

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

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

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Provider services included:	<ul style="list-style-type: none"> • Calderdale and Huddersfield NHS Foundation Trust (CHFT) • The Mid Yorkshire Hospitals NHS Trust (MYHT) • South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) • Locala Community Partnerships Community Interest Company • Change, Grow, Live
CCGs included:	<ul style="list-style-type: none"> • NHS North Kirklees CCG • NHS Greater Huddersfield CCG
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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 Kirklees. 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.

Where the findings relate to children and families in local authority areas other than Kirklees, 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 87 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.

The data shows that children and young people under the age of 20 years make up 25.3% of the population of Kirklees with 38.7% of school age children being from a minority ethnic group.

The proportion of children under 16 living in low income families is 21.3%, higher than the national average of 20.1%. Family homelessness is better at 0.9 per 1,000 against 1.9 for England. The number of children in care is higher with 70, as opposed to 60 per 10,000 for England.

The infant (aged 0 to 1 year) mortality rate is worse than England with 4.2 per 1,000 live births compared with 3.9 nationally. The child (aged 1 to 17 years) mortality rate is also worse than England at 16.2 as opposed to 11.9 per 100,000 for England.

Generally, data shows that the health of children in Kirklees is mixed compared with England averages for a range of attributes measured. For example, immunisation rates for all children are better than the national average with more than 95% of children receiving all relevant immunisations, including children in care.

Babies and young children generally have healthy weights. More children in Kirklees are born with a low birth weight than the England average whereas childhood obesity is at similar levels for children up to age 11. Children's dental health is also similar to England in relation to numbers of children with missing, decayed or filled teeth.

Under 18 conceptions are similar to England with 21.6 compared to 22.8 per 1,000 and this is an improving picture for Kirklees. The number of teenaged mothers is similar to England at around 1%.

Hospital admissions for young people with mental health conditions (37.5 per 100,000) and young people over 10 years through self-harm (264 per 100,000) are significantly better than national averages at 85.9 and 431 respectively. Admissions through alcohol related conditions or substance misuse are slightly better (fewer) than the England average whilst admissions through asthma are slightly more.

The number of children killed or seriously injured on roads is almost twice that of the England average. The number of children aged 0-14 and the number of young people aged 15-24 admitted to hospital with injuries are around the same as the rest of England, whereas the overall number of children aged 0-4 attending the emergency department is slightly higher at 643 against 588 per 1,000 for England.

The Department for Education (DfE) provide annual statistics derived from outcomes for children continuously looked-after. Although the numbers of children looked after by Kirklees throughout the year increased from 655 to 700 between March 2016 and March 2017, the outcome data for those children looked after for 12 months or more at March 2017 was not available at the time of our review. As at March 2016, however, Kirklees had 455 children who had been continuously looked-after for more than 12 months (excluding children in respite care), 45 of whom were under five.

The March 2016 DfE data indicates that most of Kirklees' looked-after children (98%) had an annual health assessment, more than the average for the rest of England (90%). The data also shows that 97% of looked-after children were up-to-date with their immunisations, better than England with 87%, and 95% 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.

Commissioning and planning of most health services for children, including children's mental health services and specialist services for looked after children, are carried out by two CCGs, NHS Greater Huddersfield CCG and NHS North Kirklees CCG. Kirklees Council (Public Health) commission a range of public health services including the sexual health and substance misuse services for children and adults.

The integrated 0-19 community health services, known as 'Thriving Kirklees' began providing services for children and young people aged 0-19 in April 2017 and includes services commissioned both by the CCGs and by Kirklees Council. Children and young people or their carers or advocates contact these services through a single point of access. 'Thriving Kirklees' comprises health visiting, school nursing and looked after children nursing services provided by Locala Community Partnerships Community Interest Company (referred to throughout this report as simply Locala); the children and young people's mental health services provided by South West Yorkshire Partnership NHS Foundation Trust (SWYPFT); and the children's emotional wellbeing service (ChEWS) provided by Northorpe Hall Child and Family Trust. We did not visit Northorpe Hall as part of our review.

A number of other services are provided under 'Thriving Kirklees', such as service for children with learning disabilities and the family support charity known as 'Home Start; however these services were also not visited by us during our review.

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

- Calderdale and Huddersfield NHS Foundation Trust (CHFT). An emergency department is located at Huddersfield Royal Infirmary (HRI). There is a stand-alone birth centre based at HRI and a consultant led maternity unit based at Calderdale Royal Infirmary (CRH).
- The Mid Yorkshire Hospitals NHS Trust (MYHT). An emergency department is located at Dewsbury District Hospital (DDH) (although the DDH emergency department also houses a walk-in centre provided by Locala). There is a midwife led maternity centre at DDH with consultant led services at Pinderfields Hospital.

Adult mental health services are provided by SWYPFT. Adult substance misuse services are provided collaboratively by Change, Grow, Live (CGL), Locala and the Basement Recovery Project. Children and young adults' (up to age 21) substance misuse services are provided by CGL.

The last inspection of safeguarding and looked-after children's services for Kirklees that involved the health services took place in October 2011. This was a joint inspection with Ofsted. At that time, the effectiveness of the arrangements for safeguarding children and those for looked after children were judged to be 'good'. Recommendations for the providers arising from that review were considered during this review. We also considered the Children Looked after and Safeguarding (CLAS) reviews of Wakefield and Calderdale (from November 2015 and April 2016 respectively) as they relate to the principal health providers in Kirklees.

Ofsted carried out a single agency inspection of Kirklees council and Kirklees safeguarding children board (KCSB) in September and October 2016 and were judged as 'inadequate'. This was followed by two Ofsted monitoring visits in June 2017 and October 2017 to check on progress made since the inspection. Ofsted noted some limited progress had been made but that the expected pace of change was too slow. We have taken account of the Ofsted findings during this review.

All four of the principal providers identified above (Locala, SWYPFT, CHFT and MYHT) have been inspected by the CQC through 2016 and 2017 as part of the hospitals regulatory inspection programme. The findings of those inspections in relation to children and young people have been considered as part of this review.

Health services in Kirklees follow the KSCB procedures, which are derived from the online resources used across neighbouring local authority areas under the West Yorkshire Consortium for Safeguarding Children. At the time of our review, professionals from all agencies working with children in Kirklees followed the Kirklees thresholds guidance known as the Continuum of Need Response Framework (CoNR). The CoNR describes levels of intervention closely associated with those described in Working Together to Safeguard Children (2015); broadly, support through universal services, early help, child in need assessment or child protection intervention.

However, since October 2017, and in order to make significant improvements in the management of individual cases as a result of the Ofsted findings, the local area have implemented a new process for making initial contact with the duty and advice service (the children's safeguarding front door). This new process requires a practitioner to have an initial conversation with a duty and advice social worker to support the practitioner in making decisions about where a child or family might receive additional services or early help. A contact form is used in those cases where ordinarily a 'referral' would be made for further assessment or for consideration by the multi-agency safeguarding team within the centre.

During our review we looked at the effectiveness of health practitioners' engagement with the process during the transition period between the existing processes and the new approach and our findings are outlined in this report.

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

One parent of a young person who had been receiving support from CAMHS said:

“We were beginning to feel that we had lost our daughter. The (named CAMHS practitioner) has been supporting, not only my daughter, but our family as a whole and this has helped us to understand what she is going through and deal with our own feelings. We have now got our daughter back”.

A 16 year-old girl living in a children’s home told us:

“I have a really good looked after children nurse. She has discussed sexual health with me and helped me know how to look after myself. Sometimes I have problems with my weight and she has been able to help me with that. She has given me some really good advice.”

The mother of a new baby and toddler using community health services in who had moved into the area:

“Early years health services are fantastic in Kirklees and things feel more joined up than they were when we were living in (another borough). My daughter has feeding difficulties and following regular checks of her weight at clinic, the nursery nurse passes on information promptly to the health visitor. The process feels very reassuring. The breast feeding café approach is great. I feel well informed and able to make what I think is the right decision for my daughter. I also have valued the opportunity to seek advice from the 0-19 team about my older child’s behaviour.”

One new mother we spoke with who had attended the birthing centre at Dewsbury and District Hospital as her 14 day old baby was due to be discharged from midwifery services. She told us:

“All the community midwives have been lovely. I feel that I could ask them anything. I am only here today to get discharged. They said that they would come to my house to do it, but I sense that they are really stretched so I offered to come here to help them out. I don’t mind, we have a car but that would be tough for someone who didn’t and they would have to just wait around all day.”

Another mother had just given birth at home in the early hours, and had attended the birth centre for her post birth checks told us:

“The midwives are fantastic. I wanted a home birth but the consultant was against it. My midwife really supported my decision, helped me weigh up the risks and fought my corner with the consultant. I managed to have the non-medical birth that I wanted thanks to her. We came in here today though because they were supposed to come over to do the checks but they are short staffed so we had to come here instead.”

