

Review of health services for Children Looked-after and Safeguarding in North Yorkshire

Children Looked-after and Safeguarding The role of health services in North Yorkshire

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

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

About the review

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

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

How we carried out the review

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

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

Our tracking and sampling also followed the experiences of looked-after children to explore the effectiveness of health services in promoting their well-being. In total, we took into account the experiences of 137 children and young people.

Context of the review

The latest published information from the Child and Maternal Health Observatory are those from March 2017. These figures are published by Public Health England at the time of writing this report and so they are used to set the context for the area; although the post-date the inspection by a week, they represent a more contemporary picture than the 2016 figures.

The data shows that children and young people under the age of 20 years make up 21.5% of the population of North Yorkshire with 7.8% of school age children being from a minority ethnic group. Generally, data shows that the health of children in North Yorkshire is better than the England average.

The proportion of children under 16 living in low income families is 11.9%, significantly fewer than the national average of 20.1%. Family homelessness is better at 0.7 per 1,000 as opposed to 1.8 for England. The number of children in care is significantly fewer with 35, as opposed to 60 per 10,000 for England.

The infant (aged 0 to 1 year) mortality rate is similar to the England average with 3.5 per 1,000 live births. The child (aged 1 to 17 years) mortality rate is also similar to the rest of England at 9.8 per 100,000.

The ChiMat data shows an overall better picture for the general health of children and young people in North Yorkshire with most of the attributes measured being similar to or significantly better than the rest of England. For example, immunisation coverage for all children is similar to the national average with the coverage for children in care being better than the rest of England.

Babies and young children have generally healthy weights with fewer children having a low birth weight and fewer children up to age 11 categorised as obese. Children's dental health is also better than the rest of England.

Under 18 conceptions are fewer than England whilst the number of teenaged mothers is similar to England.

Hospital admissions for young people with mental health conditions and for young people over 10 years through self-harm are both similar to the national averages. Admissions through alcohol related conditions or substance misuse are also about the same. Admissions through asthma are fewer than the rest of England.

A minority of the attributes measured are worse than the England average. For example, the number of children killed or seriously injured on roads, the number of children aged 0-14 and the number of young people aged 15-24 who are admitted to hospital with injuries is higher (worse than) the rest of England.

The Department for Education (DfE) provide annual statistics derived from outcomes for children continuously looked-after. As at March 2016, North Yorkshire had 305 children who had been continuously looked-after for more than 12 months (excluding those children in respite care), 45 of whom were aged under five.

The DfE data indicates that a smaller proportion of North Yorkshire's looked-after children (85%) had an annual health assessment than the rest of England (90.0%). The data also shows that 98% of looked-after children were up-to-date with their immunisations, better than England with 87.2%, whereas only 92% of looked after children had received a dental check compared with 84.1% in England as a whole. However, all (100%) of the looked-after children aged under five had received an up-to-date development assessment, better than the 83.2% for the rest of England.

The commissioning and provision of health care services for children and young people in North Yorkshire has a complex picture due to the large geographical area, the number of local authority districts and the coverage of the CCGs.

Commissioning and planning of most health services for children, including looked after children, are carried out by five North Yorkshire CCGs. Four of these (NHS Hambleton, Richmondshire and Whitby CCG, NHS Harrogate and Rural District CCG, NHS Vale of York CCG and NHS Scarborough and Ryedale CCG) collaborate in the 'Partnership Commissioning Unit' with responsibility for commissioning most of the children's health services across the area. This is known locally and collectively as 'North Yorkshire and York (NYY) CCGs', a term we have used in this report.

NHS Airedale, Wharfedale and Craven (AWC) CCG commission children's health services for the Craven local authority district to the west of the area. NHS Cumbria CCG are also responsible for health services for a very small rural population to the north and west of the Craven area. Health services commissioned by Cumbria located outside of the North Yorkshire area were not inspected as part of this review.

Specialist health services for looked after children are co-ordinated by Harrogate and District NHS Foundation Trust.

Acute health services including emergency care and maternity are provided by the following acute trusts:

- Airedale Hospitals NHS Foundation Trust (principally at Airedale Hospital but located in Keighley in the West Yorkshire area).
- Harrogate and District NHS Foundation Trust (principally at Harrogate District Hospital).
- Humber NHS Foundation Trust (at Whitby minor injuries unit – MIU – only). Whitby MIU was not inspected as part of this review.
- South Tees Hospitals NHS Foundation Trust (principally at Friarage Hospital in Northallerton).
- York Teaching Hospitals NHS Foundation Trust (principally at Scarborough Hospital). The York Hospital that serves people living in the Selby area was inspected as part of a recent review in the York local authority area so was not inspected as part of this review.

Community health services for children and families (health visiting and school nursing), are commissioned by Public Health at North Yorkshire County Council and provided by Harrogate and District NHS Foundation Trust

The child and adolescent mental health services (CAMHS) are commissioned by the CCGs and provided by Tees, Esk and Wear Valleys NHS Foundation Trust in most of the area and by Bradford District Care NHS Foundation Trust in Craven. These are the same arrangements for mental health services for adults. Specialist inpatient mental health services for children and young people are provided by Leeds York Partnership Foundation Trust, which are not in the scope of this inspection.

Contraception and sexual health services (CASH) are commissioned by Public Health at North Yorkshire County Council and provided by York Teaching Hospitals NHS Foundation Trust.

Child substance misuse services are commissioned by Public Health at North Yorkshire County Council and provided by Compass Reach. We did not inspect Compass Reach as part of this review. Adult substance misuse services are commissioned by Public Health and provided by North Yorkshire Horizons.

The last inspection of safeguarding and looked-after children's services for North Yorkshire that involved the health services took place in September 2009. This was a joint inspection with Ofsted. At that time, the effectiveness of the arrangements for safeguarding children were judged to be 'adequate' and those for looked-after children as 'good'. Recommendations for the providers arising from that review were considered during this review.

Ofsted carried out a single agency inspection of the local authority and the local safeguarding children board in April 2014 and were judged to be 'good'. We have taken account of the Ofsted findings during this review.

All of the principal providers identified above have been inspected by the CQC through the course of 2015 and 2016. The findings of those inspections in relation to children and young people have been considered as part of this review.

Health services in North Yorkshire follow the North Yorkshire Safeguarding Children Board (NYSCB) procedures for making referrals for children and young people who require additional services according to their level of need. Those levels are described by the NYSCB guidance for determining those levels of need as follows:

- Universal Services – where children have no additional identified needs and needs are met from services available to the whole population
- Prevention – where children might need additional support or guidance for a variety of issues and from a broad range of services that generally come within the meaning of ‘Early Help’
- Specialist – where children with more complex needs require more specialist or targeted forms of early help or a statutory level of intervention as a ‘Child in Need’
- Acute – where children require more complex, structured or intensive intervention, for example, in relation to significant harm.

All referrals to universal services are made direct to the services themselves. Any referrals for children who require additional support can be made to one of a number of local ‘Prevention’ teams across the area. Referrals for children with more complex needs are made to the North Yorkshire County Council Customer Contact Centre. The contact centre is a single point of access that screens all referrals and may choose to re-direct any referral to the ‘Prevention’ services or to a children's social care team for assessment. Referrals are followed up in writing within 24 hours using a universal referral form. During our review we considered the effectiveness of health services’ participation in these arrangements.

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 a child and parent in attendance at the Friarage Hospital emergency department (ED). When asked of their experience the young person told us;

“It’s been OK so far. I’m not sure what happens next but it’s quite nice here.”

The young person’s parent told us;

“We are just waiting to be seen now. I prefer it here than at the (name) hospital. I just wish they had a children’s ward here.”

A parent of a young child at Airedale Hospital ED said:

“We were seen pretty quickly (waiting 20 minutes). The staff are really nice; everyone has been really lovely. My worries about my child’s injury have been listened to. The waiting area is child friendly and safe.”

A new, young mother on the post-natal ward at Airedale Hospital told us:

“The care I have had is exceptional – all staff have been really caring and very respectful of my wishes.”

A new mother on the post-natal ward at Harrogate District Hospital said:

“When it became high risk, instantly I had one to one care and they stayed with me throughout the whole time which was really nice because it meant we had the same person by our side.”

The parent of a young boy with special educational needs and a disability who had accessed a range of services at Harrogate District Hospital said:

“It’s been a great service from start to finish. Right back to my local GP who was wonderful at the beginning supporting us and then all the different services who have seen my son. We’re really lucky to have all of them.”

The carer of three teenaged looked after children told us:

“I’ve always been satisfied with the service the children have had. They have always had their yearly health assessments and they always do it at home. I think they feel more comfortable having it done there and it gives them the confidence for when they get older to be able to talk about their health. The nurse would check out that they were happy to have it done and that they were ok, but to be honest I think they liked the attention.”

A 17 year old young person in care said:

“The School Nurse is really lovely. It doesn’t feel pressured and I feel open with her. She is a good listener and has given me advice about stuff, like contraception and leaflets which have been helpful. She has also talked to me about my weight and given advice on what I eat and how to make changes to the way I am. I can call her whenever I need anything.”

A 14 year old looked after young person told us:

“Some of my health assessments were done by a School Nurse and some were by a Social Services nurse. Sometimes I found that a bit confusing having to see someone else but other times it was good as you got to meet someone new. I’ve been to see the School Nurse a couple of times if I have hurt myself. She would take a look at it and then be really nice and ask what’s up and how I did it. She’d give me what I needed like a plaster or whatever. I am cautious about my weight but I didn’t know that I could speak to them about that as I want it to be kept in the house as it’s confidential.”

Another 14 year old young person looked after said:

“I had my last one (health assessment) in August. She (the looked after children nurse) came to the house, which I like, and did my weight and height, all the medical stuff and explained in detail why she was doing things. I used to have it at school which I didn’t like because it should be kept private but the last couple have been at home which has been better.”

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 Opportunities for identifying families that would benefit from early help are appropriately taken at the Friarage hospital midwife led maternity centre. This includes effective and timely liaison with health visitors both ante- and postnatal, and the use of relevant documentation to support hand over. For example, additional risk factors, such as teenage pregnancy, mental ill-health, substance misuse, or learning difficulty are identified at the point that women book their pregnancy care.

1.2 Midwives provide health visitors with early notification of the additional risk factors through the use of a health visitor liaison form. The documentation is updated through the course of the pregnancy and forms the basis of effective hand-over to the health visiting service which promotes continuing assessment of need.

1.3 The process also helps to inform plans made during pre-discharge meetings, which are also shared with other appropriate services such as substance misuse practitioners. This means that a woman's additional needs for extra support to help her care for her new baby are properly communicated across services and this enables effective continuity of care and the delivery of appropriate early help.

1.4 Of particular note is the good working relationship with family liaison and welfare services from the extensive local armed service communities with whom information about particular risks or additional needs is shared. This is an important local relationship as it helps to mitigate any risks to vulnerable women and their new babies within this large and diverse community.

1.5 It was not always clear in the records we looked at, however, where and how well the routine enquiry about domestic abuse is recorded; recording was inconsistent. Managers are aware of this and have just implemented new templated documentation to enable midwives to specifically record this enquiry in the woman's hand-held record. It is too early to assess whether this has helped midwives comply with relevant guidance on this. [Recommendation 1.1](#).

1.6 At Harrogate maternity we saw evidence of early assessment of impact on the wellbeing of mother or the unborn child due to increased vulnerability through domestic abuse, substance misuse or mental illness. This early assessment is enabled by the completion of a 'Maternal / Partner Profile' form for all women. Any identified additional needs results in the use of a maternity safeguarding record to support additional work. Good protocols are in place to facilitate the management of the care of vulnerable women by case holding midwives with oversight by the named midwife or the public health midwife. This enables a consistent approach to be taken and a general increase in the safeguarding expertise of staff.

Good practice example

One of the cases we looked at identified a strong approach to joint working to support and protect a mother and her unborn baby within Harrogate maternity services.

The maternity records provided a detailed summary of the history and areas of risk due to the woman's substance misuse and experience of domestic abuse.

A referral was made to children's social care following her first appointment in order to trigger early intervention work. A joint visit was undertaken with the family outreach worker (employed by the local authority) and liaison took place with the substance misuse service.

Consultation with the named midwife helped the case-holding midwife to understand the woman's evolving complex needs and the risks of domestic abuse.

Information was shared with other services on an ongoing basis and the woman continues to receive additional services to support her in preparing for the birth of her baby.

1.7 Pregnant teenagers using the Harrogate maternity services are supported by an allocated community midwife and have access to an eight week children's centre based programme. This programme is jointly run by the community midwife and teenage pregnancy health visitor. The rolling programme covers learning about pregnancy but also equips young mothers-to-be with the means of accessing appropriate benefits and building support networks. This is a positive initiative to support this vulnerable group of women to maintain a healthy pregnancy and build understanding of their future parenting role.

1.8 A review of maternity records in Harrogate, however, did not offer assurance that a routine enquiry about potential domestic abuse is being asked on more than one occasion. This practice does not take account of the fact that such risks evolve, and can increase through pregnancy. [**Recommendation 2.1**](#).

