pm.
- 2.4 Ensure that in adult mental health services, safeguarding risk assessments are completed and or reviewed at identified points of the adults contact with the service. This will help to safeguard the hidden child beyond the initial assessment.

- 2.5 Develop the mandatory use of the 'PAMIC' tool in the adult mental health service to ensure it is used in every case when adults disclose that they have contact with a child or young person.
- 2.6 Ensure timely assessment of children and young people admitted to the paediatric ward awaiting CAMHS assessment to minimise effects of increased demand and decreased capacity to inpatients on the paediatric ward.
- 2.7 Identify a pathway with children's social care to ensure that practitioners are made aware of changes to child protection conferences and that lack of communication from children's social care is escalated to allow incidents to be appropriately addressed.
- 2.8 Ensure that all CAMHS practitioners are aware of the escalation pathway so that safeguarding risks to children and young people are addressed in a timely manner.
- 2.9 Ensure all CAMHS practitioners document a child protection plan within the client's electronic record so that it can inform the plan of care for a child or young person.
- 2.10 Ensure the adult mental health service document plans pertaining to safeguarding children in the electronic record so that it can inform the plan of care for the child.
- 2.11 Ensure that the adult mental health service discuss and record consent to refer to children's social care with adult clients unless this will put the child at increased risk of harm.
- 2.12 Ensure the adult mental health service record the referral and the reasons for referral to children social care in the electronic patient record to inform ongoing care and planning.
- 2.13 Ensure that managerial oversight in the adult mental health service includes a regular review of records to be assured that intended staff actions to safeguard children are completed and managers maintain oversight of risks within the caseload.
- 2.14 Ensure that GP's and out of hours GP services are aware of the CAMHS support and pathways that are available to children and young people in York to help meet their needs.
- 2.15 Adopt a record keeping system that is capable of being a single electronic record, including a facility for uploading documents.
- 2.16 Implement regular audit of supervision documentation in CAMHS and Adult mental health records. Including ad hoc supervision. For example, those children and young people who don't have child protection plans. This is to ensure that supervision is being recorded and that it is informing practice.

- 2.17 Ensure that trajectory of staff attending safeguarding children training is achieved.
- 2.18 Ensure that within the adult mental health service, there is an opportunity for manager oversight of safeguarding referrals to children's social care to improve standards and communication and timely access to services for children and young people.

3. Vale of York CCG should:

- 3.1 Further develop MARAC information sharing processes so that GPs are informed of the pending MARAC meetings regarding their patients and are requested to contribute as appropriate to the risk assessment by submitting a report or attendance at the meeting.
- 3.2 Ensure that the regular liaison between GP's and community health staff is defined and consistent across GP practices in York to ensure effective planning can take place for children as identified in a recent learning lessons review.
- 3.3 Work with the multi-agency partnership to identify a CSE screening tool to be used by health service providers to identify children and young people that are at risk of child sexual exploitation.
- 3.4 Ensure the engagement of all primary care at VEMT meetings so that they are fully contributing to the multi-agency VEMT processes across York.
- 3.5 Ensure that information sharing pathways with children's social care are clear to frontline practitioners so that GPs can effectively contribute to child safeguarding activity.
- 3.6 Ensure that work takes place with City of York children's social care to standardise the way in which GP's are invited to attend or contribute to child protection case conferences in order to allow an appropriate amount of time for a GP to attend or contribute.
- 3.7 Ensure that work is undertaken with the LSCB to provide assurances that frontline professionals and their managers are aware of and are using local escalation procedures when they are concerned about safeguarding practice and processes that impact on children and young people.

4. Harrogate and District NHS Foundation Trust should:

- 4.1 Ensure that the Looked After Children Team continue to work with CoY local authority to ensure appropriate access to the LA electronic systems. This will support improved timeliness of information sharing regarding children and young people who come into care and the subsequent timeliness of Initial Health Assessment.

- 4.2 Ensure the Looked after Children team continue to follow the health assessment escalation procedure, as agreed by the Strategic Partnership for Children in Care (SPCiC). Where it is established that this escalation procedure is not proving effective the HDFT Looked after Children team should escalate to the SPCiC, to the HDFT Safeguarding Children Governance Group and review the risk scoring on the risk register. With the effect that there is minimal impact to a looked after child. This established process should be used for initial and review health assessments.
- 4.3 Ensure professionals completing RHA's capture the voice of the child and this is scrutinised by the quality assurance tool.
- 4.4 Ensure that induction and training for professionals completing RHA's includes writing SMART action plans and that this is reflected by the quality assurance tool.
- 4.5 Ensure that health needs identified in assessment during RHA's are reflected by the health action plans and this practice is benchmarked and developed by the quality assurance tool.
- 4.6 Ensure completed SDQ's are used to inform all health assessments for children in care, as seen used well at IHA's for children and young people in York.
- 4.7 Ensure that all quality assurance processes are documented on the electronic patient record and any pertinent actions for practitioners taken to drive improvement in standards of health assessments.
- 4.8 Ensure that audit of IHA's and RHA's develops to facilitate benchmarking and improved practice for looked after children.
- 4.9 Ensure that all communication regarding provision of a child or young person's care is recorded on the electronic patient record. This is to provide an audit trail and to ensure key information is not overlooked.
- 4.10 Ensure that the specialist Looked after Children Team continue to support CoY LA CSC and the York Healthy Child Service in the implementation of Health Passports for all looked after children.
- 4.11 Ensure that GP information is informing health assessments for children in care undertaken by the HDFT Specialist Nurses for Looked after Children. When information from GPs is requested and not received, this also needs to be documented, monitored and escalated appropriately. The current practice does not allow HDFT to identify how engaged GP's are in the process.
- 4.12 Work with primary care colleagues to ensure that GP's are fully aware of the functions of the HDFT children in care team and associated information sharing processes.

5. Vale of York CCG and Tees Esk and Wear Valley NHS Trust should:

- 5.1 Consider and promote awareness of the resources available for children and young people to support their emotional wellbeing when they do not meet the threshold for tier 3 CAMHS services.

6. Vale of York CCG, Tees Esk and Wear Valley NHS Trust and York Teaching Hospitals NHS Foundation Trust should:

- 6.1 Work together to develop a formal perinatal mental health pathway that is NICE compliant and build on the strengthening relationships between maternity and mental health services.

Next steps

An action plan addressing the recommendations above is required from NHS Vale of York 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.