A new mother who had recently used the birth centre at Huddersfield Royal Infirmary said:

“I think the birth centre at Huddersfield Royal Infirmary is wonderful. The staff are really great. I was worried about my birth and the consultant midwife spent lots of time with me and answered all of my questions. I felt really listened to and I was treated really well.”

The child's journey

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

1. Early help

1.1 Health services in Kirklees generally have robust approaches to identifying children and families with additional needs and in providing appropriate support to those families, with some areas demonstrating strong practice. There are also some areas where useful initiatives are less effective due to variable practice.

1.2 For example, the maternity unit at Dewsbury and District Hospital uses a safeguarding integrated care pathway that utilises an established vulnerability assessment tool. It provides a contemporaneous record of care, contacts and conversations that the midwife has had with the mother and other professionals with the information ultimately being transferred to the records of the new baby. In cases we looked at we saw evidence of these being completed well with midwives adopting a strengths based approach to assessing and meeting needs. In one case we were tracking across services we saw that the midwife had worked closely with the substance misuse service including carrying out ante-natal visits at the substance misuse clinic. This ensured the woman remained engaged and professionals could establish a good picture of her behaviours that might give rise to risk. However, in some of the integrated care pathways, information was illegible and sections of the pathway were not recorded electronically as intended. This can lead to some key risk features being overlooked by future users of the records. [Recommendation 1.1](#).

1.3 The maternity unit at Huddersfield Royal Infirmary have effective arrangements to support vulnerable women affected by poor mental health, substance misuse and domestic abuse, and have a clear picture of a woman's social situation. Specialist midwives hold cases where there are particular, identified concerns and support community midwives where such concerns are emerging. An under 18 pregnancy pro-forma is used effectively to gather information about a young person's health, social and familial history. This enables midwives to identify care priorities and plan interventions to support pregnant young women to reduce risk and produce the best possible outcomes for the mothers and their babies.

1.4 Midwives at Huddersfield Royal Infirmary also involve prospective fathers-to-be to enable them to get a better understanding of the needs of expectant mothers and their babies. For example, in one case we sampled, the young pregnant mother disclosed that the father of the unborn baby was a low level cannabis user. The midwife met with the father and obtained details of his health history including details of his cannabis use. As a result, a referral was made to the Family Nurse Partnership (FNP) so that both parents could begin work to mitigate any risks to the new baby.

Good practice example – co-ordinated early help to meet specific needs

Specialist midwives at Huddersfield Royal Infirmary, the sexual health service and the substance misuse service have worked creatively to ensure that they broaden their availability for those women who are hard to reach and difficult to engage. For example, an increasing cohort of pregnant sex workers within the community are engaged and supported to access ante-natal care through regular targeted work at substance misuse clinics. In turn, this allows the midwife to continually assess any evolving risks or additional needs and ensures that robust plans are in place to protect and meet the needs of mother and the new baby.

1.5 There are good arrangements for handing over the care of vulnerable women from midwives at Huddersfield Royal Infirmary to health visitors, facilitated by the electronic patient records. However, there are some gaps in these arrangements for midwives at Dewsbury and District Hospital. This is acknowledged by the trust as an ongoing concern and is an area they are attempting to address. Currently, there is a risk that this could lead to delay in enabling prompt identification and sharing of concerns about pregnant women and their partners. [Recommendation 1.2.](#)

1.6 One of the most effective initiatives in Kirklees providing children and families with early help is the integrated 0-19 service known as 'Thriving Kirklees'. Health visitors and public health nurses work with, and are co-located with, the family nurse partnership and CAMHS and practitioners have developed new ways of supporting children and families. This means that children and young people with a range of different needs can have those met in a co-ordinated way at one location by staff who have developed different skills through joint learning and experiences. We saw evidence during our week in Kirklees of a number of creative ways of engaging and supporting children and young people and families from each of the health disciplines in the 0-19 service. These are important areas of practice that demonstrate the breadth of the integrated approach to early help, including stronger joint working with CAMHS and social care. Examples of these are set out below.

1.7 The 'nurturing parent programme' was introduced in July 2017 in 'Thriving Kirklees'. This is a programme aimed at enabling parents to support the emotional needs of their children to promote positive behaviour and achievement of long term goals. Anecdotal reports from staff indicate that this has strengthened parental engagement and capacity across agencies and that it is already beginning to lead to positive outcomes in some families where this has been introduced. For example, in one case we reviewed we noted some effective work by a health visitor and nursery nurse from the 0-19 service to support the parents of a young child where they themselves had previously been looked after and had autism. The provision of regular health advice and guidance was helping them to build their parenting capacity and to keep them engaged in health services to meet their needs and those of the child. Although examples such as this are positive reports, we have not reviewed any data that demonstrates the impact of the programme in the short time it has been implemented.

1.8 'Whole family' approaches to the emotional wellbeing of children are taken by a range of disciplines that help to prevent family breakdown. For example, there are good links and effective multi-disciplinary work between the 0-19 service and the adult mental health and substance misuse services. This is further evidence of the 'whole family' approach enables more holistic, targeted support to be provided to families and we noted good examples of this in cases we looked at in both the 0-19 and the adult services. Furthermore, we also saw examples of these holistic approaches that demonstrated an understanding of, and respect for, families' different ethnic identity and cultural needs.

1.9 CAMHS adopt a whole families approach to carrying out longitudinal work with families as well as young people. Our review of one case showed how a young person was supported to improve their emotional resilience and manage harmful behaviour through therapeutic work with the young person and their family. The family expressed how this had made a positive impact on their relationship resulting in a significant improvement in the young person's emotional wellbeing.

1.10 Multi-disciplinary and multi-agency work is also a strong feature of CAMHS throughout a young person's treatment pathway. This is evident through their presence as a key partner within 'Thriving Kirklees' where, for example, CAMHS practitioners work with school nurses to support them to deliver short term interventions. School nurses report that this enables them to directly support children and young people with emotional resilience issues as opposed to making a referral to CAMHS. This early intervention prevents delay and, importantly, reduces the potential for escalating into more serious anxiety problems and potential self-harm.

1.11 The re-introduction of school health drop-in sessions works well and allows young people flexibility to see a health practitioner at the time of their choosing. School health nurses review and update the child's records dynamically so they provide a full picture of their health needs. The sessions also provide good access for pastoral care staff and safeguarding leads within the school to share concerns with health practitioners and seek appropriate support for individual children.

1.12 There are greater opportunities for families to get support and advice throughout the day from the 0-19 service's 24-hour single point of access. Health visitors are commissioned to provide out-of-hours coverage as part of the contact centre offer. In practice, however, calls remain low and further work is needed to ensure the workforce is effectively deployed and that the service offer is adding value as part of the wider local health and care system. [Recommendation 2.1](#).

1.13 CAMHS have made inroads into waiting times for children requiring assessments for autistic spectrum disorder (ASD). At the time of our review, though, these remain high at just under one year. The trust is optimistic that, as a result of significant additional investment by commissioners to tackle this issue, they are on schedule to reduce waiting times for beginning an assessment to within one year of referral to the service by September 2018. In the meantime, children and young people who are awaiting assessment, and their parents, can get access to additional support, either over the telephone or through the 'Thriving Kirklees' 0-19 service. This ensures that parents or carers are helped to support children and young people with behaviour that challenges and keep them safe in the interim.

Effective practice example – early help co-ordinated by health visitor

In one case we looked at, four children in one family of South Asian heritage were identified as needing additional support during a baby's 6-8 week review.

The baby's mother spoke no English and had some deteriorating mental health due to her husband's long term health problems and his need to live away from the family. The family were socially isolated and had no wider support and this led to an incident of physical assault on the younger child.

Following referral to children's social care, it was agreed that the health visitor would manage this case through a multi-agency team around the family (TAF). The health visitor creatively used the 'three houses' approach to explore the children's worries, sources of stability and hopes for the future. This approach to 'hearing the voice of the child' enabled better understanding of the children's experiences and was used as the basis for the desired outcomes for the TAF.

As lead professional she co-ordinated work by the school (to monitor and support the emotional wellbeing of the older children); the nursery (to support the youngest child), early help family support for mother and the children, interpreting services and the housing services for adaptations to meet father's physical needs.

The father is now able to live at home, the mother has begun to learn English, the family are no longer isolated, and the children are very happy at their schools, on track to meet their developmental milestones.

1.14 The use of specific safeguarding screening tools in the emergency department (ED) at Huddersfield Royal Infirmary is inconsistent. Whilst mandatory questions at the point of booking-in are always asked, the more helpful prompts for understanding a child or young person's social and family history are used to a varying degree. Furthermore, the safeguarding prompts to assist practitioners to explore a number of different issues upon discharge were not checked in any of the records we looked at. This reduces the opportunities for staff to consider hidden harm and means some children at risk may be missed. [Recommendation 3.1](#).

1.15 In contrast, the practice in the ED at Dewsbury and District Hospital is more robust. Data fields on the paper based 'Casualty cards' to capture social and family history were completed in every record we looked at and the number of attendances over the last 12 months and in the child's lifetime were also noted. However, age specific safeguarding screening tools were not always completed, such as a prompt for the risks of child sexual exploitation (CSE) for young people aged 14 and over. This means potential areas of risk might be missed. [Recommendation 1.3](#).