1.9 Expectant women in Scarborough book their pregnancy care with midwives, usually in GP practices, children's centres or clinics operating within the local area. Details of the pregnancy are shared with health visitors at 28 weeks. Cases we looked at during our visit to the Scarborough Hospital maternity unit, however, indicate that assessment of risk is not always robust. There is an over-reliance on standard risk assessments for social vulnerability and these are not repeated through pregnancy as required by trust policy. There is no evidence of any enhanced assessments, such as early help assessments for expectant women with additional vulnerabilities. Furthermore, routine enquiries in relation to potential domestic abuse are not always carried out and not all women are seen alone. This means that women with additional needs are not well identified and their timely access to further support may be delayed. [Recommendation 3.1.](#)

1.10 We saw evidence of vigilance to the risks of potential domestic abuse in the Airedale hospital maternity service including effective information sharing with health visitors. We also noted some good use of alerts on the hospital electronic patient records system to flag safeguarding concerns and of the 'pink' safeguarding forms for the same purpose in paper records. However, the effectiveness of this is not fully embedded and in some cases key information is overlooked or not taken account of due to the impact of reconciling the use of both electronic records in the hospital and paper records in the community. Our review of cases indicated that risks of domestic abuse, of maternal mental ill-health or of previous history of abuse are not always fully understood due to incomplete assessments. We are aware that there are plans to implement one common electronic system across the whole maternity service, which will support consistent assessment and record keeping. However there is no current timescale by which this system is to be introduced. [Recommendation 4.1.](#)

Assessing risks in maternity

In one case we looked at in Airedale maternity, concerns about alcohol and substance misuse of the mother and her partner were appropriately flagged, as well as concerns over mother's history of anxiety and depression.

However, key information about mother's mental ill-health, of the involvement of a mental health support worker and of a previous history of childhood trauma and neglect that were evident in the records relating to an earlier pregnancy had not been sufficiently explored or incorporated into the woman's current assessment.

In another case we looked at, a mother had renewed an earlier relationship with an abusive partner and there was a history of a previous child being adopted.

Although domestic abuse risks had been flagged as a concern, there was no domestic abuse risk assessment on the record and the midwife's contribution to multi-disciplinary planning work was not clearly shown.

In both of these cases, the records did not provide an up to date picture of risks to help safeguard the unborn child and inform birth planning.

1.11 The main challenge to the effective delivery of the healthy child programme's mandated contacts is the coverage of antenatal visits. Operational managers advised only around 57% of women benefited from antenatal visits at the time of the inspection. Performance in antenatal contacts was negatively impacted by inconsistent notification of pregnancies from midwifery services in each of the acute trusts. Efforts have been recently directed towards the consistent use of a newly devised information sharing protocol, intended to ensure timely notification from maternity teams to health visitors. The protocol has been shared through informal staff networks only at this time and this limits its impact across the variety of providers in North Yorkshire. [Recommendation 13.1](#).

1.12 Positively, health visitors are actively involved in referring, assessing and leading early help interventions for children and families. We have seen examples of the positive impact of the engagement with the Prevention team which facilitates transparent packages of support for children and families accessing early help. This engagement is underpinned by a weekly case meeting chaired by the Prevention team manager and attended by health visitors, family outreach workers and school nurses. Multi-agency discussions ensure that the child and family are allocated to the most appropriate professional to lead the package of support and provide the means for reviewing ongoing work with open cases.

Good practice example

In one of the cases we looked at we saw that the health visitor had carried out an antenatal visit at an address where the expectant mother was living whilst she awaited a housing allocation. Conditions were noted to be so poor that the health visitor judged the dwelling to be unsafe for a newborn baby.

A referral to children's social care was made that appropriately detailed the risks to the unborn child and the health visitor was tasked by the Prevention team to complete a joint visit with the family outreach worker to enable an assessment to be undertaken and support relocation to a safer home. Whilst the outreach worker facilitated contacts with the housing department, the health visitor undertook weekly visits until the baby was born in order to promote the mother's good health and the continuation of the delivery of care afterwards.

The evolved package of care includes the offer of a more suitable property, support from a children's centre, help with financing and budgeting and continued additional visits by the health visitor. This has maintained the positive outcomes achieved as a result of intensive work before and after the birth of the new baby and demonstrates the effectiveness of this joint work.

1.13 We also learned of the ‘young parenting programme’, a new service offer in North Yorkshire delivered by health visitors and supported by family outreach workers. This has been developed in response to an increase in teenage pregnancies and the decommissioning of the family nurse partnership programme. A specialist health visitor holds a caseload of young parents and offers support and guidance to health visiting teams when they work with young parents. A support worker from the Prevention team offers a minimum of five visits as part of the pathway. It is too early to measure the impact of the programme, although there are plans to formally evaluate it against pre-determined outcome measures.

1.14 The practice of routinely making enquiries of women about whether they are experiencing domestic abuse is underdeveloped in the health visiting service. In most records we looked at there was no record of this question being asked. Further, no record is made if the question is not asked due to the circumstances, such as if the woman’s partner is present. This limits the opportunities to identify any additional support for the woman and to safeguard her young child. [Recommendation 2.2.](#)

1.15 Health visitors are not routinely notified of incidents when police have contact with children, for example when there is an incident of domestic abuse. ‘Operation Encompass’, an initiative intended to inform key adults at a child’s school about domestic abuse incidents, is soon to be rolled out in the local area. At the moment, the capacity of the health visiting service to identify cumulative risks to young children and families is limited. [Recommendation 2.3.](#)

1.16 The 5-19 service provides all schools with a named school nurse. This offer extends to ‘drop in’ sessions at secondary schools where advice can be provided on topics such as healthy relationships and emergency contraception. Young people are also offered more targeted work on specific topics such as healthy eating and emotional wellbeing. Young people are signposted or referred onwards from these sessions to more specialist services. This work, carried out by healthy child practitioners, enables children and young people to receive appropriate guidance or support for a variety of needs at their school; an accessible and convenient location.

Good practice example

The 5-19 service use information from year-6 screening to deliver targeted work on areas that children have raised as a concern to their health. For example, data from 2015 to 2016 screening in one locality highlighted a significant number of children recording headaches as an issue. An after school session was offered to the children by the healthy child practitioners and family support workers from the Prevention team on hydration and healthy eating. This was a positive use of data to deliver creative targeted work to a cohort of children with specific needs and to support their ongoing physical health.

1.17 Links between the 5-19 service and the CAMHS have been developed to assist the service in supporting children and young people with their emotional health and wellbeing where they would not ordinarily warrant an intervention by the community CAMHS. Joint development training days are held to increase understanding of the roles of each service. The 5-19 service practitioners have also been supported by management to access a university based multi-agency course on 'Mindfulness and Resilience'. This is a positive initiative to increase the skills of practitioners in supporting an increasing number of children presenting with emotional wellbeing issues as identified in the 2015 to 2016 year-6 screening.

1.18 All attendances at the hospital emergency departments (ED) of school aged children received by the 5-19 service are reviewed by an experienced practitioner and assessment made as to the need for any follow-up action. Healthy child practitioners undertake targeted work for identified issues, including asthma advice, minor illness care and advice following alcohol intoxication. This ensures young people are supported in the most appropriate way following their attendance.

1.19 At both Friarage ED and Airedale, ED systems are in place to ensure the wider social circumstances of children are properly explored and recorded and that GPs and community teams are alerted of a child's attendance. This is particularly so for children who are removed from the ED prior to being seen. GPs, health visitors and the 5-19 service are automatically notified through the electronic patient records system and this enables the child or family to be followed up without delay. For example, we noted good use of the electronic system by ED staff at Airedale to share concerns and ensure follow up care to a seven month old baby who had presented with shortness of breath and who was removed by a parent before being treated. Our review of the record showed that this information had been shared with the GP and health visitor and that the GP had seen the baby the following day.

1.20 At Scarborough ED all attendances of young people under 18 are screened by a safeguarding nurse and passed to health visitors or the 5-19 service to consider additional support. At Harrogate ED, a paediatric liaison health visitor is employed three days each week to undertake this role and share information about children and young people who attend. Thus, children and young people across North Yorkshire who go to all four hospitals for urgent care are assured of this being notified to primary and community services for follow-up action where required.

1.21 In Scarborough ED, the dedicated paediatric liaison nurse role provides positive, retrospective scrutiny of children's attendances, although gathering information at the point of attendance is less robust. An increasing number of children who attend Scarborough ED benefit from a systematic approach to identify safeguarding concerns with a tool using a mnemonic; 'A Child'. The trust's safeguarding team have worked hard to embed the tool, reintroduced recently following the learning from a serious incident. However, children do not always have details of their reason for attendance and the identity of the person who came with them captured at the earliest opportunity. Most records we looked at did not have this important information recorded at the time of booking in. Instead we noted a reliance on the clinician carrying out the triage to obtain this information. This restricts the opportunities to identify conflicting details early. [Recommendation 3.2.](#)

1.22 We looked at other cases in Scarborough ED and in the Minor Injuries Unit (MIU) provided by Yorkshire Doctor Services (Vocare Limited). A robust approach in the identification of the 'hidden child' was not evident in either unit in relation to adults who come to hospital with risky behaviours such as substance misuse or mental ill-health. Electronic records do not support the recording of details of children and do not prompt practitioners to explore this with patients. This means that children at risk or with additional needs arising from adult or parental behaviour could be overlooked. [Recommendation 5.1.](#)

1.23 At Harrogate ED the documentation used for booking children into the hospital allow for parental details or the identity of an accompanying adult to be noted, although this information is completed inconsistently. On two of the records we looked at we saw that parents and siblings details were recorded, but on the remaining seven we considered during our visit, these details were missing. Two of the records were marked as 'N/A'. [Recommendation 2.4.](#)

1.24 Further, a safeguarding assessment of children and young people attending Harrogate ED is not consistently carried out. For example, a young person was brought by ambulance to the hospital following his parents' concern of his level of consciousness when collected from a party where he had become aggressive. The records noted the medical care and observations. However, safeguarding risks, such as the bruise to his face, were not effectively explored and the history on this was brief. In addition, the records did not evidence the 'child's voice' as it was not clear to what extent the young person had been included in his assessment or whether he had had the opportunity to provide his own history. [Recommendation 2.5.](#)

1.25 We looked at three records in the Harrogate ED where adult behaviours could have had an impact on children. None of these records noted whether the person had responsibility for a child. The documentation used for adult ED patients does not prompt practitioners to make this enquiry and so there are missed opportunities here, as with Scarborough, to identify and safeguard the 'hidden child'. [Recommendation 2.6.](#)

1.26 Children and young people attending the Friarage hospital ED are directed to a separate reception area away from the adult area. Children wait in a dedicated waiting area for nurse triage away from adult patients. Children and young people are triaged by a nurse in a room that is also separate from adult assessment areas and there are two dedicated paediatric bays where those children can be treated. This is good practice. Further, young people aged between 16 and 18 (and young people with a learning disability up to 19) are given a choice as to whether they would like to be seen in the adult or children's ED. In this way, the environment for the entire urgent care pathway experienced by children and young people is welcoming and child focused.

1.27 Similarly, the ED in Airedale hospital has a dedicated children's waiting area. This is valued by parents and provides a safe, child friendly environment whilst they are waiting to be seen.

1.28 The children's waiting area at Scarborough ED is small and only suitable for young children. Although a window has been installed to increase visibility it is still not possible for children to be easily monitored. There is also no sign to prompt adults attending with children to alert staff if their child becomes suddenly unwell and so a child whose condition is deteriorating may be missed. [Recommendation 3.3](#).

1.29 Infants attending the Scarborough ED are not routinely weighed as there are no paediatric scales in the department. Apart from inhibiting weight calculation for accurate prescribing, it also limits the effective monitoring of growth and the overall assessment of very young children's needs. [Recommendation 3.4](#).

1.30 In the CQC inspection of Harrogate hospital in February 2016 a number of issues relating to the compliance of the children's ED environment with the relevant guidance on children and young people in urgent care settings. We are aware that a building programme is due for completion by March 2017 which will increase ED cubicle capacity and will ensure a children's cubicle is routinely available. The children's waiting area at Harrogate is segregated from the adult area by a wall and is not a closed area. Neither is it within sight of the nurses' station, triage nurse room or reception area and so staff are not well placed to observe a deteriorating child or parental interaction while they wait to be seen. [Recommendation 2.7](#).

1.31 The community CAMHS provided by TEWV in most of the geographical area of North Yorkshire provides consultation and advice to early help practitioners. The processes support the managed step-up and step-down between themselves and, for example, the healthy child team or the Vulnerable, Exploited, Missing and Trafficked (VEMT) processes. Children are directed to the most appropriate intervention early through triage at the CAMHS single point of access (SPoA) and we saw examples showing that this is effective practice. Practitioners told us they feel this process could be strengthened by incorporating the SPoA into the multi-agency safeguarding team (MAST) front door arrangements so as to improve the case discussion between the CAMHS and the Prevention teams although it is not clear if there is scope to develop this idea further. [Recommendation 6.1](#).

1.32 The Craven CAMHS provided by BDCT is focussed and responsive to the needs of young people who would benefit from early help services. The service's primary mental health worker is used as a flexible consultation and referral triage so that referrals that do not merit community CAMHS intervention are referred into appropriate early help. In addition we noted the effectiveness of the bespoke IAPT provision known as 'My Wellbeing College' offering educational courses in stress and depression as well as CBT. This is particularly beneficial for older teenagers up to age 18, who might not go on to transition to adult services.

1.33 The 'think family' model is very well embedded in the North Yorkshire Horizons (NYH) substance misuse service. Clients undergo a comprehensive, family focussed assessment. The assessment includes the number of children under 18 currently living with the client or with whom they have contact. In cases we looked at we saw that the assessments were thorough and that the client's family composition was consistently recorded along with details of children's dates of birth and ongoing social care involvement.