1.16 At both hospitals' effective systems are in place to notify the 0-19 team and GPs of a child's attendances through paediatric liaison nurses employed for that purpose and the use of information sharing documentation. In cases we looked at this was working effectively and in a timely way. This ensures that practitioners in primary care are alerted to any additional needs and can take any further action to promote the health and wellbeing of children who attend hospital.

1.17 There are effective processes in place at both hospital EDs for the exploration of the hidden child. Case records we looked at showed that staff are professionally curious about children of adults who present with behaviours that might present a risk to children and young people. We noted some good practice in relation to the support provided to women who were victims of domestic abuse through hospital based Independent Domestic Violence Advisers (IDVA). This ensures appropriate steps can be taken to support women and any children living in abusive situations.

1.18 The sexual health service has consulted with young people to ensure the service is more accessible. For example, the service has produced a more discrete type of condom card for use by young people from black and minority ethnic communities. The service has also introduced a weekly young person's clinic to support young people who might otherwise find it difficult to attend the mainstream sexual health clinic. Both initiatives support safe sexual health for young people, promote accessibility and provide the opportunity for young people with additional needs or risks to be identified.

Effective practice example – Adult substance misuse and ‘Think Child’

The adult substance misuse service has a good ‘think family’ culture and good links with other services.

In one case we looked at we saw that a woman who was using the service disclosed that she was pregnant but was reluctant to access other health services. The woman's recovery worker was alerted to additional risks presented by the woman's partner who was also misusing substances.

Through persistence, diligence and liaison with the woman and other health care providers, the recovery worker ensured that the woman could access the appropriate health care. This included co-ordinating her appointments with all health providers to ensure she, and her unborn baby received all ante-natal care.

Through ongoing monitoring, and work with the client and other providers the recovery worker has been able to support the woman to make positive changes to her lifestyle to enable her, after the birth, to meet the needs of her baby.

1.19 A ‘think child’ approach is also well embedded in the adult mental health service. This begins at the point at which a new client accesses the service and continues throughout a client's treatment. Each comprehensive assessment includes prompts to enable practitioners to consider whether a client has access to children and results in a further safeguarding assessment. The ‘whole family’ approach adopted by the trust that we have reported above enables practitioners to be well sighted on the needs of children and the impact of parental mental ill-health. This is supported by the trust's mental health families team. This is a small children's social work team based in the community mental health team, who support practitioners to develop care plans that take account of the needs of families and we noted case examples where this had been effective.

1.20 Primary care link health visitors are well established with, and attached to, each GP surgery. Health visitors report good information exchange and effective use of face-to-face safeguarding forums to share intelligence and monitor risk and progress although we found that this was only true for two of the three practices we visited. In the third, information is shared between the health visitor and GP through tasks on the electronic patient record system. Whilst this ensures information about individual children is passed on, it is a missed opportunity to consider the context of the information, to monitor the progress of vulnerable families through shared understanding and to develop a clear picture of the number and make up of vulnerable families in a practice's patient list. [Recommendation 4.1](#).

1.21 Most GPs in Kirklees use the same electronic patient record system which enables vulnerable children to be appropriately and consistently identified when they attend for a consultation. However, in one of the practices in the south of the area we saw that children and adults are not always correctly identified and coded. For example, one person who was an adult was incorrectly recorded as being a looked after child. We are advised that the practice has not carried out a data cleanse since moving from one electronic patient record system to another. This ultimately means that the practice may not have a clear picture of vulnerable families in their patient list. [Recommendation 4.2](#).

1.22 By contrast, one GP practice we visited keeps a 'watch list', which is regularly reviewed and discussed. This list notes children or families where no safeguarding concerns have been identified at present, but where GP's have observed some changes in behaviour or other concerns. This enables good oversight of those children who might not meet thresholds for a referral to social care and ensures any emerging risks or additional needs can be readily identified and responded to.

1.23 We heard that in North Kirklees there is a large cohort of families where English is not spoken as a first language. In one practice we visited we saw that family members are sometimes used to provide interpretation. This practice is not encouraged, as it limits the opportunity for the patient to discuss their needs confidentially with the GP. Furthermore, the GP cannot be certain that the person providing interpretation is relaying the patient's concerns and wishes accurately, which means that risks and concerns can be missed. [Recommendation 4.3](#).

1.24 There is some inconsistency among GPs in the way that risk is considered for children who are not brought to appointments. In one practice we saw that GPs proactively track those children that are not brought to appointments. Contact is made with the family where a child is not brought for three or more health appointments with any of the health providers. In another practice visited, there was no clear policy in place for such instances. Patients who do not attend three or more appointments are removed from the practice register and this includes children. This can lead to children with additional needs or risks being overlooked. [Recommendation 4.4](#).

2. Child in need

2.1 Our inspection process includes reviewing a number of children's cases in health services to determine their effectiveness across the breadth of safeguarding work, from early help to child protection. During our visits to services, practitioners were readily able to identify cases of children and families that were being supported through early help. This is a strong focus of health services, largely due to the multi-disciplinary approach used by 'Thriving Kirklees'. We also found good engagement and oversight by individual health practitioners or health teams working together with children and their families in those few cases where care, at that time, was already being managed at a child in need level.

2.2 However, practitioners found it difficult to identify new cases of children in need that had arisen within recent months. Some children and families that might ordinarily be managed at this level are being supported at the early help level with health practitioners taking the lead role, often when the circumstances have a relatively high degree of complexity. This uneasiness was expressed by health practitioners and was evident in cases we looked at in services when circumstances indicated that a more comprehensive assessment might otherwise have been considered. We are concerned that the strength of the early help arrangements and the confidence that local leaders have of the ability of those arrangements to meet needs may result in a decrease in children being identified as requiring statutory assessment. This has a corresponding risk that additional needs in some children or families might be overlooked or remain unidentified. [Recommendation 4.6](#).

2.3 The 0-19 team use a good range of assessment tools and templates, such as universal health needs assessments and safeguarding and supervision templates. These support a good standard of practice and ensure a consistent approach is taken to promote the voice of the child and to understand and monitor children and young people's health needs. For example, routine use of anxiety and depression scores supports good vigilance of children's mental wellbeing. This enables prompt identification of those children who would benefit from additional targeted support from the Children's Emotional Wellbeing Service (ChEWS). This is an example of improvements made in practice following learning from a serious case review and demonstrates the responsiveness of the new integrated service.

2.4 The recently introduced perinatal mental health pathway represents a strong offer for pregnant women and their unborn or new-born infants who are vulnerable through maternal mental ill-health. Multi-disciplinary meetings involving the perinatal mental health practitioners and the midwife discuss the needs of the mother, the family and the unborn baby and a plan is agreed. Each woman's evolving needs are reviewed weekly and risks to her or the unborn child are red-amber-green (RAG) rated to determine or modify an appropriate plan of care. In two cases we were tracking across services we saw effective multi-disciplinary work between maternity units at both Huddersfield Royal Infirmary and Dewsbury and District Hospital, the 0-19 service and the mental health service's families team. The whole family approach in both cases led to early, positive outcomes for the new mothers and their babies.

2.5 The use of postnatal mental health care plans is effective in alerting other professionals who support women and their babies to indicators of potential relapses in mental health and any subsequent risks to the baby. However, there are no formal means of sharing these plans with maternity services. In one case it was left to the mother to hand her postnatal plan to the midwife, a situation which might have left the midwives unsighted on any additional needs or risks. [Recommendation 5.1](#).

2.6 There are contrasting arrangements for receiving and treating children and young people at both EDs that service Kirklees. The children's facilities at the Dewsbury and District Hospital ED are designed with the young patient in mind, have plentiful treatment cubicles and discrete waiting areas that can be monitored for signs of a deteriorating child or to observe interaction between children and parents. As previous CQC inspections have found the arrangements at Huddersfield Royal Infirmary are not currently suitable for children, with limited treatment areas and no facility for children to wait separately from adults. We have commented on this further under 'leadership and management' below.

2.7 There is a clear pathway for CAMHS to respond to children and young people attending ED at Huddersfield Royal Infirmary and Dewsbury and District Hospital with mental ill-health or having self-harmed. There is also clear guidance on when a CAMHS assessment should be completed and the criteria for making a referral to CAMHS on completion of a paediatric mental health pro-forma assessment. Mostly, assessments take place in the ED by the CAMHS crisis team, operating 9am to 8pm each day. Out-of-hours, or when children require medical treatment for an injury or overdose, they may be admitted to the paediatric wards at Calderdale Royal Hospital in Halifax or Pinderfields Hospital in Wakefield, both of which are outside the Kirklees area. In such cases, children are seen the next day with hospital staff supported out-of-hours by the availability of a CAMHS consultant accessed through the 24-hour single point of access. Recent trust data shows that the service meets the four-hour target for responding in such instances over 90% of the time and this means that young people in crisis are seen without delay.

2.8 However, during our discussions in the EDs at Huddersfield Royal Infirmary and Dewsbury and District Hospital and the children's wards at Calderdale Royal Hospital and Pinderfields Hospital, staff told us that this four-hour target is often breached and young people are left waiting for an assessment longer than necessary. This is at odds with the data provided by the CAMHS service and indicates that staff in the acute settings have not been fully apprised of the differing response times for assessment in different circumstances and may be unclear about the availability of out-of-hours support. [Recommendation 6.1](#).

2.9 Where there is a need to admit a child or young person and transfer them to another hospital site for paediatric care, ED staff carry out comprehensive risk assessments. In one case we looked at, a 16 year old young person had attended Dewsbury and District Hospital ED having taken an overdose and required admission for treatment of the overdose prior to a CAMHS assessment. Staff at the ED worked with the young person and the young person's family to complete a thorough self-harm assessment as well as a patient safety assessment prior to transfer. This ensured the young patient was appropriately safeguarded throughout the transfer and during the period as an inpatient whilst awaiting assessment.

2.10 Both the children's and the adult's substance misuse services work together and undertake joint assessments before any transitions take place from the youth to the adult services. This means children and young people, especially those with a learning disability who are assessed with the involvement of their family, can receive therapeutic interventions in the most appropriate service.

2.11 Practitioners from both the adult mental health and adult substance misuse services routinely attend all child in need meetings. This ensures the impact of parental mental ill-health and substance misuse on children is understood and properly planned for.

2.12 In one young person's case we reviewed we found that systemic shortfalls led to him remaining in unsuitable adult social care accommodation even though he had been assessed as requiring hospital treatment under the Mental Health Act since August 2017. We acknowledge that there is a known critical shortage of suitable beds for young people with acute mental health needs and that it is clear the social care and clinical teams have worked hard to establish a suitable placement for him. However, early recognition of the inappropriateness of the current placement, combined with the unacceptable delay in finding him a suitable place has potentially resulted in him being socially isolated and suffering physical harm that might have been avoided if his needs had been able to be assessed in a more suitable clinical setting. During our review, we asked NHS England, the CCG, Kirklees Council and Locala to work together as a priority to meet this patient's needs and this has now been done with his planned transfer to a more appropriate clinical placement. This is now subject of a system review involving NHS England, the CCG and Kirklees council. [**Recommendation 8.1.**](#)

3. Child protection

3.1 As we have reported above, the Kirklees safeguarding partnership use a recently implemented 'front door' decision making process that has been in place in the duty and advice centre for just over two months prior to our review. The specialist safeguarding nurses who are employed in the centre perform a key role in the processes for more complex cases and make a significant contribution to decisions made about those children. This involves the research, analysis and sharing of information, participation in strategy meetings and daily risk assessment meetings at the centre. The nurses are clear about their role and, since the implementation of the current case management pathway, are confident that their contribution has an impact on decisions about interventions to support children and families. This is a strength and was borne out in our review of records of some of the cases that had been subject of strategy discussions on the day of our visit and in the week before.

3.2 The case management pathway is still in its infancy and so there is insufficient data at this time to determine whether it will consistently lead to good outcomes for children. However, there is optimism among the health practitioners in the duty and advice centre about their revised role and increased responsibility within the system. Their perception is that their contribution is already leading to better informed, more appropriate decisions and interventions.

3.3 On the whole, the work that we would ordinarily undertake to test the effectiveness and the analysis of risk in health services' child protection referrals has been limited. This is owing to the process having just begun and the relative uncertainty of many health practitioners about how such cases will be brought to notice. We have commented on this below under 'leadership and management'. Nonetheless, we found that practitioners in front line health services, usually, had a good understanding of risks and could explain when their view of a child's situation amounted to significant harm. However, there were some inconsistencies in this and some service specific examples are set out in this section.

3.4 Midwives at both trusts have a good understanding of domestic abuse. They follow good practice guidance about seeing women alone and speaking to them about the risk of such abuse on more than one occasion through the pregnancy and when safe and appropriate to do so. Audits have shown good compliance with this practice. This increases the opportunity to establish any risks to mother and her new baby from a violent situation. Midwives at Dewsbury and District Hospital have developed a coding system that is used in conjunction with a woman's hand-held records to alert staff to a variety of different vulnerabilities, particularly domestic abuse. This is a creative way of ensuring practitioners who will support a woman ante- and post-natal are aware of such issues without exposing her to further risks.

3.5 Midwives at Dewsbury and District Hospital do not routinely use genograms and chronologies to support assessment and planning. Such tools are important in enabling midwives to understand families that are extended or where the woman's needs are complex. Their absence means that midwives miss the opportunity to gather this key information that would enable them to identify evolving risks arising from a woman's family members or from her history. [Recommendation 1.4](#).

3.6 Health professionals in both the 0-19 service and CAMHS have a good understanding of when they need to make a referral when there is a risk of significant harm, and generally use supervision well to explore ongoing concerns about a case. Frontline practitioners are aware of their professional accountabilities for reporting female genital mutilation (FGM) and CSE. One case we looked at indicated that staff acted promptly on concerns in relation to burns and bruising in a young child. Staff are also appropriately involved in and informed about the multi-agency work on domestic abuse and have been trained to undertake domestic abuse and sexual harm (DASH) assessments. This demonstrates that children and young people using the 0-19 service who are at particular risk are appropriately protected by initial action taken by professionals.

3.7 This good practice extends to the involvement of practitioners in ongoing child protection processes. The staff in both the 0-19 service prioritise attendance at initial and review child protection conferences and at core groups. Reports to conference are child focused, comprehensive and provide a clear professional view about the risks to children and protective factors. There is a good standard of case recording; notes made after each contact visit reflects well any progress made, ongoing risk and the impact for children.

Effective practice example – Family Nurse Partnership and core group work

Two very young children of young parents supported by the family nurse partnership were subject of a child protection plan. We saw positive longitudinal work undertaken by the family nurse who maintained good oversight of the family through both pregnancies by continued and frequent contacts and visits.

The family nurse was able to track the risks to the children arising from the changing parental and environmental situation, such as fluctuating mental health, substance misuse, house moves and parental separation. Information about the family's situation was regularly and effectively shared with other professionals.

This ensured the parents had regular support to build their capacity to better meet their children's needs. This also supported fellow professionals in the family's child protection network to have a clear and accurate picture of the evolving risks.

3.8 CAMHS staff, are attuned to risk in relation to their clients and understand when it is appropriate to make a referral to children's social care. In cases we looked at we noted good description and analysis of risks where there were concerns. For recent cases of concern where information had been shared with the duty and advice centre under the new contact arrangements, we saw that full records were kept of discussions with the duty team. Neither of the recent cases we reviewed had resulted in a formal, written referral but the recording of the discussion was nonetheless detailed and set out a clear rationale for the contact.

3.9 CAMHS practitioners routinely attend child protection conferences and provide written reports. Records we looked at showed full and active involvement in child protection conferences, child in need meetings and core groups and the written reports were of good quality. This means that decisions made by conference take full account of a young person's mental health needs.

3.10 Good use is made of the child protection information sharing (CP-IS) system in both EDs when a child or young person is booked in. Staff are alerted to children who are subject of a child protection plan or who are looked after and of their previous recent attendance at any other ED. This informs the triage and clinical consultation and ensures the child's social worker is informed of the attendance.

3.11 Staff in both of the EDs in Kirklees have a good understanding of risks posed to children from adults who attend the hospital with particular presentations, such as mental ill-health, substance misuse or domestic abuse. In cases we looked at we noted good professional curiosity of staff to identify if patients in these situations had access to or cared for children. In one case of a man who attended Dewsbury and District Hospital with alcohol abuse, staff identified he had children at home and checks revealed they were known to children's social care. Information was appropriately shared and ensured the social worker was apprised of the person's current risks. In another case of a woman who attended Huddersfield Royal Infirmary with an obstetric issue and abdominal pain, staff identified that the woman was a potential victim of domestic abuse. With the support of the IDVA, staff initiated a referral to the Kirklees Multi-Agency Risk Assessment Conference (MARAC).

Effective practice example – multi-agency liaison to safeguard a child

A very young child was brought into the ED at Huddersfield Royal Infirmary in relation to alleged sexual abuse by a parent. Staff very quickly identified additional concerns in relation to potential neglect and parental mental ill-health.

Contact was made with the family's social worker and the concerns of staff were fully explored. Contact was also proactively made with the child's GP and health visitor and with the mental health service and this information was also shared with the social worker.

The child was subsequently transferred to Calderdale Royal Hospital children's ward and remained there with the agreement of the child's parent whilst police and social care carried out an investigation and the child was medically examined.

A strategy discussion was held on the children's ward involving the hospital staff, the mental health service, the police and children's social care. A multi-agency plan was put into place to protect the child upon discharge into the care of the child's grandparents whilst investigations continued.

This case demonstrates a whole systems approach to safeguarding the needs of this child, preserving evidence and considering the wider needs of the child and family whilst the child was still in hospital.