1.34 A home visit is often included in the assessment depending on the age of the child or the level of concern identified. The local shared care arrangements with GPs ensure that the service can share information when necessary and that clients have access to GPs and other community services. This also means that clients have access to a range of locally delivered programmes offered by the service such as the 'Through My Child's eyes' educational programme which enables clients to understand the impact of substance use on their children.

1.35 In the adult mental health service provided in Craven by BDCT, 'think family' is well established. Children and young people are identified early in the assessment process and the focus is maintained throughout the client's period of care. In the service provided by TEWV in the rest of the area, children and young people are readily identified through assessment at the point of access. In TEWV it is encouraging to see an improving picture in maintaining a focus on children of clients in comparison to recent reviews of other areas where TEWV is the provider. In both trusts, we saw active involvement of practitioners in early help processes with documented attendance and contributions to team around the family (TAF) meetings.

1.36 An open and welcoming environment for young people within the all ages integrated sexual health service is actively promoted. Receptionists are aware of their safeguarding responsibilities and are vigilant in identifying risks. Scenario based supervision has enabled staff to spot and report concerns to the examining clinician.

1.37 There are no young person-specific integrated sexual health clinics in North Yorkshire. However, the Specialist Clinical Outreach Team (SCOT) provides a range of targeted support to young people in the place they prefer such as at home, local clinics and at school. This enables young people who might find it difficult to access such a service to maintain good sexual health and increases the opportunity of the service to assess additional needs and any risks.

1.38 The SCOT team, together with school nurses and the youth justice team recently piloted a new approach to support young people involved in the criminal justice system. Outcomes from the work have included improved access to childhood immunisations, dental care and vision checks, with clear pathways in place to address health, wellbeing and safety risks relating to sexual health and substance misuse. This is a strong new approach to reducing the health inequalities experienced by these young people.

1.39 In the GP practices area we visited within the NYY CCG we noted that information sharing arrangements between practices and community health teams was generally well established and strong in most cases. For instance, in one practice the regular meetings with health visitors are recorded and this enables the practice to keep track of further work with families from meeting to meeting.

1.40 In another practice, notifications from the ED are routinely monitored by staff who are vigilant to trends in, for example, repeated attendances or children who were removed before being seen. Overall, the generally robust approach to monitoring, discussing and recording information about vulnerable children ensures that GPs have good insight into the needs of children, young people and their families in their patient list and are able to direct the provision of early help.

2. Child in need

2.1 In the Friarage hospital maternity service, midwives are attuned to the specific needs of travelling communities and have developed ways of working, including enhanced supervision, to provide appropriate care and support to young mothers where community sensitivities might exist. This good practice enables such young women to remain engaged in maternity processes leading to better outcomes for them and their new born infants and we saw examples of this during our visit.

2.2 Relationships between maternity services at Friarage hospital and the community mental health service are reported to be generally good, and we noted examples where this had enabled information sharing to take place. However, generally, arrangements to support women who are mentally unwell during pregnancy are not well developed in North Yorkshire. There is no clearly defined peri-natal pathway that fully meets the requirements of the relevant Department of Health commissioning guidance and the NICE clinical guidance.

2.3 Airedale hospital midwives have received additional training in peri-natal mental health, although local arrangements are not yet supported by the appointment of a consultant psychiatrist. Therefore, women who are mentally unwell during pregnancy receive a service that does not benefit from this key area of clinical leadership and this can lead to deficiencies in the co-ordinated approach between the maternity and the mental health services. For example, in one case we looked at we saw that a woman was being supported by the adult mental health 'Living Well' team and that there was some involvement of the CAMHS with an older child. However, the case record did not show any contact with the mental health team or the GP in relation to mother's current mental health.

2.4 A recent project driven by TEWV and operating in Harrogate and Scarborough, enables expectant women with mental ill-health needs to access a weekly IAPT clinic. Women are progressed through the service in shorter timescales to assessment and treatment. A facility also exists to prioritise women who are more acutely unwell into the community mental health teams although we did not see any examples of this and understand such occasions are not common. The project, which is soon to be adopted within the rest of North Yorkshire, within the TEWV footprint is not well defined and there are no clear measurable outcomes or indicators of success. This offer is limited and there is a risk that women who are particularly unwell during pregnancy may not be properly supported in managing their mental health and therefore present a risk to their unborn baby.

[Recommendation 7.1.](#)

2.5 In the Airedale maternity service, there are gaps in information recorded in the maternity safeguarding records about women's social situation and about family members, including fathers and siblings. For example, in one record we noted that the history of cannabis use by the woman's partner and the risks to the unborn baby associated with homelessness were not well recorded even though it was recognised that the family were known to children's social care. It was also not clear what contact had been with the social worker or the health visitor. Such gaps in information means that any additional needs may not be properly identified or that plans are not fully informed. [Recommendation 4.2.](#)

2.6 In Scarborough maternity, as well as the limited peri-natal mental health support, there are no specialist midwives for substance misuse or teenage pregnancy so all women with additional needs are cared for by community midwives. In addition, the YTHFT teenage pregnancy pathway for Scarborough is out of date and refers to key posts that no longer exist. In addition there are no routine opportunities, outside of formal child protection processes, for multi-agency discussion to share and co-ordinate care for those expectant women when such additional vulnerabilities are identified. [Recommendation 3.5.](#)

2.7 Children and young people attending the Friarage hospital ED in mental health distress and with injuries have their immediate clinical needs met prior to a referral being made for a CAMHS assessment. On the rare occasion that a CAMHS assessment needs to be carried out at the Friarage hospital then this is undertaken on the short stay paediatric assessment unit if deemed appropriate. Those in acute mental health distress who require admission to a paediatric ward, or who present out of hours, are taken by emergency ambulance to the James Cook University Hospital (JCUH) in Middlesbrough. Here, there is 24 hour CAMHS provision and paediatric staff have received additional training in the care and support of patients who are emotionally unwell. This ensures that young people in the North of the area receive care and support that is designed specifically to meet their needs.

2.8 CAMHS, adult mental health and alcohol nurses are reported to provide good support to the ED at Airedale hospital enabling young people and their families to benefit from timely, specialist support. BDCT provide mental health advice and support 24 hours-a-day, seven days-a-week through a 'first' and 'second' line on-call response, and the ED has a quiet room so that young people can be seen away from the otherwise anxiety provoking environment.

2.9 Young people who present with mental ill-health, self-harming behaviour and overdose risks are routinely risk assessed prior to their admission onto the paediatric ward at Airedale. The application of this good practice is inconsistent, however, as is illustrated by the differential recording of such risks between the ED and the paediatric ward in one of the following case that we were tracking across services.

2.10 The ED records of a 16 year-old child who had taken an overdose and self-harmed clearly identified who had parental responsibility and that the child was no longer attending school and under the care of CAMHS. A check of their health history highlighted a longstanding anxiety disorder. Safeguarding screening was undertaken with appropriate liaison with CAMHS. Domestic abuse risks to the child's mother were clearly recorded, including the impact on the child. The overall assessment was comprehensive with good recording of the voice of the child and their personal ambitions and this enabled the staff to devise a clear management plan, which included admission to the paediatric ward.

2.11 This approach was not as robust in the paediatric ward where we noted some gaps. We noted good use of the safeguarding pink form to build on the picture of the initial risks identified in ED. Once again there was a strong focus on the voice of the child and recording of the home circumstances and parental relationships.

2.12 However, in one case we looked at there were gaps in recording of mental health risks arising from a child's harming behaviour. Whilst cutting to upper limbs was referred to in the case notes, it was not detailed on a body map and the nature, severity and stage of healing was not clear; this would have helped other staff on the ward to better understand the extent of the child's needs. [Recommendation 4.4](#).

2.13 Furthermore, the referral made to children's social care provided limited analysis of the risks. The parental risks and protective factors were not sufficiently detailed given the level of information that staff were already aware of. This prevents the recipient of the referral from clearly understanding what the young person's needs are. [Recommendation 4.5](#).

2.14 Children under 16 identified by Scarborough Hospital ED with additional mental health needs who require transfer to the paediatric ward have their needs clearly identified on an enhanced transfer form. This includes details of any safeguarding concerns, including the risks of self-harm, substance misuse, harm to others or behaviour disturbance. This is good practice as it enables practitioners who receive the young person on the ward to manage their care safely. However, this good practice does not currently extend to young people aged 16–18 who are transferred to adult wards and do not benefit from the same enhanced communication. This is acknowledged as a gap by the ward sister and the named safeguarding nurse who have undertaken to extend this enhanced processes and documentation for older young people with immediate effect (see also our note in 'Governance' below). [Recommendation 3.6](#).

2.15 Whilst the transfer of children under 16 with emotional and mental health needs is generally well managed, the needs of children and young people who self-harm are not adequately met when they are admitted out-of-hours or at weekends. Children are admitted to the ward and are cared for by paediatric nurses who have not received any additional training in assessing risks to their safety or in creating care plans that meet their emotional and mental health needs. Further, there is limited coverage by CAMHS staff during these out-of-hours periods and this leaves children and young people without the most appropriate support at this time.

[Recommendation 8.1.](#)

2.16 As with Scarborough, the CAMHS teams provide assessment and support to young people in mental health distress at Harrogate hospital between 9am and 5pm, Monday to Friday. This means that should a young person attend the ED outside of these hours in mental health distress then they will be admitted to the paediatric ward to await an assessment at the next available opportunity. This can result in young people being located on the ward over a full weekend, and this too, means their needs are not being appropriately met. **[Recommendation 8.1.](#)**

2.17 We should acknowledge that a project has recently begun as part of NHS England's Urgent and Emergency Care Vanguard that is intended to provide greater coverage for the mental health crisis response for children and young people in North Yorkshire. The project eventually aims to provide a four-hour assessment timescale to children and young people up to 18 years old who present in urgent care settings. The project is in its implementation phase at the time of our review and, although this is an encouraging initiative, we cannot assess its likely impact in meeting the acute needs of young people in crisis at this time.

2.18 The transition of the care and treatment of young people with mental ill-health in North Yorkshire is governed by a transition pathway. In the area covered by the services provided by TEWV this pathway takes place through discussions between the adolescent and adult services beginning when the young person reaches 17½ years of age. There is no specific offer or resource dedicated to managing the transition to adult services although it is reported that most young people have their care stepped down to lower threshold services. We did not see any examples of this during our review. In the CAMHS provided by BDCT in the Craven area there is a stronger offer with a dedicated transition staff member who co-ordinates the transition arrangements between the adolescent and adult services and provides oversight for each young person who is undergoing this transition. The absence of such a dedicated transition resource with oversight of the process for individual young people in the service provided by TEWV may result in the needs of some young people with more severe or chronic mental ill-health being overlooked.

[Recommendation 6.2.](#)

2.19 Along with other multi-agency partners, NYH are important members of the Family Drug and Alcohol Court (FDAC) process across North Yorkshire. The focus of the process is to enable the service to work closely with, and monitor the progress of clients and families who meet certain criteria with the objective of maintaining a safe family relationship. The process is intensive and requires practitioners to provide up-to-date reports to inform the courts to assist with their decision making.

2.20 We also saw that NYH actively contribute to child in need processes. In one case we looked at, we noted good recognition of risk to the children of a client. The practitioner made an appropriate referral to children's social care in a timely manner, and provided a detailed account of potential concerns in relation to the impact of the client's behaviour on their children. The case was managed within the child in need processes and there was evidence of the practitioner's regular attendance at meetings. This involvement is effective in enabling agency partners to understand the evolving impact of substance misuse on children.

2.21 The 'Spotting the Signs' risk assessment tools used by the SCOT team provide a clear picture of children and young peoples' vulnerability, with regular review and updating as their needs and personal circumstances change. The team is vigilant to bullying, emotional and mental health risks as part of their assessment of the young person's self-identity and resilience. This ensures they have a complete picture of the factors that influence the risks of exploitation.

2.22 Good joint working with other health disciplines enables young people who have experienced abuse to have access to a wide range of care and follow-up support to help them manage the impact of their experience.

Good practice example

A teenaged boy came to the clinic for support with STI testing. Sensitive discussion with the young person by the receptionist led to him revealing an incident of sexual abuse six months previously. This information was promptly shared with the SCOT team.

Although it was clear that a range of actions had taken place to investigate the assault at the time, no follow up support had been offered to the boy. With his consent, the SCOT team liaised with relevant other partners including the police, sexual assault referral centre (SARC) and paediatrician to ensure he was medically examined and received counselling and appropriate advice and support.

This has also enabled the service to better understand his experience and has contributed to wider multi-agency learning about providing follow-up services.

3. Child protection

3.1 When risk to both expectant mothers and unborn children are recognised, such as the risk of domestic abuse, Friarage Hospital midwives and community midwives complete an ante-natal alert form. This form is then forwarded to birthing units across North Yorkshire where there is a possibility the expectant mother might attend to give birth. This is an important communication as it enables those units to be aware of unexpected risk should the birth take place on a unit other than at the Friarage Hospital or at JCUH.

3.2 Midwives at Friarage Hospital are fully engaged in the child protection process, routinely attending all initial child protection conferences and providing written reports to inform those meetings. This ensures the conference is apprised of all information about the pregnancy that might affect their decision and supports midwives to incorporate safety measures in birth planning.

3.3 The practice of recognising risk factors and taking appropriate action in the Airedale maternity unit was inconsistent. For example, in one case we were tracking across services, we noted that risks to a new born baby were recognised and relevant safeguarding professionals were consulted for advice and guidance.

3.4 In another case, however, the risks to a premature baby and an older sibling arising from significant concerns about coercion and intimidation of mother and labour ward staff by the baby's father were not appropriately escalated. The ward records did not recognise father's behaviour as domestic abuse and the mother's wishes and feelings were not recorded. This led to an incomplete picture of the current risks posed to her, the baby and older toddler, and of her protective capacity. There was also no recorded evidence that concerns were shared with other professionals, including handover to the health visitor or checks with children's social care. We have since been assured that this case has been reviewed.

[Recommendation 4.3.](#)

3.5 Unborn babies are usually protected well by Scarborough maternity services. When completed, a suite of child protection case notes provide ready access to key information, including chronologies of significant events, birth plans and post discharge requirements. In all files we looked at, good support was provided by a member of the trust's safeguarding team.

3.6 Midwives at Scarborough routinely attend key conferences and core groups and always provide child protection reports to assist conference decision making. Records of child protection conferences are held in midwifery case records. However, midwives do not routinely receive a set of minutes from the core group; this could prevent evolving information from having an impact on birth planning.

[Recommendation 3.7.](#)

3.7 Midwives at Harrogate are expected to attend all child protection conferences and submit reports on the LSCB templates although we were unable to identify any cases to sample to demonstrate whether this was happening. There is currently no database or other tool kept to offer assurance to management that this process is adhered to. Further, the named midwife does not routinely see child protection conference reports or referrals to social care and so cannot be assured of compliance or quality. [Recommendation 2.8](#).

3.8 There are effective child protection practices in the health visiting service. These include child protection processes, good quality referrals with a good level of analysis and active participation in Multi-Agency Risk Assessment Conference (MARAC) processes, all of which are subject to strong oversight by the trust safeguarding team. There is good use of documentation and records that support this effective practice. For example, whenever there are child protection concerns, communication between health visitors and children's social care is timely and detailed. Health visitors attend strategy meetings and child protection conferences and upload records of these onto patient's files to inform delivery of care. Child protection conference reports are comprehensive, fully outline risks and are shared with parents prior to conference. These robust processes ensure that multi-agency plans to keep children safe inform practice and minimise the risk of drift.

3.9 Similarly, child protection practice in the 5-19 service is also strong with robust processes, manageable safeguarding case-loads, effective links with GPs and good use of recording systems. For example, the specialist community public health nurses case-hold safeguarding matters and the number of cases managed by these practitioners is overseen by management. HDFT have established links with GP practices. All GP practices have a link specialist community public health nurse with a number of practices involving the nurses in their monthly multi-disciplinary meetings. This supports good, co-ordinated work in relation to, for instance, children subject of a child protection plan.

3.10 The electronic patient records system in use at the Friarage hospital ED supports good safeguarding practice. The use of mandatory fields and algorithmic risk assessment templates derived from key questions are built into the system and enable practitioners to consider safeguarding risks appropriately and this is a strong arrangement. This is the case for children and also for adults who attend with risky behaviours. Alerts are clear and referrals to children's social care are also generated through the system. This ensures information for the clinical record is faithfully transferred and we saw examples of this during our visit. The provider is currently developing a template to support staff to consider the risks of CSE and this will enhance an already strong process.

3.11 All referrals and notifications are automatically copied into the STHFT safeguarding team who monitor them so that good examples can be shared and advice or further training provided where required. Referrals examined during our review were comprehensive and detailed. This practice supports good decision making within children's social care and the MAST.

3.12 The ED in Airedale hospital has appropriate systems in place for identifying and flagging safeguarding risks to children, and a safeguarding screening checklist forms part of the Emergency Department record. This is routinely undertaken for all ED attendances and includes a range of key questions to help staff determine risks such as checks on the person accompanying the child, whether they have parental responsibility, their interaction with the child and whether the child is known to children's social care. Cases seen indicate good attention is generally paid to identifying risks including numbers of previous attendances

3.13 Further questions relating to consistency in reporting the history of any injuries and the timeliness of the presentation prompt staff to explore risks further. We also note there is a clear focus on head injuries to infants under one year old, burns and fractures to non-mobile children and perineal injury that might indicate sexual abuse. All cases we looked at demonstrated good application of this tool, which reduces the chances of any potential abuse being overlooked.

3.14 We saw that appropriate checks are made with children's social care and that referrals made by ED staff contain a good level of detail to enable the recipient to understand any concerns.

3.15 However, as we have already commented in 'Child in Need' above, whilst there is generally good risk management and recording practice in Airedale hospital, there are sometimes exceptions in respect of children with mental health needs who are transferred to the paediatric ward.

Continuity of safeguarding information

In one case we looked at in Airedale hospital, a child had taken an overdose and had been admitted overnight due to suicidal thoughts. However, this had not led to the development of a pink safeguarding sheet despite information being known about the child's vulnerability, the involvement of children's social care and risky home circumstances in relation to the child's father's substance misuse. This is a gap as it does not alert staff to identified risks. The child was discharged the following day for a follow-up by CAMHS at home that day.

Then a week later the same child was readmitted to the paediatric ward for assessment by CAMHS. On this, second admission, a pink safeguarding sheet was completed by ward staff but was recorded as the first attendance. The risks and history of concerns arising from the previous attendance were not clearly identified. The social worker visited the child on the ward, but the ward records indicate that no information was shared with ward staff. The CAMHS practitioner highlighted concerns that the child was being discharged into an 'unsafe, hostile home environment'; however, there was no multi-disciplinary discussion to obtain a picture of emerging concerns.

Whilst we have since been assured that this case has been subsequently reviewed, it nonetheless means that robust safeguarding processes designed to build a picture of risks were not followed, thus limiting the capability of the staff to effectively plan for safe discharge. [**Recommendation 4.4**](#).

3.16 All ED records at Scarborough Hospital are flagged to indicate if a child or young person has a child protection plan, if they are looked after or if they are known to the VEMT or MARAC arrangements. This supports staff to be professionally curious about potential abuse during the clinical consultation.

3.17 All referrals to children's social care that are made by Scarborough hospital staff are scrutinised by the trust's safeguarding nurse who assesses the referral for quality before forwarding onwards. This is a pilot project intended to increase the quality and appropriateness of referrals. Urgent referrals are telephoned through to the emergency duty team for a rapid response. Arrangements are in place to provide cover for when the safeguarding nurse is not on duty but we found some occasions when these arrangements had failed and there had been no review by a safeguarding specialist. [Recommendation 3.8.](#)

3.18 Children and young people who attend Scarborough ED are reviewed by a streaming nurse who decides whether they need treatment within the hospital's ED or whether they can be seen within the MIU run by Yorkshire Doctors, based on the same site. The 'A Child' safeguarding triage is not completed at this stage and we saw some cases of children less than one year old with injuries, including head injuries, being diverted to the MIU. This is not good practice and does not reflect the recent LSCB guidance on treating injury and bruising in non-mobile infants. [Recommendation 5.2.](#)

3.19 In most cases we looked at, arrangements to protect and safeguard children who attend the Yorkshire Doctors MIU and on-call service were effective, despite there being no formal safeguarding triage in place. This includes recording of key issues such as any delays in presentation and the appropriateness of the relationship between adults and the child. We were told that where safeguarding issues are identified then a separate process is instigated by using a safeguarding tab on the electronic record but we were unable to review any case examples where this was being used and so cannot assess the impact.

3.20 As we reported above in 'Early Help' comprehensive safeguarding assessments are not consistently carried out in the ED at Harrogate hospital. The documentation used for booking in children to the ED includes a seven-question safeguarding screening tool. However, on the majority of records we looked at this had not been completed adequately and did not reflect the presenting history. For example, the records of a young person who attended with the police with an allegation of rape, prior to transfer to a police suite did not indicate if the matter was being considered as a multi-agency safeguarding investigation and the screening tool was incomplete. This lack of detail means that key information could be overlooked on the young person's journey through the ED and onwards to primary care or other health services once discharged. [Recommendation 2.5.](#)

3.21 In the CAMHS provided by both TEWV and by BDCT we saw that practitioners are engaged in child protection processes, including attendance at child protection conferences and core groups. Staff from both trusts make referrals to children's social care; in each case we looked at, the quality of referral was good with clear risks thoroughly described.

3.22 For example, in one case we looked at in the TEWV service a young person with a history of being sexually abused who was exhibiting extreme violent behaviour at home was referred appropriately to children's social care. Both the case records and the referral records were detailed and contained a clear picture of the ongoing and current risks. The CAMHS practitioner supported the creation of a safety plan to help mitigate any risks at home, such as the removal of dangerous implements and media equipment. The active engagement of the practitioner with other agencies enabled the partnership to develop a clear picture of the risks to this young person and to take action that was appropriate to, and took account of their mental ill-health.

3.23 In another case we looked at in the Craven CAMHS provided by BDCT, a young person who had experienced earlier abuse in another part of the country was referred to children's social care. The referral contained good analysis of the current risk factors. Once the young person was made subject of a child protection plan, the CAMHS practitioner contributed information to core group activity so that the young person's evolving emotional wellbeing featured strongly in decisions made. This case also demonstrated effective professional challenge within the core group by the practitioner and good management and safeguarding support by the trust's safeguarding team.

3.24 As reported above in 'Early Help', the 'think family' model is well established in the NYH substance misuse service where we also saw evidence of good practice that supports child protection work. This includes re-assessment of the client's family whenever there are significant changes in their life such as moving address or entering a new relationship. The service also routinely shares relapse and recovery plans with other agencies when appropriate and this helps the multi-agency partnership to know when children of clients of the service may be at greater risk.

3.25 Where it is established that children are involved with social care, contact is quickly made with the social worker to make them aware of the adult client's involvement and progress in treatment. Referrals made by NYH that we looked at were detailed and set out risk clearly. Staff routinely attend child protection conferences and provide reports that help the conference understand the impact of substance misuse. The quality of information in the cases we looked at was good and this supports good decision making.

3.26 In both adult mental health services we saw evidence that practitioners are engaged in child protection processes. In each case this includes mandatory attendance at child protection conferences. In the service provided by TEWV we saw that the 'impact of parental mental health' or 'PAMIC' tool was still in the process of becoming embedded into practice although its use is more developed than it has been in recent inspections where we have visited this provider.

3.27 In the Craven service provided by BDCT the use of the safeguarding section of the client record was not routinely utilised. This means that much child safeguarding information was buried in the log of contacts on the database and was difficult to retrieve quickly. This can adversely affect the understanding of risk factors if the case is handed over to another practitioner. [Recommendation 9.1](#).

3.28 The SCOT team are increasingly involved in strategy discussions when CSE risks are identified. However, their involvement in local child protection case conferences and protection plans is currently very limited. The SCOT team advise they have not been asked to contribute a report to a child protection conference, and are unaware as to whether they have accountabilities for supporting the areas for action identified in the young person's CP plan. [Recommendation 3.9](#).

3.29 Discussion with the SCOT team leader also highlighted that the integrated sexual health team had not made a referral to children's social care team in the last year. This is an area for further exploration to ensure that practitioners and front line managers have a sufficient focus on work to proactively identify young people at risk. [Recommendation 3.10](#).

3.30 In three of the four GP practices we visited we noted that good safeguarding practice is embedded; one of the practices would be described as operating an outstanding safeguarding model. Information about vulnerable children and their families is well maintained and up to date in each of these practices. This is largely due to consistently applied coding and use of the electronic patient records systems to alert staff to such children but is also as a result of a strong safeguarding culture.

Good practice example

In one GP practice, for example, a young woman under 18 who had attended for emergency contraception was identified as being vulnerable. On reviewing the records, the practice staff noted that the young person had attended the ED on several occasions for emergency contraception and had previously had a social worker allocated. Contact was made with the social worker and it was confirmed that she had been sexually exploited in the past. This vigilant practice enabled the consulting clinician to undertake a full assessment of risks and the information was shared with the social worker for use in the VEMT process.

3.31 Generally, GPs participate in local safeguarding processes and attend meetings wherever possible. For example, in one practice attendance at child protection conferences is improving whilst in another we noted that GPs attend MARAC meetings. Detailed information is presented to child protection conferences through the use of a templated report; this consistency helps to standardise practice and facilitates understanding in non-health partner agencies. We also saw good use of domestic abuse and CSE risk assessments, which enables GPs and their teams to have a clear picture of particular risks to individual patients.

3.32 There are good arrangements for sharing information with health visitors and school nurses through regular, scheduled regular multi-disciplinary team meetings. This enables health practitioners across primary care and community teams to have good insight into the needs and risks in children and families in their patient lists.

3.33 Safeguarding remains a strong focus for GPs in most of North Yorkshire with the adoption of common and consistent approaches for the management of safeguarding information and practice. However, not all practices in the Craven area have adopted the standardised model. In one surgery we visited in this locality we noted that there was some information about young people that was out of date; a data check revealed that some young people were flagged on the system as being looked after, but they were in fact over 18 years old. Further, there was no general understanding or familiarity with the child protection information sharing template or of the arrangements for MARAC. In one case we noted that information had been shared with children's social care for a child protection conference by way of a letter but the information was clinical in nature and had limited analysis of risk. We have discussed the implications of this in 'Governance' below. [Recommendation 10.1](#).

4. Looked after children

4.1 A large number of looked after children and young people in North Yorkshire do not receive an initial health assessment (IHA) within statutory timescales; a shortfall that has persisted for over a year. For example, an audit completed in May 2016 revealed that 38% of children have their health assessments completed within 20 days of coming into care, a decrease from the already low number of 45% in 2015. This is not compliant with statutory guidance and means that there is a delay in identifying health needs for more than half of children who are new to care.