3.12 Practitioners in the adult mental health service are supported to identify children of clients who might present a risk to children through templates on the service's electronic patient record system. Together with a strong think family culture, the templates trigger practitioners to consider the impact of parental mental ill-health on children and young people. This was evident in the records we looked at where the risks to children were considered at the point when a person accessed the service and also at different times throughout their period of care. Practitioners also attend child protection conferences and core groups where they are working with the parents of the children although sometimes they are unable to attend due to short notice. In such cases, reports submitted are relevant and enable the conference to understand the impact of the adult's mental health on the child.

3.13 The electronic case recording system used by sexual health staff ensures staff are aware of children and young people who are vulnerable to exploitation and abuse. The under 19 safeguarding assessment provides a clear and structured approach to identifying and analysing risk and in ensuring this risk is understood by partner agencies. For example, the under 19 safeguarding assessment was used in the case of a 17 year-old girl who experienced repeated missing episodes and frequent unprotected sex. The assessment provided a comprehensive picture of the risks to the girl and useful intelligence that was appropriately shared with relevant other partners. This is one of a number of cases we looked at in the service where the safeguarding assessment had been used to good effect to understand and reduce risks.

3.14 Staff in the adult substance misuse service are not clear about the processes for referring cases to children's social care or of the need for consent to be obtained when cases do not meet the threshold for a child protection referral. Staff advised us that they felt unable to make referrals to children's social care for child protection cases as such referrals are often declined due to the absence of consent. In one case we looked at, we noted that the child of a client was subject of a contact with the duty and advice centre. The referral was declined by the duty and advice centre owing to there being no consent in place. There was no evidence that consent to make a referral had been sought, whereas staff advised they had not sought such consent as they were concerned the client would refuse based on previous experiences. We have drawn this issue to the attention of Kirklees council public health commissioners. We have commented further on the understanding of health practitioners of the front door arrangements below under 'Leadership and Management'.

3.15 Child protection practice is variable in the GP practices we visited. For example, two of the GPs we visited routinely send reports to child protection conferences. However, one practice had not been invited to, and had not contributed to child protection conferences for more than two years. Instead, contributions were made by health visitors through reference to the shared electronic patient record system. This means that information supplied to conferences may not be accurate and would not contain the GPs opinion on the nature of any risk to the child subject of the conference. [Recommendation 4.5](#).

4. Looked after children

4.1 Kirklees has continued to expand the capacity of its specialist looked after children health team and this supports stronger partnership working with children's social care. Specialist looked after children nurses hold a small case load of children and young people with more complex needs and offer additional support to individual children and their carers to address risks to their health and wellbeing. Specialist nurses also have monthly meetings with children's homes staff to discuss children about whom they have concerns. This helps to make recommendations for their health needs dynamically rather than just at specific review times.

4.2 The designated doctor for looked after children is supported by a part time paediatrician, and dedicated business support staff helps to ensure effective information sharing and updating of changes in children's care arrangements. The specialist looked after children health team and social care colleagues are co-located within the Council and have access to the Council's IT system. This enables good sharing of information and helps the services to meet their statutory responsibilities.

4.3 The looked after children service has expanded to include 15 personal advisers who have been trained to provide contraception and sexual health advice, chlamydia and pregnancy testing and promotion of the C-card system. This is a key service for looked after children who are particularly vulnerable to exploitation and provides opportunities for such exploitation to be identified.

4.4 The designated doctor for looked after children values the ongoing support the team receives from children's social care with 95% of clinics being attended by social workers. This means that additional important information about children and their wider social and health histories is captured in discussion with birth families and the social worker at assessment. This provides a holistic picture of the child's needs and experiences that informs wider care planning.

4.5 Looked after children health services in Kirklees perform well in meeting the required timescales set out in statutory guidance. For example, the year-to-date data for initial health assessments (IHA) indicates 98% have been undertaken within the 20 day timescale against a target of 95%, whilst 95% of review health assessments (RHA) have been undertaken within the required timescale. Good performance in relation to immunisations (92%) and registration with dentists is also evident (97%). Most delays are attributed to children placed out-of-area that are reliant on other organisations giving priority to this work. Significant efforts are made to forecast any risks and track delays to out-of-area reviews taking place to help ensure children receive the levels of support they need irrespective of where they are placed.

4.6 The quality of initial health assessments seen is acceptable but not as strong as the review assessments (see below). The IHAs we looked at were handwritten and in some cases they were not very clear or legible. Health care plans largely focus on children's physical health with limited exploration of risks and impact on the emotional wellbeing of children. [Recommendation 9.1.](#)

4.7 The designated nurse and the specialist looked after children team provide good operational management oversight and quality assurance of looked after children health assessments and care plans that are undertaken by universal health services. This includes those assessments and plans for children and young people placed out-of-area. A clear system of challenge is in place to send back for further work any out-of-area assessments that do not meet the required standards. This has helped drive continuous improvement in the standards of practice, including holistic recognition of children's needs and vulnerabilities.

4.8 Locala's 0-19 workforce has a clear understanding of their professional responsibilities for undertaking the RHAs of children in care. Assessments are of a very good quality overall and provide a comprehensive representation of children's needs. Health care plans are SMART and checks are made to ensure all outstanding actions from the previous review have been met. This is further discussed and monitored by the Independent Reviewing Officer as part of the child's statutory review. This ensures the health team has a good understanding of progress made in addressing concerns about looked after children's development, health, personal safety and wellbeing and supports continuity of care over time.

4.9 The process for carrying out RHAs is focused on the needs and wishes of children and there is good evidence of the child's voice throughout. Assessments provide a clear picture of the child or young person's strengths, identity and the things that matter to them expressed in their own words. Children are asked where they would like to be seen, and encouraged to give their feedback on their experience either as part of the review or via a smart-phone app. This allows children to value their contribution to their own assessments. In one case we looked at we noted good practice in the work of a Youth Offending Service (YOS) nurse who skilfully recorded the wishes of the young person in relation to disclosure of sensitive personal information. This helped the young person to recognise what needed to be shared with others.

4.10 There is a focus on risks to the emotional and mental wellbeing of children and young people and this is evidenced well in the looked after children health assessments we reviewed. Strengths and difficulties questionnaires (SDQ) scores are routinely included within review health assessments and used to inform referrals to specialist CAMHS for looked after children. Young people are actively encouraged to rate their emotional and mental wellbeing and this, too helps them to better understand their needs and how they can be met.

4.11 Review health assessments we looked at also demonstrate that other social factors that have an impact on children and young people's health are considered alongside specific health needs. For example, screening for drugs and alcohol is routine and ensures young people receive health promotion advice with referrals to the young people substance misuse service being made whenever substance misuse is becoming a concern. In a small number of records we also saw that concerns about children being groomed or sexually exploited are appropriately and sensitively recorded, including levels of risk which are then appropriately communicated to the child or young person's social worker.

4.12 Children with special educational needs or a disability, including those who have an education health and social care plan (EHCP) are also clearly identified within the health assessment records. This ensures those particular needs set out in EHCPs are prominent in health care planning.

4.13 The records of assessments of children who are looked after by virtue of them being unaccompanied and asylum seeking demonstrate good recognition of their background and country of origin. This ensures that screening of risks to their physical health and wellbeing appropriately takes account of their cultural identity and faith.

4.14 Letters to young people are now consistently provided when they leave care. The approach and quality of these care leavers' letters, however, is limited with only basic, largely factual information recorded that outlines key events. The letters are not actively informed by feedback from children and young people do not provide a personalised depiction of key information about the child's history. For example, one letter stated, 'seen by CAMHS in 2015' without any explanation as to what this was for or what the outcome was. This does not support young people leaving care or other health practitioners they encounter in adulthood to understand relevant history that might have an impact on the current needs. [Recommendation 2.2.](#)

4.15 The contribution of GPs to the looked after children health assessment and planning process is variable. Although GPs are routinely notified of annual or six-monthly reviews they are often not actively involved in the process with some information being difficult to access in a timely way. For example, a small number of GPs in Kirklees, 11 of the 66 practices, use an electronic patient record system which is not compatible with the rest or with the Locala system. This is a challenge to information sharing. [Recommendation 7.1.](#)

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 As has been identified in previous CQC inspection reports, this review also found that the environment and layout of the ED at Huddersfield Royal Infirmary does not adequately meet the current needs of child patients. We are aware that the future establishment at Huddersfield Royal Infirmary is related to the transformation plans for the single hospital estate based at Calderdale Royal Hospital and that requirements of CQC regulatory inspections have influenced the progress of this activity. These plans are well advanced and the changes will take place within the next financial year. This will mean children and young people in the south of Kirklees who require urgent care will be able to attend a single, but well-equipped paediatric ED. In contrast, the self-contained paediatric facilities at Dewsbury and District Hospital have been well designed to ensure children and young people are triaged, seen and treated in an area that is child friendly and safe.