4.2 The CCGs and HDFT have explored the reasons for this through a series of audits and have escalated this issue appropriately. The timeliness of assessments is now a part of the safeguarding governance risk register. This has driven recent activity that has shown an improvement in timeliness of notifications from the local authority which has increased from 59% to 84%. This is mainly due to improved relationships with the local authority and the specialist looked after children health team being enabled to access the local authority's electronic systems.

4.3 However, data arising from more recent audits, the latest in January 2017, shows that whilst the timeliness of notifications has improved there is no corresponding improvement in the number of IHAs being completed by paediatricians within 15 working days of receiving the request. Through the course of this review we have not been presented with evidence of a plan or agreement between the CCGs and the providers about how this picture might improve. The practical effect of this is that children and young people still experience delays in having their health needs assessed and met within a reasonable time-frame.

[Recommendation 11.1.](#)

4.4 The CCGs and the HDFT specialist nursing team have developed a pathway for children and young people who have declined their health assessments. This is accompanied by a short, online animated video resource designed in collaboration with the Children in Care Council for North Yorkshire and the City of York. The purpose of this video is to provide explanation and reassurance to young people about participating in a health assessment. Our view is that this child-focused resource should be effective in enabling more young people who are new to care to undergo a health assessment and ensure their needs are met, although there is currently no data available to assess its impact.

4.5 We reviewed some IHAs that were of good quality and others that had less detail and that did not take account of the child's voice. For example the designated doctor carried out an initial assessment of a young person aged 16 with emotional difficulties. The young person was offered the opportunity of being seen alone and the doctor explored whether they had a trusted adult they could talk to. The assessment captured the young person's likes and dislikes and a clear picture of their feelings and aspirations was evident in the assessment record.

4.6 The Strengths and Difficulties Questionnaire (SDQ) report had been completed and was used to help the doctor understand the person's emotional wellbeing. This report was shared with the CAMHS practitioner to whom the person was referred and this, too, is good practice. The health action plan was clear and SMART, took account of the young person's views, and was tailored to ensuring the young person was supported through the forthcoming period of transition from the adolescent service to adult services.

4.7 Another case record we looked at, however, was less effective in depicting the young person's needs. The young person's father had completed a SDQ in respect of the young person but the SDQ was not evident in the assessment. There was also limited information about the young person's wishes and feelings that demonstrated the direct involvement of the young person in the assessment. This inconsistency in practice was identified in the most recent audit of January 2017 that showed that, whilst some areas of work had improved over an audit carried out in the Summer of 2016, other areas had deteriorated; a key area for focus was identified as ensuring the 'voice of the child' is fully captured. [Recommendation 11.2.](#)

4.8 Unaccompanied asylum seeking children benefit from thorough initial health assessments. Consent is documented and interpreters are used appropriately. Paediatricians attend the 'Welcome Centre', a local residential facility opened by North Yorkshire County Council for such children, where they carry out the assessment. Paediatricians also use online resources available from Kent to support this work that includes the use of specific templates for IHAs for asylum seeking children. Relationships with other services such as TB services and sexual health, have improved as a result of this work which means that young people can receive a timely referral to meet their particular needs.

4.9 A change in location of the healthy child teams that complete review health assessments (RHA) has challenged the ability of HDFT to maintain their timely completion. The administration staff within the looked after children's team have recently aligned themselves to the social care geographical boundaries to provide consistency in the management of the RHA requests. In addition the named nurse for looked after children attends the 0-19 healthy child service business meeting to report on timeliness and address emerging issues. It is too early to see the impact of this change. Recent figures for February supplied by the team suggest that there has been an increase in the number of RHAs completed within statutory timescales from 77% to 89%.

4.10 The quality of review health assessments is variable. For children aged 0-5, records consistently demonstrate the voice of the child, SMART action plans, holistic assessments that consider aspects of care, such as access to nursery funding and a review of the previous action plan. Children and young people aged between 5-19 benefit from holistic assessment, however, none of the records we examined reviewed the previous health action plan. This limits the ability to review the effectiveness of interventions and whether the child or young person has been able to access the identified service. [Recommendation 2.9.](#)

4.11 The looked after children's nurses effectively support the most vulnerable looked after children. For example, a young child who had been referred for an autism assessment in April 2016 was not able to access a convenient assessment due to the foster carer's address being in East Yorkshire. The looked after children's nurse liaised with the designated doctors, foster carers and commissioners to secure an appropriate assessment that ensured continuity for the child and reduced the anxieties associated with traveling for this vulnerable child.

4.12 There is a dedicated looked after and vulnerable children's CAMHS service across North Yorkshire (except in the Craven locality) provided by TEWV. Working relationships are reported to be positive and there are no reported delays to young people accessing the service. The CAMHS service offer for children and young people who are looked after includes consultation to foster carers, adoptive parents, social workers and anyone involved in the child's care networks such as schools. The CAMHS teams undertake assessments for vulnerable children and group work with foster carers at a variety of venues; with training provided to local authority staff on mental health. This enables this particularly vulnerable cohort of young people with mental health needs to receive appropriate services without delay. Close liaison with the 'No Wrong Door' service provides accessible wrap around care for young people in care or on the edge of care.

4.13 A recent development in the liaison relationship between the looked after children service and the CAMHS has included agreement that CAMHS will inform the looked after team of all children they have seen or who are not brought to appointments. This needs to be fully embedded to enable the looked after children nurses to have effective oversight of the care of those young people.

4.14 SDQ's are not routinely used to inform health assessments for looked after children. Out of a sample of six records, only one documented the SDQ and its relevance to the young person. This was seen in records when there was an identified or unmet emotional or mental health need. A text box has been added to the health assessment paperwork that prompts practitioners to consider the SDQ score, who it was completed by and the interventions that are proposed or are in place. We did not see any of the boxes completed on the records that we reviewed. We acknowledge that until October 2016 SDQs were not routinely shared with the specialist nurse team and that this practice has only recently become established. However, the lack of use of this information is a missed opportunity to holistically assess young people's emotional needs and consistently evaluate interventions between health assessments. [Recommendation 2.10](#).

4.15 Young people leaving care are offered a health passport. This 'blue book' has been developed in conjunction with young people and is ordinarily provided by children's social care as the child or young person enters care to act as an ongoing record of their health. Young people leaving care who have not been given a blue book are offered an alternative passport by the specialist nurses. We examined two copies of health passports that detailed the young person's health history. Although these were satisfactory we were not clear that there was a system in place to monitor and review their use and effectiveness. [Recommendation 2.11](#).

4.16 Looked after children are not consistently offered a CSE assessment when vulnerabilities are identified. Practitioners were able to talk about the ‘Spotting the Signs’ risk assessment tool but we did not see it used in any of the records we looked at. Within the records for both IHAs and RHAs, we could see that professionals were aware of behaviours that might indicate that the young person was at risk of exploitation. However, this did not lead to an assessment of risks. This could mean that some young people who are at risk of being exploited might not be identified. [Recommendation 13.2.](#)

4.17 Following a recent CLAS review in York, the looked after children’s team have strengthened the recording of information on the electronic record. The system is now used to record all follow-up work with young people and is now a complete patient record. Further development work is ongoing to enable the team to report on documents that are uploaded such as GP reports that might be provided to support health assessments

4.18 Foster carers and children’s home staff value the help and support they receive from the SCOT team of the sexual health service for young people at risk of CSE or missing from home. For example, the team offers sexual health awareness days at venues across North Yorkshire that are open to any professional, youth workers, social workers and foster carers. They also provide staff at the annual foster carers’ conference. This has been effective in prompting foster carers to request further advice and information about sexual health and potential exploitation. SCOT team members visit council run and independent children’s homes monthly or bi-monthly to work with individuals, groups and staff offering a range of contraception, STI checks and support for young people at risk of CSE. However, their input into health assessments or care plans, or their work alongside other professionals for looked after children is not sufficiently clear. [Recommendation 14.1.](#)

4.19 Generally, GPs have a good understanding of children looked after and their health needs (with the exception of the practice we discussed above at 3.32). Case records we looked at in GP practices included the child’s previous health assessments and care plans with clear details about their care arrangements. GPs have also been provided with additional guidance on helping to address the complex health needs of unaccompanied asylum seeking children. However, GPs are not currently being invited to contribute to RHAs. This is identified as an area for development by the team who recognise the valuable contribution that GPs already make to IHAs. [Recommendation 12.1.](#)

5. Management

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

5.1 Leadership and management

5.1.1 There are a number of challenges to the safeguarding leadership and governance in North Yorkshire owing to its geographical size, the different commissioning arrangements in the CCGs, the acute provider landscape of four trusts and one safeguarding children board. The 'Partnership Commissioning Unit', a collaboration of four of the five CCGs in North Yorkshire and known locally as North Yorkshire and York (NYY), has responsibility for commissioning most of the children's health services across the largest area alongside Public Health at North Yorkshire County Council. NHS Airedale, Wharfedale and Craven (AWC) CCG commission children's health services for the much smaller Craven local authority district to the west of the area but are also responsible for commissioning services in the Bradford local authority areas. Despite the differences in procedures and population demographics, we found evidence during our inspection of effective informal co-operation between the NYY CCGs and the AWC CCG.

5.1.2 Both the NYY CCGs and the AWC CCG are active and visible leaders in safeguarding practice across health services in North Yorkshire. In the largest area covered by the NYY CCGs there are a number of CCG led initiatives that provide structured support and organisational safeguarding development to the providers. These include regular involvement in the provider safeguarding governance processes; a close supervisory relationship between the designated team and the provider named professionals; the bi-monthly Safeguarding Children Health Professionals Network (SCHPN) meeting and the bi-monthly Looked After Children Health Professionals Group. The SCHPN enables regular peer support between safeguarding teams; drives the implementation of local initiatives (such as the dental pathway); shares regional and national learning (such as from incidents and audits).

5.1.3 Similarly, AWC chair a bi-monthly Health Safeguarding Children Group (HSCG). The HSCG offers the same support to safeguarding professionals from the providers in the west of the area, principally those that are Bradford facing but which also provide services in Craven. Both of these groups are particularly strong arrangements as they help to standardise and align the way that practice improvements and developments are made among the complex provider network in North Yorkshire.

5.1.4 The unaccompanied asylum seeking children working group enables commissioners and providers across the North Yorkshire Partnership to continue to safely and effectively plan and manage the transfer of such children and young people. Staff from the residential setting, along with education, police, designated nurses and the looked after children named nurse, meet to monitor the risk and implications for resources and share information from national learning to support service development. For example the group have looked at how the sequence of unaccompanied asylum seeking children registering with a GP can affect the timeliness of the IHA.

5.1.5 The NYY CCGs have contributed significantly to the development of the services for children and young people who have been sexually abused or exploited. These include a lead role in the development of the VEMT processes we have reported on earlier. The commissioners have also played a significant role, alongside YTHFT, in the development of the Child Sexual Abuse Assessment Service (CSAAS) operating from York hospital but servicing the North Yorkshire area. We did not look at examples of the work of this service during our review but heard anecdotally about its impact in relation to forensic capability and effectiveness in referring young people who are the victims of sexual assault to support services.

5.1.6 The NYY CCGs have taken significant steps to promote and standardise good safeguarding practice among GPs through the employment of a safeguarding nurse consultant. We found strong and effective leadership by the nurse consultant working alongside named GPs in each of the separate CCGs to embed such practice and this was evident in our visits to the three GPs in the NYY area.

5.1.7 A robust and supportive system is in place to help continuously improve standards and quality-assure safeguarding practice in primary care. For example, the GP audit toolkit self-assessment is promoted in all GP practices in North Yorkshire. Feedback so far indicates a high level of compliance. Areas for development highlighted in the audit positively shape the future work programme led by the named GPs and nurse consultant, including a programme of continuous professional development for primary care staff. The approach taken shows a high level of professional commitment and openness to organisational learning.

5.1.8 As part of the work programme, GPs are working to strengthen their attendance at child protection conferences for example, with excellent attendance in one locality we visited, supported by good advance planning of the GP rota. As we have already reported above, partnership working with community health professionals is particularly strong. This enables early identification and scrutiny of ongoing risks and the provision of early help through primary care led vulnerable families meetings.

5.1.9 Health service leaders recognise the positive impact of a service known as 'No Wrong Door' and have committed resources to it from mental health and the specialist looked after children nursing team. This is a service providing emotional well-being and psychological support to young people who are looked after or on the edge of care. The service provides a key-worker, one-to-one approach to young people who are supported to access a range of professionals, including a clinical psychologist who provides life-coaching. We were unable to visit this service during our review but staff we spoke with in a number of services have reported positively of the significant impact of this service to improving the life skills of young people that supports a healthy transition into adulthood.

5.1.10 There is effective oversight of the work of health professionals carrying out review health assessments. These are subject to a quality assurance review by the named nurse for looked after children in HDFT. For example, in two cases we looked at we saw examples of completed assessments being returned to the practitioner for additional information to be added, ensuring that the health action plan took account of the assessment of need. This quality process helps to improve practice and ensure good health outcomes for looked after children are properly planned.

5.1.11 The hybrid system of both electronic and paper hand-held notes in use by community midwives in the Friarage hospital currently does not support ready access to safeguarding information. The system does not alert midwives to current risks in every case and midwives are unable to access the system in community settings. Further, a recent audit of STHT community midwifery hand-held notes showed that there has been an overall improvement in the recording of safeguarding information. However, it also highlighted that the records were not always complete as some notes of attendance at the JCUH post-natal ward did not always make their way to the record. Therefore, there is risk that community midwives might not always be in receipt of a complete patient record. [Recommendation 1.2](#) and [1.3](#).