5.1.2 Considerable capacity issues also remain in relation to paediatric qualified nursing staff within the ED at Huddersfield. Problems with recruitment of suitably qualified nursing staff have led to a workforce model where the paediatric ward at Calderdale deploy rotational nursing posts into the ED, although this has not worked well or provided the degree of coverage intended. The limited paediatric qualification of staff at Huddersfield is acknowledged by the trust and is currently an item being managed through the trust's risk register. The future plans for the single hospital site at Calderdale is expected to alleviate the paediatric staffing issues. The trust has introduced a range of interim measures, such as additional training and an on-site advanced paediatric clinical practitioner to ensure that staff have skills in supporting a sick child. This provides the trust with some assurance that children and young people's needs, particularly those of any deteriorating child, are met by an appropriately competent and experienced workforce. [Recommendation 3.2.](#)

5.1.3 The staffing levels and skill mix in the ED at Dewsbury and District Hospital meet the relevant guidance for children's urgent care settings although the trust is currently using a tool to review staffing levels as they are reportedly stretched. The staff skill mix on the Children's Assessment Unit (CAU) at Dewsbury and District Hospital includes children's nurses and the availability of a paediatrician during the CAU's opening hours of 10am to 10pm. Children who attend the ED outside these times who require a further paediatric review after being seen in ED are transferred to the CAU at Pinderfields Hospital in nearby Wakefield. This ensures children in the north of Kirklees can be seen and treated by appropriately qualified staff.

5.1.4 There are contrasting features of the resources of the maternity services at Huddersfield Royal Infirmary and at Dewsbury and District Hospital. For example, there are considerable challenges to capacity in Dewsbury. Community midwives hold individual case-loads that are in excess of the numbers recommended by the relevant guidelines with higher numbers of women with complex needs or cases that involve vulnerable women and higher risk pregnancies. Whilst there are professionals within the trust's safeguarding team with expertise in areas such as FGM, mental health and learning disabilities, there is no specialist midwife resource to help provide advice, guidance and expertise for these cases on the front line. This means greater risks for some women and their babies may not be effectively identified or adequately resourced. [Recommendation 1.5](#).

5.1.5 In contrast, in Huddersfield Royal Infirmary maternity, community midwives have lower, safer case-loads, and are supported by well-established specialist midwives who also provide specialist support and interventions to women with more complex needs. Specialist midwives also have well-developed relationships with other services in the local area, such as adult substance misuse. This enables the most vulnerable and difficult to engage women to access support in locations other than in doctors' surgeries and clinics and this increases opportunities to monitor and observe for any changes in risk.

Effective practice example – supporting women in North Kirklees

Midwives at Dewsbury and District Hospital are supported to better meet the needs of women who come into their care whose first language is not English. Three, band-4 support workers who are fluent in languages most commonly spoken in South Asian Communities are deployed alongside midwives in clinics. This enables women who cannot communicate in English to access equitable care and allows midwives to identify any additional needs or risks to women in these communities or their unborn babies.

5.1.6 Midwives at Huddersfield Royal Infirmary have a well-developed electronic patient record system where safeguarding concerns are clearly flagged and identifiable. This enables maternity staff to have good oversight of needs and risks. Correspondence from other professionals and agencies, meeting records and birth plans are consistently uploaded onto patient records and this provides a full picture of a woman's needs for other users of the record. In addition, community midwives have been provided with laptops. This provides them with the means to update records with information as soon as they have had contact with a patient or attended a meeting to discuss a case. This prevents delays in record keeping and lessens the likelihood of omitting key information from the patient record.

5.1.7 Conversely, there are shortfalls in the recording systems at Dewsbury and District Hospital maternity that we have reported on in 'early help' and 'child protection' above. Furthermore, the current electronic system in place is not sophisticated enough to allow midwives to upload some documents onto patient records. For example, system flags and birth plans can be uploaded whereas child protection plans cannot. This results in some records not being complete and means there is a risk that some important safeguarding information may be overlooked.

[Recommendation 1.6](#).

5.1.8 Leaders and managers of both midwifery services in Kirklees are responsive and committed to service development and improvement. At Dewsbury and District Hospital there is a consistent approach to carrying out audits, the findings of which are discussed at quality performance meetings. Although, as stated above, this has not yet resulted in an alleviation of the capacity issues in the service. At Huddersfield Royal Infirmary the named midwife has good oversight of all cases where there are child protection concerns or cases where there are emerging safeguarding concerns and vulnerabilities. This is supported by regular audits of records which ensures managers are well sighted on the effectiveness of midwives' safeguarding practice.

5.1.9 Locala is establishing a new Safeguarding Hub model to ensure its approach to responding to invitations to initial child protection conferences is rigorous and effectively managed. The approach will ensure a practitioner is allocated to undertake a full review of children's records to inform their report to conference and visit the family, enabling better performance in the provision of initial reports and ensuring high attendance at conferences. This initiative was about to be implemented at the time of our review so we cannot evaluate its effectiveness.

5.1.10 Transformation of the services provided by Locala is underpinned by clear and ambitious plans that place children and families at the centre of the process. The 0-19 Locala team commended the accessibility, leadership and support they receive from team leaders and managers at all levels within the organisation. They fed back that some tough decisions have had to be made about skill mix and levels of resourcing. Staff we spoke with report that changes to working conditions had been handled well, with staff engaged and able to continuously develop their professional practice. This has been particularly evident for the school nursing service which was challenged in relation to its capacity to deliver a safeguarding function in the same way as similar services elsewhere. However, the re-design of the service as a 0-19 offer has positively strengthened its capacity to support young people aged 16 to 18, including those out of school provision. More flexible and responsive whole family approaches have also enabled greater efficiencies in service delivery.

5.1.11 There is a growing shift within Kirklees to strengthen community capability and build networks of support around schools as community hubs to support better co-ordination and integration of activity across agencies. The 'Thriving Kirklees' services are at the heart of this with a number of key initiatives that are either underway or soon to be implemented at the time of our review. For example, we have already reported on the 'nurturing parent programme' implemented in June 2017 which is beginning to show positive outcomes for families.

5.1.12 The 0-19 team also has plans to start delivering a 'Preparing for Parenthood' course. This is intended to positively complement other local approaches to provide a clearer picture of the needs of local communities and ensure school health staff work proactively to reduce local risks such as rates of teenage pregnancy. Other local initiatives include joint work with leisure centre staff. This provides support from a child development worker within the 0-19 team so that parents can undertake exercise classes whilst their children are cared for in a locality where engagement levels are low. Whilst these initiatives are encouraging, they are not yet secured by a clear and agreed Prevention Strategy and this is acknowledged by Locala and its partners as an area that might be strengthened.

5.1.13 There is good, responsive safeguarding leadership in the mental health services provided by South West Yorkshire Partnership NHS Foundation Trust (SWYPFT). This is consistent with findings from our previous reviews of Wakefield and Calderdale where this trust provides services. In Kirklees, however, joint working between the CAMHS and other services is a particular strength. The collaborative work as part of 'Thriving Kirklees' has enabled CAMHS to take stronger, whole family approaches to safeguarding and caring for young people that we have commented on elsewhere in this report.

5.1.14 The CCG and the local authority have worked together effectively to enable Locala to secure additional specialist nursing resources to provide targeted support to children and their carers with complex needs. This was to address organisational pressures arising from a significant increase in the numbers of children looked after locally. As a result, the looked after children health service is able to be more responsive in meeting the needs of children and young people placed out-of-area whilst also securing better value for money for commissioners. The in-reach work undertaken by the specialist nurses within children's homes is also highly valued by the young people and those caring for them.

5.1.15 The health leadership arrangements for looked after children in Kirklees are not compliant with guidance within the Intercollegiate Framework Standards (2015) which requires designated and named roles to be held by separate post holders to avoid potential conflicts of interest. Limited progress has yet been made in addressing this issue in Kirklees. The capacity of the Designated Doctor for looked after children also does not meet the suggested levels of coverage given the numbers of children looked after. [Recommendation 7.2.](#)

5.1.16 The health practitioners in the contact and advice centre are diligent in their approach to sharing information about children and young people and their families; record keeping in relation to this is robust and accountable. System templates have been devised by the Locala safeguarding team that supports the practitioners to note the extent and purpose of information sharing on the electronic patient record system. This provides a clear audit trail and appropriately alerts other users of the system in health services. This ensures that other health practitioners, principally GPs and the 0-19 service, are fully apprised of any child or family's situation and this was evident in all six cases we reviewed in the centre.

5.1.17 In previous sections of this report we have referenced the new model for referring cases to the local authority children's social care, the 'front door' arrangements known as the duty and advice centre. This is based on a similar model operating in the neighbouring Leeds area which has been successful. This new process requires a practitioner who has concerns about a child to have an initial conversation with a duty and advice social worker to support them in making decisions about where a child or family might receive additional services or early help. A re-designed contact form is used in those cases where ordinarily a 'referral' would be made for further assessment or for consideration by the multi-agency safeguarding team in the centre. Written referrals in the first instance are no longer automatically accepted at the front door without the initial conversation taking place. We have commented in 'child in need' above about an emerging potential impact of this process on newly identified cases of children in need.