5.1.12 When policies are being updated within midwifery services at the Friarage Hospital, the named midwife ensures that a 'policy on a page' format is developed and circulated amongst appropriate practitioners. This format provides all the pertinent information needed by practitioners in a given situation in a succinct accessible format with hyperlinks to supporting information. This is a useful 'at-a-glance' resource that supports busy practitioners.

5.1.13 The STHFT safeguarding team undertake regular assurance rounds in relation to safeguarding children. Every month, five staff members from a designated ward or department at both the Friarage hospital or JCUH are asked 10 questions to test their knowledge of safeguarding processes. These questions include asking staff, for example, whether they can identify adult behaviours or lifestyle choices that may increase the risk of harm to children or if they can identify the signs of potential CSE. This, too, helps maintain good practice and drive improvements.

5.1.14 The STHFT safeguarding team maintain good oversight of all child protection and safeguarding cases at the Friarage Hospital. The use of the electronic patient records system allows the named nurse for safeguarding and looked after children and the safeguarding team to easily audit the quality of referrals made. This helps to maintain good practice.

5.1.15 AFT does not offer 24 hours-a-day specialist paediatric nursing cover in the ED. However, the trust has strengthened access to additional training and added two further posts that include nurses with a paediatric interest. Back-up advice and support is provided by the children's ward if required. [Recommendation 4.7.](#)

5.1.16 There is good joint working between paediatric ward staff at Airedale and CAMHS in developing a timely response and shared approach to caring for young people with mental health needs. Monthly, joint CAMHS meetings are held and this provides opportunity to discuss referrals and share assessment approaches.

5.1.17 We are aware that the Director of Nursing at AFT is considering an external review of safeguarding children to establish the effectiveness of current arrangements and areas where improvement or additional capacity is required. We note that safeguarding midwifery capacity is currently relatively limited. For example, the interim named midwife is also the maternity ward manager, with 15 hours per week available to undertake the named midwife role. Previously this was a full time role. In addition, a new post of drugs and alcohol liaison midwife has been created. This is also 15 hours per week. Midwifery caseloads are reported as approximately 90 for each case-holder. Given the volume and complexity of activity spanning the three local authorities served by the trust including North Yorkshire, this means that expertise in safeguarding and in guiding and monitoring the work of staff who are supporting vulnerable women is stretched. [Recommendation 4.6.](#)

5.1.18 Similarly, capacity within YTHFT safeguarding team is stretched. The arrangements for the new named doctor are unclear in terms of session allocation to fulfil the duties of the role and the accessibility of the post-holder to other staff. At the time of the inspection the named midwife was on long term absence and whilst her duties have been allocated across the head of safeguarding, named nurse and specialist nurse, it was not clear how there is sufficient time to carry out audit and quality assurance as evidenced in maternity and ED records. [Recommendation 3.11.](#)

5.1.19 Children and young people who attend Scarborough ED are not always cared for by paediatric qualified nurses. Currently there are no children's nurses employed by the department and not all nurses have completed the Paediatric Life Support (PILS) course. The current e-rostering system does not ensure a nurse with PILS training is allocated to cover each shift. [Recommendation 3.12.](#)

5.1.20 The named midwife at Harrogate maternity department attends conferences when support for new or inexperienced practitioners is needed and when cases are highly complex. This is good, accessible leadership and offers midwives the opportunity to reflect post conference with an experienced practitioner and build on their own level of expertise.

5.1.21 The named midwife in Harrogate uses case sample audits effectively to improve practice. A regular audit of 12 to 15 maternity records each month has recently been established and has already identified a need to review and streamline the maternity safeguarding paperwork. This was borne out in our inspection when we noted variability in the use of the paperwork with the paper records being difficult to navigate through.

5.1.22 There are only three paediatric trained nurses within ED at Harrogate and so each shift cannot be covered adequately. A number of staff have undertaken a university based six month course on the care of children in emergency settings to ensure an increased number of nurses with enhanced paediatric skills are available in the unit. [Recommendation 2.13](#).

5.1.23 Managers in HDFT have been proactive in recruiting paediatric nurses to the children's ward and all but one of the nursing staff are now paediatric trained. This is an improvement on staffing levels at the time of the last CQC inspection.

5.1.24 HDFT have taken a number of steps to increase the safety of young people admitted to the ward who have self-harmed. This has included working with estates and CAMHS to identify and modify a cubicle for use in these situations. A supporting document which grades the young person demeanour and behaviours while under observation supports the assessment being undertaken by CAMHS. Operational meetings have been established between CAMHS and HDFT senior managers to foster good working relationships and undertake joint work which will enhance the experience of the paediatric ward of young people who have self-harmed. This has included an induction for staff of both organisations which incorporates visiting each other's sites to understand roles. A joint CAMHS and paediatric care plan to support staff in meeting needs of young people admitted to the ward is currently in draft.

5.1.25 A well-resourced 5-19 service has been established in HDFT. There are clearly defined roles within the skill mix teams. Work has been undertaken to support weighted workload within the teams across the localities to reflect areas of deprivation and need. Each team has a specialist community public health nurse, a 'Healthy Child' practitioner, an assistant practitioner and a screening Practitioner and this enables an effective allocation of work.

5.1.26 The co-location of HDFT 0-19 staff in hubs in the localities with the local authority Prevention team supports joint working. Partner agencies also working from the hub include Compass Reach (children's substance misuse service) and community midwifery. This enables face-to-face networking and case discussion which promotes good information sharing about individual children. For example, weekly multi-agency case allocation meetings are held with consistent attendance from the 5-19 service. To support communication and case identification, electronic systems have been developed that allow access by the 5-19 service to the local authority portal so that practitioners are aware of current or emerging issues and whether the case is open to the Prevention team.

5.1.27 Staff in the CAMHS provided by TEWV take part in a daily 'Huddle.' This staff meeting enables care co-ordinators to focus on any safeguarding issues and plan any activity with clients to address such issues. We have seen this operate in other areas where TEWV provide a service and consider this to be a demonstrably effective process for front line supervision and peer support.

5.1.28 Work is ongoing within NYH to further strengthen already good relationships with midwifery services across North Yorkshire. Information sharing between services is generally good with a pregnancy protocol pathway in place at Scarborough Hospital. We were advised of plans to widen the scope of the protocol across other midwifery services in North Yorkshire and this would support a more consistent and equitable offer to all women across the county.

5.1.29 Links between NYH and adult mental health services are under developed, however. For example, there is no dual diagnosis initiative currently in place and we are advised of difficulties referring substance misuse clients into the adult mental health service. This may have an impact on either service being able to accurately assess the impact of a dual diagnosis of those clients on any children they might have access to. [Recommendation 15.1](#).

5.1.30 The SCOT team is appropriately involved in a number of joint operational forums to help promote an agreed, well-aligned approach to the engagement of young people and to improving outcomes. For example, the SCOT team leader is a member of the VEMT process and also the looked after children health professionals meetings. Such groups work to strengthen partnership arrangements to ensure an agreed, well-aligned approach to the engagement of young people and to improving outcomes in what can be long-term, complex and challenging work.

5.2 Governance

5.2.1 As reported under 'Leadership and Management' the complex health commissioning and provider landscape in North Yorkshire has led to challenges in safeguarding leadership and governance. Nonetheless we found that leaders, managers and staff within the CCGs and the providers have a strong safeguarding culture and the frameworks that enable practice improvement through organisational learning. This is the case across the county and is evident in the informal but effective collaborative relationship between the North Yorkshire facing NYY CCGs and the predominantly Bradford facing AWC CCG in respect of the Craven district.

5.2.2 Bradford Districts CCG host the safeguarding teams and designated nurses for safeguarding children and looked after children posts as part of a three-way arrangement with Bradford City and AWC CCG (although we have consistently referred simply to AWC CCG in this report as the Bradford Districts and City CCGs are not in the scope of our inspection). Together with the head of safeguarding adults, the designated nurses are accountable to a 'Director of Collaboration' who is, in turn, accountable to all three CCG boards. Accountability is maintained through regular meetings between the designated nurses and the Director of Collaboration and through bi-monthly highlight reports to the senior management team.

5.2.3 Designated Doctors for the AWC CCG as well as those for childhood deaths are provided to the CCG under an arrangement with two of the Bradford and Airedale acute trusts. As well as a named GP, AWC CCG also have two additional safeguarding posts, a Domestic Violence Manager and a CSE Specialist Practitioner. We did not review any of the work of these practitioners during our inspection and so we are unable to make any assertion of their impact.

5.2.4 The safeguarding team for the tripartite arrangement that AWC CCG is part of are active members of the Bradford Safeguarding Children Board (who are not in the scope of our inspection). However, the Director of Collaboration is also part of the North Yorkshire Safeguarding Children Board (NYSCB) in respect of the Craven district. This ensures they have oversight of, and are accountable for safeguarding practice in this locality where the North Yorkshire safeguarding procedures prevail.

5.2.5 Safeguarding performance in NHS trusts and other providers commissioned by AWC CCG is maintained through commissioning and contract monitoring arrangements as well as through section 11 (Children Act 2004) audits. However, the CCG report that they do not currently receive safeguarding assurance from GP practices. This is a gap and means that the CCG are not clear about the effectiveness of safeguarding practice in the five GPs in the Craven district. During our inspection we visited one practice in the Craven area and, as we note above under 'Child Protection', there is a disparity in the application of safeguarding processes, particularly in relation to information management, between this practice and those in the NYY CCG area. This suggests that the needs of, or risks to, vulnerable children in the Craven area may not be properly understood with the CCG being unaware of the extent of the practice gap. [Recommendation 10.1](#) and [10.2](#).

5.2.6 In the NYY CCG area, the safeguarding team are accountable to each of the four respective CCGs that make up the North Yorkshire collaborative arrangements; Hambleton, Richmondshire and Whitby; Scarborough & Ryedale; Harrogate and Rural District and Vale of York (which also incorporates the City of York, not in scope of our inspection). Lines of accountability vary according to the CCG but predominantly the safeguarding team provide assurance about their work and that of the providers to the Chief or Executive Nurses of each of the four CCGs through the various quality or performance committees.

5.2.7 The safeguarding team are comprised of two designated nurses for safeguarding and looked after children, two designated doctors, a designated doctor for child deaths and a nurse consultant for primary care whose role we have already reported on extensively.

5.2.8 A Designated Nurse, a Designated Doctor and the Chief Nurse from Scarborough and Ryedale CCG are active, full members of the NYSCB. The Designated Nurse and Chief Nurse from Scarborough and Ryedale CCG are also members of the Board Executive. The Designated Nurse is also vice chair of the Board. The Designated Nurse and Designated Doctor are also members of the two board sub-groups; Learning and Improvement, and Practice Development as well as the multi-agency 'Strategic partnership for children in care'. All provider trusts are also represented fully on the board and so in this way, health professionals provide a significant contribution to partnership work and are key influencers.

5.2.9 The NYY CCG safeguarding team have developed five key strategic priorities for their work: To develop robust assurance processes; to support and continue to develop strong multi-agency partnerships; looked after children; supporting safeguarding practice in health providers; developing the CCG's safeguarding children team; child death overview processes. The CCG's most recent annual report for 2015 to 2016 asserts that good progress has been made against these objectives with several initiatives developed to support that progress, some of which we have commented on in this report.

5.2.10 Of note is the improvement in standardised safeguarding practices in GPs driven by the safeguarding nurse consultant. There is a quarterly named GP forum attended by each of the named GPs in the four CCGs (as well as the AWC CCG named GP). These are followed by the quarterly practice safeguarding leads forum held in each CCG. These meetings provide the platform to share good practice and ensure messages are consistently disseminated to GPs across the county.

5.2.11 The NYY CCGs assure safeguarding performance through section 11 audits and provider reporting against local quality requirements (LQR) with the quality sub-group of the contract monitoring board although the latter process was still being developed at the time of our inspection. Notably, GPs in the four CCGs have been required to complete the NHS England Safeguarding standards self-assessment tool. This exercise was nearing completion at the time of our visit and so we cannot report on its effect, but this demonstrates a commitment from the CCGs to ensure safeguarding remains a key focus for GPs.

5.2.12 Through the use of assurance mechanisms, the CCGs have a clear picture of the challenges they face across the variety of settings in the county and have been candid about these during our visit. For example, we reported earlier about the provision of CAMHS services for young people who have self-harmed. The CCGs are aware of the issues and have worked with providers through contractual arrangements to develop a revised service specification for a 24 hours-a-day crisis response, soon to begin in Scarborough. This revised service specification has yet to be fully implemented so we are unable to comment on its impact.

5.2.13 Governance and accountability arrangements in each of the provider trusts are robust, firmly established and enable effective audit and practice improvement. For example, the results of audits undertaken by the safeguarding team at the Friarage hospital are reported to the strategic safeguarding group and operational safeguarding group who continually monitor compliance and feed-back any strategic or practice developments through quarterly reports to practitioners.

5.2.14 HDFT governance structures are well established and the HDFT maternity risk management group feeds into the Safeguarding Strategic Quality Group. This enables review of training data and audits and enables practice improvement such as the maternity documentation audit we reported above in 'Leadership and Management'.

5.2.15 In Airedale, senior managers ‘walk’ the floor each week in the ED. This helps to strengthen awareness of care delivery and the experience of patients and frontline staff. Further, monthly auditing of 20 cases by the paediatric liaison nurse, along with a mechanism for feeding back to staff is a key performance indicator for the trust and this helps reinforce required standards for safeguarding practice.

5.2.16 Learning from serious incidents or learning lessons reviews is strongly promoted in AFT. For example, a root cause analysis of a non-accidental head injury of a baby strengthened practice with the expectation that in all cases of a head injury the baby is admitted to the paediatric ward for further observation. In addition, auditing of safeguarding activity shows that the ED has clearly identified risks to children in key areas such as domestic abuse and CSE.

5.2.17 AFT has committed to understanding the experience and voice of children and young people by encouraging their feedback to help shape future delivery of paediatric services. The trust has established a ‘Youth Forum’ which has been in place for six months. This has strengthened the trust’s approach to recognising the needs and preferences of children and young people. Close links have been established with local schools with twice weekly visits to ED to help children be more aware of what to expect should they need to attend hospital.

5.2.18 Similarly HDFT have established a ‘Children and Young People’s Forum’. The cohort of young people aged 13 to 16 has been drawn from local schools. Work has been undertaken on young people’s perception of ED and what would make more of a young person focused environment. The outcome of this piece of work is that the young people have devised a number of questions to be asked as part of a ‘secret shopper’ approach to evaluating the service from a young person’s perspective in the coming months. This is a positive initiative in young people shaping service development.

5.2.19 Scarborough hospital can demonstrate learning from a recent serious incident. Action plans have been developed to meet recommendations and we were able to see evidence of improved practice.

5.2.20 However, audits to promote good safeguarding practice within Scarborough ED are limited because of the current restrictions of the coding within the IT system. The use of generic labels does not support accurate auditing to demonstrate compliance on key processes such as, for example, the identification of injuries to non-mobile infants, self-harm (including overdose), non-accidental injuries and identification of the hidden child. We were also not assured that safeguarding practices had been embedded into the new electronic patient records system shortly to be introduced across ED in Scarborough. [Recommendation 3.13](#).

5.2.21 HDFT paediatric ward have used patient feedback to shape service delivery. For example, feedback from young people, including those who have self-harmed, found it particularly difficult to share their information in an open ward, especially at night when being admitted. The ward staff identified an area that young people’s history can be taken in privacy prior to them being admitted to their own bed; a seemingly small but important change in practice that supports young people who may be anxious.

5.2.22 The quality assurance of safeguarding practice within sexual health service records is not yet in place although YTHFT undertakes case audits. This is recognised by managers as an area for development. The IT system in use within the integrated sexual health service does not effectively provide a clear and efficient overview of the child's journey and the activity of partner agencies.

Recommendation 3.14.

5.2.23 In the Craven CAMHS provided by BDCT, the involvement of young people in consultative exercises is well developed. As well as using the friends and family test, the trust have a group of 'Young Dynamos' who work with practitioners to research young people's views to ensure the service meets their needs. The trust also employs 'youth panels' as support for interviews of prospective staff members.

5.3 Training and supervision

5.3.1 Safeguarding training across the providers in North Yorkshire generally meets the requirements of the intercollegiate guidance with relatively good, but fluctuating compliance reported across the providers and settings. There are also generally good opportunities for attending multi-agency training provided by the NYSCB although the take-up of such training is variable. Attendance is generally monitored by each provider's safeguarding team through centrally held attendance data and compliance is assured through effective management processes. However, in some instances, such as with the mental health services provided by TEWV, training databases do not fully credit staff with having attended multi-agency training due to incompatible coding and so monitoring compliance is a regular challenge.

5.3.2 All providers we visited have delivered single agency training according to a rolling programme on emerging topics such as CSE, FGM and PREVENT in accordance with current government priorities. We have reported below those instances where this is not the case or where there are good examples of training provision.

5.3.3 Both the CCGs and the providers make use of learning from serious case reviews and local learning lessons reviews, either those that have arisen in North Yorkshire or in adjoining areas. For example, a recent learning review from North Yorkshire led to the development and application of a protocol for bruising in non-mobile infants. Another serious case review emanating from the neighbouring City of Durham area prompted a review of the way that health services are linked in with MAPPA processes. The impact of the resulting newly implemented protocol and information sharing processes have yet to be assessed. However, the introduction of the designated nurses on to the MAPPA strategic board is likely to ensure continued improvements in the engagement of health services and lead to a better understanding of risk in individual cases.

5.3.4 Looked after children specialist nurses have three-monthly group supervision with a focus on case discussion. It is expected that the key points and a plan are uploaded to the patient record however we were unable to locate a supervision plan on the records we looked at. This means that the effectiveness of the case discussion and resulting plans cannot be tested properly. Therefore, there is a risk that supervision will not directly inform practice and could lead to drift of safeguarding plans. [Recommendation 2.14.](#)

5.3.5 The looked after children nurses team have access to a range of multi-agency training through the NYSCB. Staff we spoke with told us that they find this training to be readily available and relevant to their work. This meets the requirements of the relevant intercollegiate guidance and all staff are up to date.

5.3.6 Midwives at the Friarage Hospital, including those working within the community, have all received level three training with additional learning opportunities provided beyond the core requirements. Community midwives receive supervision every 12 weeks which requires mandatory attendance and are allocated protected time to attend. This takes place in a group setting to encourage peer support and discussion. Midwives take 'live' cases to discuss at the meetings or raise as a subject of concern. The outcomes of supervision are recorded appropriately on the electronic patient records along with expected outcomes and dates for completion. The supervision process supports staff to understand complex issues and to clear about their role in individual cases.

5.3.7 Staff at the Friarage hospital ED have the opportunity to seek safeguarding advice and guidance whenever they feel it necessary from a highly visible safeguarding team. As non-case holders there is no specific safeguarding supervision provision in place but we were made aware by staff that access to supervision when required is easy and readily available. Those members of staff who hold cases are provided with specific safeguarding supervision, including staff that hold a case that is open to child protection procedures. Records of supervision are held on the patient records and this supports staff with difficult or complex decisions.

5.3.8 The capacity issues affecting the interim named safeguarding midwife at Airedale adversely affect the strength of supervision arrangements. Closer links with the named midwife at Bradford hospital have recently been developed in order to support the interim named midwife at AFT. Additionally, the interim named midwife has recently undertaken safeguarding children training to help expand organisational capacity to provide advice and guidance to midwives. Whilst there is good access to support for one-to-one advice or queries, the coverage and recording of safeguarding supervision is currently limited by the interim named midwife's time and capacity. This means that midwives do not have robust support; the absence of an effective means of recording or tracking the outcomes of advice and guidance means that case may drift. [Recommendation 4.6.](#)

5.3.9 The interim named midwife at AFT, alongside other safeguarding leads, has given high priority to meeting the learning and development needs of staff. A two-hour session is now delivered monthly with the intention of addressing the continuing professional development needs of the midwifery team in relation to emerging issues and topics such as domestic abuse, voice of the child and FGM.

5.3.10 Safeguarding supervision in ED and the children's ward at Airedale is still evolving and positively, more staff have received safeguarding supervision training to help expand the trust's supervision offer. Group safeguarding supervision is undertaken with ED staff every six to eight weeks and this is open to all staff. A recent record of attendance, however, indicates relatively low take up by staff. The ED group supervision records we looked at provide a basic overview of the areas of practice discussed but actions on the recording sheet that further inform practice were not completed. [Recommendation 4.8](#).

5.3.11 Children's ward staff at Airedale have access to group safeguarding supervision with medical staff, but it is acknowledged that nursing staff would benefit from additional development within local supervision arrangements. Staff reported that they felt that supervision was simply 'slotted into doctor's teaching' and that it was not specific to their role as nurses.

5.3.12 The focus on safeguarding within preceptorship arrangements for midwives employed by YTHFT at Scarborough is limited. Knowledge and understanding of safeguarding is not directly linked to, or embedded within practice within the preceptorship programme. This could lead to the attrition of knowledge over time with the risk that vulnerable women and families may not be properly identified and a corresponding lack of appropriate action. [Recommendation 3.15](#).

5.3.13 Not all nurses employed at Scarborough hospital ED have had access to level three training due to staffing pressures and this could lead to loss of key knowledge over time that inhibits effective practice. Furthermore, supervision in safeguarding practice across Scarborough hospital remains underdeveloped. The policy that mandates twice-yearly supervision cannot be achieved as key groups of staff in ED and the paediatric ward cannot be absented from work due to the same staffing pressures. The safeguarding team reports it is working creatively to develop support packages to improve compliance and develop bespoke packages of training and supervision to help improve the offer. [Recommendation 3.16](#).

5.3.14 Midwives are specifically identified within the intercollegiate guidance as requiring specialist training at level three; a minimum of 12 to 16 hours over a three year period. Managers at HDFT advised that midwives are encouraged to attend LSCB multi-agency training and this would support compliance with the guidance; however, data of attendance is not captured at the moment. The compliance rate for midwives attending the trust's standard level three training currently stands at 88% as opposed to the trust target of 95%. This means that the trust cannot be assured that all midwives have the requisite skills and understanding to support women and their unborn children who are vulnerable. [Recommendation 2.15](#).

5.3.15 HDFT maternity services do not have a formal supervision model. In particular the primary care midwife who case holds a more complex cohort of women's cases does not receive supervision. Further, community midwives are not part of a formal supervision programme although the named midwife receives three-monthly supervision. This means that there is no effective means of challenging or supporting practice for staff with difficult cases and could lead to drift. Managers recognise the gap in provision and report they are keen to strengthen practice in this area. [Recommendation 2.16.](#)

5.3.16 The safeguarding team within the acute setting at Harrogate recognise that training levels are below the 95% expected levels. The ED medical staff are a particular group with low compliance with only 68% of doctors being up to date at the time of our inspection. We are advised that a trajectory is in place to meet the shortfall and that steps have been taken to address this with the introduction of level three on-line training. However, this is insufficient to meet the requirements of the relevant guidance. [Recommendation 2.17.](#)

5.3.17 Managers in Harrogate hospital recognise that further work is needed to support practitioner knowledge in the identification of CSE. The HDFT strategic safeguarding governance group has identified that understanding of CSE within the ED is a target area. An annual update which covered the subject was included as part of the trust's training in 2015 and the subject is also covered in the trust's level three programme. However, the ED lead and paediatric ward matron are unable to identify any staff member that had undertaken CSE training provided by the NYSCB or any cases that had been identified as potential CSE. [Recommendation 2.18.](#)

5.3.18 Staff we spoke with in the ED at Harrogate and from the health visiting and school nursing services report that they use the HDFT safeguarding team as a resource for advice and consultation and where necessary to support escalation of concerns. Staff spoke positively of the availability of support and the value they obtained from the guidance offered. Supervision discussions and plans are recorded on the electronic patient record and inform service delivery.

5.3.19 The 0-19 service do not include looked after children assessments as part of their preceptorship programme for new staff, despite this being a key area of their work in which they should demonstrate competence. The looked after children nursing team offer five sessions each year for staff to receive training in reviewing and recording the health needs of looked after children. However, as the training is currently not mandatory, there is no assurance that practitioners have completed the appropriate training in relation to their roles and responsibilities for looked after children and in completing a review health assessment. Moreover there is no assurance that they are regarded as competent to do so. For example, in one case we were tracking across services, a child had moved into the area and the health visitor had completed the 'transfer in' paperwork. The health visitor attended a looked after child review but as the RHA request had not been properly handed over the need for a RHA was overlooked. The assessment was subsequently completed out of timescales. [Recommendation 2.12.](#)

5.3.20 Formal safeguarding supervision is delivered to health visitors and school nurses using a model known as the 4x4x4 model. Safeguarding supervision is delivered quarterly in groups by the specialist nurses for child protection who have all received appropriate training in supervision but with a specific focus on individual case discussion. Any cases requiring one-to-one supervision are identified either at group sessions or by practitioners who might request this. Practitioners reported that they found the model benefited their practice because they learn from other practitioners and that they have increased confidence in challenging situations.

5.3.21 There is also an effective process of one-to-one post-conference consultation by the safeguarding team with practitioners following initial or complex review child protection conferences. A standard template records the discussion and actions on the child's record. This is a strong arrangement and provides the opportunity for the practitioner to debrief the conference, reflect on and understand the decisions made and gain specialist support to ensure a focused approach to future work with the family.

5.3.22 There are some good opportunities for review and scrutiny of cases in some of the acute services in Harrogate. There is a well-established consultant-led peer review where the safeguarding lead consultant brings safeguarding cases, including young people's mental health, for discussion and learning with medical colleagues. HDFT have also recently established a three-monthly paediatric ward and SCBU safeguarding supervision model facilitated by a safeguarding nurse specialist and using case reviews. Where the child or young person is still an inpatient, actions are written in the patient's record.

5.3.23 Lastly, the paediatric senior nurse has worked with CAMHS to develop training and debrief sessions to increase the confidence of staff in engaging with young people admitted to the ward who have self-harmed. This latter action was as a direct result of a 'lessons learnt' meeting on the ward following a number of admissions that staff found particularly challenging. These examples show good evidence of embedding learning into practice to improve outcomes for young people.

5.3.24 Whilst these supervision opportunities exist in the HDFT 0-19 teams and in some of the acute teams, this is not the case for staff in the ED at Harrogate where a formal safeguarding supervision programme has not yet been established. Ad-hoc sessions provided by the safeguarding team are available but staff do not receive formal group or one-to-one supervision sessions. It is expected that the appointment of a link safeguarding nurse specialist will address this issue and provide supervision opportunities but this had not been implemented at the time of our inspection.