5.1.18 As we have also reported under 'child protection' above, there is some uncertainty among health practitioners about how to bring cases to notice although the understanding of what constitutes significant harm is generally good. Some practitioners said they were aware of the new process, had received some training on it and understood it. Others said they were not made aware until the change had been implemented, had not received formal training and were still unsure how to proceed. The need for, and management of, consent from families to pass information to children's social care is also not well understood by some practitioners as we highlighted in previous comments about the substance misuse service.

5.1.19 It is clear from our discussions with leaders and with practitioners that the new arrangements were implemented by the local authority very quickly and that health practitioners were advised of the changes without delay. Since that time the new approach has not been communicated well to practitioners in health services as is evident by this uncertainty. [Recommendation 4.8.](#)

5.1.20 There is a lack of consistency in the front door processes reportedly experienced by some health practitioners in relation to advice given, the readiness to accept a referral and feedback provided about referrals made. There is also no mechanism for ensuring a shared record is made of any contact if it does not result in a referral for assessment. Instead, practitioners are required to make a full record of the contact in their own organisation's systems whilst a separate record is made by the duty and advice social worker in the local authority system. This can lead to a lack of consistency and clarity as to the reason why a particular decision was taken.

5.1.21 This lack of clarity is highlighted in one case we identified during our visit to the health practitioners in the contact and advice centre that we asked to be looked into further. A contact had been initiated by staff at Huddersfield Royal Infirmary with the duty and advice centre in accordance with the local multi-agency 'Bruises, burns and scalds protocol' about the attendance of a non-mobile infant in the ED. There was no resulting strategy meeting on this contact despite this being required by the protocol. There was also no record of the contact made in the duty and advice centre although it later transpired there were other risks in the family that would have warranted a potential child protection investigation. This means that key information that would have affected decision making would have been overlooked. The CCG, the KSCB and the local authority have undertaken to carry out a system review in this case to identify how processes can be improved to prevent a future occurrence. [Recommendation 4.7.](#)

5.2 Governance

5.2.1 There is strong, visible safeguarding leadership within the CCGs with effective governance processes, demonstrated by a commitment to ensure the progress of improvements demanded by serious case reviews (SCR) and inspections and the involvement of all providers in strategic thinking about safeguarding. Both of the Kirklees CCGs, together with Calderdale CCG share an integrated safeguarding children and adults team, led by the head of quality and executive lead for safeguarding. There is a designated nurse for safeguarding children for the Kirklees CCGs whilst a named nurse for safeguarding children supports the designated nurses for both Kirklees and Calderdale. The designated doctor for safeguarding children for all three CCGs is employed by Calderdale and Huddersfield NHS Foundation Trust (CHFT). This shared function enables good collaborative working and synthesis of safeguarding processes across the Kirklees CCGs and the Calderdale CCG, particularly since two of the NHS trusts provide services in both Kirklees and Calderdale (CHFT and SWYPFT).

5.2.2 Foremost amongst strategic thinking in Kirklees is the developments that have been necessarily brought about by the report of the Ofsted inspection of the local authority and the safeguarding children board in October 2016. Since the findings of the inspection related to failings of multi-agency processes, the issue has been regarded by the CCG as a shared risk and has been subject of the CCGs' risk register. This has provided additional impetus towards the CCGs' participation in improvement activity and has ensured that the CCGs' boards are accountable for the progress of such activity. This is achieved through active participation at appropriate senior level in the partnership's strategic work. In this way, commissioners of health services in Kirklees are key influencers in the way the improvement plans are devised and implemented. We also noted that there is strong, strategic commitment to these improvements from leaders in the health providers and this is evidence of the effective dialogue and relationships between the KSCB, the local authority, the CCG and providers.

5.2.3 Health commissioners and providers are appropriately represented at the KSCB's board at senior level and at its sub-groups. For example, the designated nurse chairs the Serious Case Review (SCR) workstream and the specialist safeguarding staff in the four main providers are all represented at the learning and development workstream, the performance intelligence and procedures workstream. This ensures a broad contribution from health across all areas of safeguarding business in Kirklees.

5.2.4 The CCGs maintain good oversight of the safeguarding performance of the providers. A January 2017 audit of the CCGs' work in this area against the 'NHS England Safeguarding Vulnerable People Accountability and Assurance Framework' showed that there were robust governance arrangements and this is borne out in our review. Safeguarding performance is assured through the presence of the designated nurse on each of the providers' safeguarding committees and through a supervision framework that sees the designated nurse and designated doctor providing supervision to the provider's named professionals.

5.2.5 All four providers have clear lines of accountability for safeguarding with demonstrable reporting from front line practice to the providers' boards. This includes appropriate executive level responsible officers and regular scheduled forums for discussing safeguarding performance through safeguarding committees. This standardised approach across Kirklees enables good co-ordination of and communication about contemporary issues among commissioners and providers.

5.2.6 A quarterly health safeguarding advisory group, set up by the CCGs following the Ofsted report, is an effective means of assuring performance and of promoting practice improvement. We saw this demonstrated through some learning that was developed following a local case involving infant head trauma. This is a dynamic group and ensures solutions to safeguarding issues can be implemented in a timely way as well as creating the environment for more considered approaches to improve policy.

5.2.7 A programme of audits carried out in 2015 under section 11 Children Act 2004 shows that providers have a good understanding of their data in relation to safeguarding activity and the governance and system arrangements. Although the audit will be repeated in 2018, the provider's annual reports demonstrate a more up to date picture of the providers' activity.

5.2.8 The annual report for looked after children demonstrates that the needs, complexity and vulnerability of this cohort of Kirklees' children are recognised by CCGs, trust board leaders, the KSCB and the council. Performance in many attributes measured exceeds local targets. For example, data on timescales in which health assessments are carried out, as shown under section 4 above, show that the service is well-aligned and resourced to meet the needs of looked after children.

5.2.9 The current Joint Strategic Needs Assessment (2017) provides reference to the needs of looked after children as a vulnerable group of children. However, data on the diversity and specific health risks and inequalities experienced by the current cohort of young people in care and care leavers is limited. The impact of work undertaken and measurement of improved health outcomes for children and young people is not yet sufficiently well understood and reported. [Recommendation 4.9](#).

Effective practice example – good governance leading to improved safeguarding performance and culture

Locala has consistently demonstrated effective safeguarding practice, and recently, in particular, has shown a strong focus on early help through the development of the 0-19 offer. There is a recognisable positive culture among staff to keeping children safe as evidenced through our review of safeguarding work and our interviews with leaders and practitioners. This is due largely to the approach described by Locala as 'mainstreaming' safeguarding practice into everyday business. This has been achieved in a variety of ways such as including safeguarding updates in staff newsletters and appointing safeguarding champions among the 0-19 workforce to ensure knowledge and understanding is embedded in culture and practice.

5.2.10 There is strong commitment to improve practice as a result of serious case reviews and robust arrangements in place to monitor actions arising from these reviews. Providers are held to account for the actions they are responsible for by the CCG and this ensures they are carried out in a timely way and that the impact on practice can be demonstrated. During our review we have seen evidence that demonstrates how clear and SMART actions driven by the SCR workstream have impacted on practice. Some examples of good practice illustrate this;

- The effectiveness of the paediatric liaison function in both hospitals in alerting community health teams and primary care services to the attendances of children at the ED
- The development of the integrated safeguarding supervision process in 'Thriving Kirklees'
- Whole family approaches taken by the mental health services that we have reported on above
- Monthly sampling of case records by managers and peer audits of practice in the Locala services to assure a consistent standard of safeguarding practice.

5.2.11 The CCGs have provided strong and visible leadership to GPs in Kirklees. This has included visits to practices by the designated nurse following the GP's CQC inspection where safeguarding concerns have been identified to support them with strengthening safeguarding practice. The CCG also co-ordinates twice yearly safeguarding leads meetings to provide practices with information on topical issues and have also provided safeguarding master classes to ensure GPs have good knowledge and understating of safeguarding processes.

5.2.12 There is good evidence of providers listening to the voice of children and young people about the services they need. For example, Locala has a well-established parent and young person's network. These networks have been involved in the design of surveys, such as the schools health needs assessment. In this way young people have effectively influenced the re-design of the 0-19 service. As a result, school drop-in sessions have been reinstated which supports easier access to health professionals and helps to bridge the recognised gap in service in the development of school health plans.

5.3 Training and supervision

5.3.1 There is a firm commitment from commissioners and providers to ensuring health practitioners are appropriately trained according to their required level and supported with safeguarding work through appropriate supervision. Some examples of how this takes place are shown in the following paragraphs.

5.3.2 All providers we visited deliver single agency training as part of a rolling programme on emerging topics such as CSE, FGM, domestic abuse, and the PREVENT programme in accordance with current government priorities. In addition we saw that there is good access to training provided by the KSCB, the delivery of which is also supported by health providers' specialist safeguarding teams. This ensures the workforce in Kirklees is competent and current in their knowledge.

5.3.3 Providers are proactive in identifying training opportunities for their staff as they arise from learning from case reviews. For example, through their level three training programme, SWYPFT have provided staff with a training opportunity for domestic abuse. This has been adapted from an existing, locally accredited package to be mental health service specific by the safeguarding team as a result of learning from a domestic homicide review.

5.3.4 Locala has recognised a gap in the awareness of CSE and has commissioned additional training for its staff.. Practitioners' knowledge and confidence in this area is now growing with evidence of effective joint working with the sexual health outreach nurse and engagement of young people in taking responsibility for their sexual health and understanding the risks to it.

5.3.5 We also noted some good collaboration between providers to ensure specific training needs are met. For example, as part of the integrated working arrangements in 'Thriving Kirklees' SWYPFT is providing some bespoke one-off training for Locala school nurses on supporting children and young people with ADHD. This also meets a local need of enabling young people to be more resilient whilst awaiting formal treatment.

5.3.6 Across Kirklees providers report generally good compliance with safeguarding training attendance at each of the levels although consistently the rates for level three training are not as strong as with levels one and two. A review of training figures supplied by each organisation has revealed only a small number of shortfalls, notably in a small number of the service specific figures in CHFT, MYHT and Locala. However, we have been provided with a narrative for each of these shortfalls by the providers and there is a clear plan to address them by the end of March 2018.

5.3.7 Whilst safeguarding training is at a good level, we found that there are still significant levels of uncertainty about the operation of the new front door processes. This remains an area of priority development for the CCG and the providers.

[Recommendation 4.8.](#)

5.3.8 Learning from SCRs, and lessons learned reviews is communicated to staff through briefings, newsletters and updated safeguarding training programmes. These include specific learning on adolescent suicide and self-harm, the impact of domestic abuse, sexually harmful behaviour in children and young people and identifying disguised compliance among others. The understanding of staff about these key areas or learning and their origins in SCRs was evident in our conversations with leaders and practitioners during our visit.

5.3.9 Throughout our visits to services we noted that supervision records are consistently made on patient health records. This is established as good practice as it ensures a record of accountable decisions about families and children is held in the most appropriate place. In some cases record keeping is supported by good supervision tools. For example, supervision sessions for community midwives provided by the named midwives at Huddersfield Royal Infirmary and Dewsbury and District Hospital are guided by a supervision template. Discussions and actions arising from them are uploaded on to the electronic system and attached to patient records. This means that midwives are supported and encouraged to continually develop their skills and practices, and are appropriately managing identified risk. Further, all midwives viewing the record have a clear rationale about any safeguarding plans made.

5.3.10 There is a good multi-layered supervision offer in the SWYPFT services that incorporates individual one-to-one supervision, quarterly group supervision, advice and guidance on demand and the provision of safeguarding link practitioners in each of the teams. The link practitioners in each operational team act as the conduit for information about safeguarding practice and a focal point for support for team colleagues. Link practitioners attend regular safeguarding forums to cascade information to team members so their knowledge is current.

5.3.11 'Thriving Kirklees' has strengthened its supervision offer, providing joint supervision to all members of its workforce (including the 0-19 staff and CAMHS). There is a network of named supervisors available to all members of the workforce, from reception and administration to nursing and medical staff. A register of supervisors and their background, skills and interests is available and open to staff to flexibly contact. This ensures staff benefit from a breadth of experience to support their continuous improvement.

5.3.12 Family nurse partnership practitioners have a clear and distinct professional development role and provide training to wider colleagues in key areas such as communication skills, including motivational interviewing, understanding the adolescent brain and attachment. Each of the family nurses are now integrated into the locality 0-19 teams and take on lead responsibility for safeguarding children supervision. They have received additional training in an established safeguarding supervision model to ensure regular one-to-one and group case discussion is reflective and effective.

5.3.13 Arrangements for supervision, management oversight and professional development of specialist looked after children nurses are appropriately discharged. The designated nurse for looked after children receives bi-monthly supervision from the designated nurse for safeguarding and in turn, provides regular one-to-one, team and case discussion with looked after children specialist nurses to support their continuous professional development. These bi-monthly sessions are also offered to CAMHS professionals working with looked after children, further evidence of the strong integrated approaches in Kirklees.

5.3.14 The looked after children medical team have appropriate local and peer supervision to support their ongoing development of practice. The Kirklees designated doctor for looked after children also has a role regionally in helping assure adoption medicals meet the required standards.

Recommendations

1. The Mid Yorkshire Hospitals NHS Trust should:

- 1.1 Ensure that information within the integrated care pathway in use in the maternity at Dewsbury and District Hospital is recorded legibly and entered onto the mother's and baby's electronic record to ensure it is available to all practitioners.
- 1.2 Improve the process for handing over the care of vulnerable women from the Dewsbury and District Hospital maternity to health visitors.
- 1.3 Ensure that staff in the ED at Dewsbury and District Hospital make full use of the prompts within the child's paper based patient record designed to explore age specific risk factors.
- 1.4 Develop the use of chronologies and genograms in maternity practice at Dewsbury and District Hospital to support the identification of evolving risks.
- 1.5 Develop the specialist midwifery support capacity to the maternity service at Dewsbury and District Hospital so that community midwives have access to specialist advice and guidance for complex or safeguarding cases.
- 1.6 Improve the capability of the electronic patient record system used in the maternity service at Dewsbury and District Hospital to upload documents for safeguarding purposes.

2. Locala Community Partnerships Community Interest Company should:

- 2.1 Evaluate the use of the 24-hour single point of access to the 0-19 service to measure its effectiveness and impact.
- 2.2 Develop the way that information is provided to care leavers about their health history that enables them, and other health professionals, to understand the impact it might have on their health needs in adulthood.

3. Calderdale and Huddersfield NHS Foundation Trust should:

- 3.1 Ensure that staff in the ED at Huddersfield Royal Infirmary make full use of the prompts within the child's patient record designed to explore social and family history and any suspicious or worrying presentations.
- 3.2 Ensure that the future plans for the transformation of children's emergency care services that service the Huddersfield area incorporate robust plans to deploy adequate paediatric qualified staff.

4. NHS North Kirklees CCG and NHS Greater Huddersfield CCG should:

- 4.1 Support GPs in both parts of the Kirklees area to develop consistent arrangements for regularly sharing information about and monitoring the progress of vulnerable families with the integrated 0-19 service.
- 4.2 Support GPs in both parts of Kirklees to develop accurate coding mechanisms on their electronic patient record system to ensure they have clear picture of vulnerable families in their patient list.
- 4.3 Work with GPs to ensure they have access to independent interpreting services so as to eradicate the need to rely on family members for this purpose.
- 4.4 Ensure there are clear guidelines for GPs to follow in relation to monitoring children and young people on their patient lists who are consistently not brought to health appointments.
- 4.5 Develop guidance for GPs about the submission of information and opinion about risk to child protection conferences
- 4.6 Evaluate the application of the front door arrangements by health providers to measure the effectiveness of their contributions to the identification of children and families who require statutory assessment.
- 4.7 Lead the health services contribution to the KSCB system review of processes at the front door arising from a case identified during inspection.
- 4.8 Lead the work of health providers to ensure that the new 'front door' arrangements are fully understood by health practitioners and can be applied consistently for all contacts with the duty and advice centre including the need for a shared record of decisions and feedback on outcomes.
- 4.9 Ensure that data about the diversity and specific health risks and inequalities experienced by the current cohort of young people in care and care leavers contributes to the Joint Strategic Needs Assessment.

5. South West Yorkshire Partnership NHS Foundation Trust should:

- 5.1 Develop firm arrangements for formally sharing postnatal mental health care plans with maternity services.

6. South West Yorkshire Partnership NHS Foundation Trust, Calderdale and Huddersfield NHS Foundation Trust and The Mid Yorkshire Hospitals NHS Trust should:

- 6.1 Work together to ensure staff in the emergency departments and the children's wards are fully aware of the pathway for children and young people who self-harm and of the availability of out-of-hours mental health support.
- 7. NHS North Kirklees CCG, NHS Greater Huddersfield CCG and Locala Community Partnerships Community Interest Company should:**
- 7.1 Work together to strengthen the arrangements for obtaining children and young people's health information from all GPs for the purpose of looked after children health assessments.
- 7.2 Work together to ensure that the strategic roles for looked after children comply with the intercollegiate guidance for looked after children and with the position of the Royal College of Nursing.
- 8. NHS England, NHS North Kirklees CCG and NHS Greater Huddersfield CCG should:**
- 8.1 Contribute to the local review of systems (alongside Kirklees council) in relation to the appropriate placement of young people with complex needs relating to mental ill-health or learning disability who are in the process of transition to adult services.
- 9. Locala Community Partnerships Community Interest Company and Calderdale and Huddersfield NHS Foundation Trust should:**
- 9.1 Strengthen the assessment of the emotional health and wellbeing of looked after children within initial health assessments.

Next steps

An action plan addressing the recommendations above is required from NHS Greater Huddersfield CCG and NHS North Kirklees CCG, within **20 working days** of receipt of this report.

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