[Recommendation 2.19.](#)

5.3.25 There is good evidence of both ad-hoc and formal safeguarding supervision in respect of active referrals to children's social care made by the CAMHS provided by TEWV. Records of discussions and actions are made on client files ensuring accountable oversight is maintained.

5.3.26 In the Craven CAMHS provided by BDCT we saw evidence of regular four-monthly safeguarding supervision, ad-hoc safeguarding support and agreed action plans. This is augmented by additional safeguarding discussions as part of more frequent clinical supervision. As we have reported already, the use of the safeguarding tab on the electronic patient records system is not always up to date with the current position in respect of child protection processes and this does not support effective management oversight. [Recommendation 9.1](#).

5.3.27 All level three training delivered to substance misuse nurse practitioners at NYH is delivered through the NYSCB and this is a strong arrangement. Non-clinical practitioners are trained at level two safeguarding children and this is supported by further training which includes recognising the indicators of CSE.

5.3.28 NYH practitioners do not currently receive specific safeguarding supervision although this is recognised by the organisation and is part of the current safeguarding action plan. Practitioners can, however, obtain advice and guidance from safeguarding leads based at each hub across North Yorkshire. Regular meetings take place within the organisation, including daily 'flash' meetings where safeguarding issues can be discussed. [Recommendation 16.1](#).

5.3.29 The SCOT team have access to group safeguarding supervision bi-monthly and minutes are formally recorded. Other ISHS (integrated sexual health services) staff with limited contact with children or young people are now expected to have at least an annual safeguarding supervision session, moving to bi-annually in the near future.

5.3.30 Named GPs and the nurse consultant for primary care work positively and proactively to enable lead GPs in the practices in the area to be effective in providing appropriate training to, and supervision of practice staff. A survey of lead GPs has been recently undertaken to help evaluate the impact of the named GPs and the nurse consultant roles in helping staff keep up to date and reflect on their practice. Smaller practices have particularly valued the lead GP forums in building their confidence, knowledge and expertise, particularly on topical themes such as CSE and FGM. Timely and constructive advice given by the CCG safeguarding team is highly valued by local GPs. As we have alluded to earlier, this has helped to maintain a good focus on safeguarding within primary care in North Yorkshire.

5.3.31 GP practice development sessions are delivered to all practice staff several times each year and staff also have access to a range of online learning programmes that support this.

Recommendations

1. South Tees Hospitals NHS Foundation Trust should:

- 1.1 Ensure that midwives are supported to make and record routine enquiries about the risks of domestic abuse for every expectant woman throughout their episode of care.
- 1.2 Enable community midwives to have remote access to the electronic patient records system to ensure safeguarding information is fully accessible in community settings.
- 1.3 Ensure the electronic patient records system used by midwives flags all current safeguarding risks to practitioners.

2. Harrogate and District NHS Foundation Trust should:

- 2.1 Ensure midwives make and record routine enquiries of pregnant women in their care about the risks of domestic abuse on more than one occasion during a woman's episode of care.
- 2.2 Ensure health visitors make routine enquiries with women about domestic abuse risks and make a record to signify that this has been done, what the response was and whether any further action was taken as a result.
- 2.3 Ensure timely notification of domestic abuse incidents to health visitors and 5-19 practitioners to enable them to promptly follow up concerns.
- 2.4 Ensure family and parental or carer details and those of the adult accompanying a child are consistently noted on children's records in the ED at Harrogate hospital.
- 2.5 Ensure that a comprehensive safeguarding assessment is carried out for all children and young people who attend the ED at Harrogate, including an opportunity for children to provide their own history for any injuries.
- 2.6 Implement procedures and documentation supporting staff to identify 'hidden children' associated with adults attending the ED at Harrogate hospital.
- 2.7 Ensure that the built environment for children in the ED at Harrogate complies fully with the relevant guidance on children and young people in urgent care settings.

- 2.8 Implement a mechanism in the maternity service to provide assurances of compliance and quality in relation participation in child protection processes including contribution to conferences and referrals to children's social care.
- 2.9 Ensure health actions plans arising from previous health assessments of looked after children are properly reviewed at each successive review.
- 2.10 Include information from Strengths and Difficulties Questionnaires (SDQ) within health assessments for looked after children to inform assessment of children and young people's emotional and mental health
- 2.11 Develop the system for monitoring the issue of and evaluating the effectiveness of health passports for looked after children who are leaving care.
- 2.12 Include competencies related to assessing the needs of looked after children within the preceptorship programme for health visitors and school nurses.
- 2.13 Ensure the ED is resourced at all times with sufficient paediatric trained nursing staff in accordance with the relevant guidance on children and young people in urgent care settings.
- 2.14 Ensure records of discussion and supervision of specialist looked after children nurses are uploaded to the client records.
- 2.15 Provide level three specialist training for midwives that enables them to achieve the requisite number of hours according to the relevant guidance..
- 2.16 Introduce formal safeguarding supervision arrangements for midwives.
- 2.17 Provide level three training for eligible staff, including medical staff, who work in the Harrogate hospital that meets the requirements of the relevant intercollegiate guidance.
- 2.18 Ensure eligible staff have received CSE training to enable effective identification of children whom are potential victims.
- 2.19 Develop formal safeguarding supervision arrangements for ED staff.

3. York Teaching Hospital NHS Foundation Trust should:

- 3.1 Develop the approach and documentation for assessing risk in the Scarborough maternity service to ensure any additional needs of the woman and the unborn child are more clearly understood, including making and recording the routine enquiry into the risks of domestic abuse throughout a woman's episode of care.

- 3.2 Ensure that details of the reason for a child's attendance at Scarborough ED and the identity of the person who attends with them are recorded at the point of booking in.
- 3.3 Strengthen the arrangements in the ED to enable all children and young people to wait in a welcoming and child friendly environment that is also observable by staff.
- 3.4 Procure paediatric scales for use in the ED in Scarborough hospital.
- 3.5 Ensure that maternity services for Scarborough are adequately resourced to provide specialist support where required to women with additional needs such as those with mental health needs, substance misuse issues or teenaged mothers.
- 3.6 Implement processes for assessing risk and identifying additional needs during the transfer of young people aged 16 and over who self-harm to adult wards in the same way as is the case for young people under that age who transfer to the paediatric ward.
- 3.7 Ensure Scarborough maternity records contain the notes of all child protection processes, including core group meeting records, to help inform birth planning.
- 3.8 Provide adequate cover for the absence of the safeguarding nurse to ensure that referrals to children's social care made by Scarborough hospital staff are reviewed for the duration of the pilot programme set up for this purpose.
- 3.9 Implement processes to enable the integrated sexual health team to effectively contribute to child protection conferences and the work derived from resulting plans.
- 3.10 Review the levels of knowledge and understanding of staff in the Sexual Clinical Outreach Team in relation to identification of safeguarding risks and the extent of front line oversight of safeguarding practice.
- 3.11 Ensure the trust's safeguarding roles have adequate capacity to effectively guide and monitor the work of staff.
- 3.12 Ensure the ED is resourced at all times with sufficient paediatric trained nursing staff in accordance with the relevant guidance on children and young people in urgent care settings.
- 3.13 Develop the new electronic patient records system in the ED at Scarborough so that it both enables audits of key safeguarding activity and supports staff to effectively identify risks to children.
- 3.14 Develop the electronic client records system in the sexual health service so that it enables staff to record the child's journey and the activity of partner agencies and so that audits can be effectively carried out.

- 3.15 Introduce safeguarding competencies to the midwifery preceptorship programme in order to consolidate knowledge obtained from training and improve practice.
- 3.16 Ensure there is sufficient staff coverage in the ED at Scarborough to enable the abstraction of staff who require level three training.

4. Airedale NHS Foundation Trust should:

- 4.1 Expedite the implementation of the common electronic patient records system in the whole of the maternity service to support midwives to make complete assessments of risks by taking account of domestic abuse, of maternal mental ill-health or of previous history of abuse.
- 4.2 Ensure that maternity safeguarding records are fully updated with additional social and familial needs so that they inform ongoing care and planning.
- 4.3 Ensure maternity staff have the skills and knowledge to fully recognise and record risks arising from a woman's situation and to take appropriate action through handover to other relevant health services and referral to children's social care where this is indicated.
- 4.4 Ensure that hospital staff carry out and record a full assessment of risks arising from the young person's and their social situation as well as descriptions of injuries and the use of body maps where appropriate.
- 4.5 Ensure that referrals made to children's social care contain sufficient detail and analysis of the known factors, including family situation and mental health risks, to support a better understanding by the recipient of any additional needs and safeguarding risks.
- 4.6 Ensure the role of named safeguarding midwife has adequate capacity to effectively guide and monitor the work of midwives in supporting vulnerable pregnant women, including the provision of robust supervision.
- 4.7 Ensure the ED is resourced at all times with sufficient paediatric trained nursing staff in accordance with the relevant guidance on children and young people in urgent care settings.
- 4.8 Ensure discussions and actions arising from safeguarding supervision for ED staff are properly recorded to help develop practice.

5. York Teaching Hospital NHS Foundation Trust and Vocare Limited should:

- 5.1 Implement procedures and documentation that support staff to identify 'hidden children' associated with adults who attend for urgent care at Scarborough hospital.

- 5.2 Work together to ensure that very young children under one year old with head injuries are streamed into the hospital ED to be seen by a senior clinician in line with LSCB guidance.
- 6. Tees, Esk and Wear Valleys NHS Foundation Trust should:**
- 6.1 Review the current arrangements for the single point of access into the CAMHS to determine if there is scope to incorporate this into the multi-agency safeguarding front door arrangements.
- 6.2 Ensure that the arrangements for the transition of care for young people from adolescent to adult services are adequately resourced so that young people's needs continue to be met.
- 7. The North Yorkshire and York CCGs together with Airedale NHS Foundation Trust, Harrogate and District NHS Foundation Trust, York Teaching Hospital NHS Foundation Trust, South Tees Hospitals NHS Foundation Trust, Tees, Esk and Wear Valleys NHS Foundation Trust and Bradford District Care NHS Foundation Trust should:**
- 7.1 Work together to strengthen the peri-natal mental health offer across North Yorkshire and to develop a clear peri-natal mental health pathway for all women who are mentally unwell during and after pregnancy that accords with the relevant clinical guidance and with clearly defined outcomes.
- 8. Tees, Esk and Wear Valleys NHS Foundation Trust, Harrogate and District NHS Foundation Trust, York Teaching Hospital NHS Foundation Trust should:**
- 8.1 Work together to ensure that the emergency departments and paediatric wards at Scarborough hospital and Harrogate hospital are adequately resourced with staff who are trained to assess and manage children and young people's emotional health needs and to provide adequate CAMHS guidance and support out-of-hours and at weekends.
- 9. Bradford District Care NHS Foundation Trust should:**
- 9.1 Develop the use of the safeguarding template in the client records so that safeguarding information is prominent and can be readily retrieved.
- 10. NHS Airedale, Wharfedale and Craven CCG together with North Yorkshire and York CCGs should:**

- 10.1 Review and standardise safeguarding practice in the Craven area so that the common and consistent approaches are used for information management in relation to vulnerable children and families living in this North Yorkshire locality.
 - 10.2 Work together to standardise the safeguarding assurance processes for GPs in the Craven area so that the CCG is clear about any gaps in safeguarding practice.
- 11. The North Yorkshire and York CCGs, NHS Airedale, Wharfedale and Craven CCG, Harrogate and District NHS Foundation Trust, South Tees Hospitals NHS Foundation Trust, Airedale NHS Foundation Trust and York Teaching Hospital NHS Foundation Trust should:**
- 11.1 Work together to strengthen the process that ensures young people who are new to care have their health needs assessed by a medical practitioner within the statutory timescales.
 - 11.2 Work together to ensure that paediatricians carrying out initial health assessments adopt a consistent approach to involving the child or young person in the assessment and take account of their views.
- 12. The North Yorkshire and York CCGs, NHS Airedale, Wharfedale and Craven CCG, and Harrogate and District NHS Foundation Trust should:**
- 12.1 Ensure that GPs are invited to contribute information to review health assessments for looked after children.
- 13. Harrogate and District NHS Foundation Trust, South Tees Hospitals NHS Foundation Trust, Airedale NHS Foundation Trust and York Teaching Hospital NHS Foundation Trust should:**
- 13.1 Work together to formally introduce an information sharing protocol to ensure pregnant women are properly notified to the health visiting service by 28 weeks pregnancy.
 - 13.2 Ensure that paediatricians, health visitors, school nurses and looked after children nurses are able to identify those situations when a looked after child should be subject of a CSE risk assessment.
- 14. Harrogate and District NHS Foundation Trust, and York Teaching Hospital NHS Foundation Trust should:**
- 14.1 Work together to develop the contribution of the Specialist Clinical Outreach Team (SCOT) of the sexual health service to health assessments for looked after children where they are involved.

15. North Yorkshire Horizons, Tees, Esk and Wear Valleys NHS Foundation Trust and Bradford District Care NHS Foundation Trust should:

- 15.1 Work together to develop a pathway for referring, and sharing information about clients of both the substance misuse and mental health services to support stronger assessment of impact on children associated with clients.

16. North Yorkshire Horizons should:

- 16.1 Develop a programme of regular safeguarding supervision for case-holding staff.

Next steps

An action plan addressing the recommendations above is required from NHS Hambleton, Richmondshire and Whitby CCG, NHS Harrogate and Rural District CCG, NHS Vale of York CCG, NHS Scarborough and Ryedale CCG and NHS Airedale, Wharfedale and Craven 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.