

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

Children Looked After and Safeguarding The role of health services in Leeds

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Name(s) of CQC inspector:	Deborah Oughtibridge, Jeff Boxer, Karen Collins-Beckett, Sue Knight, Kaye Goodfellow, Nikki Holmes, Rebecca Hogan
Provider services included:	The Leeds Teaching Hospitals NHS Trust Leeds Community Healthcare NHS Trust Leeds and York Partnership NHS Foundation Trust Leeds Sexual Health Services Forward Leeds – substance misuse service
CCGs included:	Leeds Clinical Commissioning Group
NHS England area:	North region- Yorkshire and Humber
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CQC Deputy Chief Inspector, Primary Medical Services and Integrated Care:	Alison Holbourn

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

Where the findings relate to children and families in local authority areas other than Leeds, 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 2018.
- Where we found areas for improvement in services provided by NHS but commissioned by the local authority then we will bring these issues to the attention of the local public health team in a separate letter.

How we carried out the review

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

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

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

In total, we took into account the experiences of 70 children and young people.

Context of the review

Leeds is located in West Yorkshire and is the third largest city in England. The communities within Leeds differ substantially in age profile, health and level of deprivation. Rural and semi-rural areas have a mix of people of a wide range of ages and backgrounds. Waterfront areas are made up of younger professionals whilst inner city areas have mixed ages and larger culturally diverse populations. Leeds Director of Public Health in his 2017 report describes Leeds as ‘a city with a greater concentration of most deprived and least deprived neighbourhoods’.¹

Life expectancy for both men and women in Leeds is lower than the England average. There are higher than average rates of obesity, smoking and alcohol related health issues. There are more early deaths from cancer and heart disease than the England average.

Children and young people under the age of 20 years make up 24.3% of the population of Leeds with 31.2% of school age children being from an ethnic minority group. 16% of children have English as an additional language. Leeds is a receiving city for migrants and asylum seeking children.

The health and wellbeing of children in Leeds is mixed compared with the England average. The latest Child and Maternal Observatory figures relating to child health (2017) shows Leeds was significantly better than the England average for nine of the 32 indicators but significantly worse than the England average for 13 of the 32 indicators. The infant and child mortality rates, and the level of poverty in Leeds are worse than the England average. The level of homelessness is better. The number of under 18 conceptions and teenage mothers in Leeds remain higher than the England average and breastfeeding initiation lower. Of particular note is the number of low birthweight babies, poor dental health and the higher rate than the England average of hospital admissions caused by injuries in children 0-14 years. The Leeds Joint Strategic Needs Assessment (JSNA) 2015 highlighted that over a third of referrals to children social care involved domestic violence /abuse.

Leeds is a ‘Priority Area’ for Prevent.

Leeds had 939 looked-after children that had been continuously looked-after for at least 12 months as at 31 March 2017, with 81 children aged four or younger. A strengths and difficulties questionnaire (SDQ) was used to assess the emotional and behavioural health of looked after children within Leeds. Outcome measures for children continuously looked after for at least 12 months in Leeds shows the SDQ figure for the last three years has been consistent and remains a borderline cause for concern.

¹ Nobody left behind: good health and a strong economy. The annual report of the Director of Public Health in Leeds 2017/18. Leeds City Council.

Most of Leeds residents are registered with a GP practice that is a member of NHS Leeds Clinical Commissioning Group (CCG), that was formed in April 2018. This was formerly three CCG's: West Clinical Commissioning Group, NHS Leeds South and East CCG and NHS Leeds North CCG.

Commissioning and planning of most health services for children are carried out by NHS Leeds CCG.

Commissioning arrangements for the health of children looked-after are the responsibility of NHS Leeds CCG and the children looked-after health team, designated roles and operational children looked-after nurses, are provided by Leeds Community Healthcare NHS Trust (LCHT).

Acute hospital services are provided by Leeds Children's Hospital, The Leeds Teaching Hospital NHS Trust (LTHT).

Health visitor and school nursing services are commissioned by Leeds City Council (Public Health) and are provided by LCHT.

Child and Adolescent Mental Health Services (CAMHS), including specialist facilities are provided by LCHT.

Contraception and sexual health services are commissioned by Leeds City Council, and provided by Leeds Sexual Health Services. (This service brings together the specialist expertise previously provided Leeds Community Healthcare NHS Trust's Contraception and Sexual Health service (CaSH), Leeds Teaching Hospitals NHS Trust's Genito-Urinary Medicine service (GUM) and Yorkshire MESMAC).

Adult mental health services are provided by Leeds and York Partnership NHS Foundation Trust (LYPFT).

Substance misuse services are commissioned by Leeds City Council and provided by Forward Leeds (both young people and adult services).

Leeds was subject to an integrated inspection of safeguarding and services for looked-after children (SLAC), a joint inspection with Ofsted in November-December 2009 (report published in February 2010). The overall effectiveness of the safeguarding services in Leeds was inadequate and capacity for improvement was adequate. Overall effectiveness of services for looked-after children and young people in Leeds was judged to be adequate. The local authority and its partners were also judged to have adequate capacity for improvement.

Following this inspection in March 2010, a Government Improvement Notice was placed on Leeds, and an Improvement Board was established. A wholesale service restructure began. A new Senior Leadership Team was appointed and a strategic vision for children's services in the city was developed called 'Child Friendly Leeds'.

An Ofsted inspection of children in need of help and protection and children looked after and the Local Safeguarding Children Board in January 2015 found Leeds to be 'good' overall with leadership, management and governance 'outstanding'.

Leeds had a Special Educational Needs and Disability inspection conducted in December 2016 (published in February 2017). There were a number of recommendations made at the time.

Progress against relevant inspection recommendations have been considered in this review.

The report

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

What people told us

Parents in Maternity Services told us

"We are really happy with the care we received. We had a tough time first time around with the birth, but I felt that all the concerns we had were listened to and taken seriously. I don't feel like we are being rushed out of hospital either even though they are busy. They want to make sure we are both okay before they let us home." (Parent of a new-born baby)

Parents with their new baby on the post-natal ward said, *"All went well, we can't thank the midwives enough"*. The father added, *"I feel the midwives involved me right from the beginning."*

We heard from parents attending the Leeds General Infirmary Paediatric Emergency Department:-

One parent waiting with a young child for assessment said, *"Waiting times are long, however staff are doing a great job, despite the pressures they are under"*.

Another parent said, *"I have used this service on many occasions with my child and I feel it's a great service"*.

A parent whose child had accessed the service before commented, *"I am happy with the service, although the waiting times can be long"*.

Another parent attending with a young child said *“I am happy with the care my child has received today”*.

Two young people in the CAMHS secure unit told us:

“The therapists are really good. They encourage you to follow your interests which is how I got into the drama stuff. Before I came here nobody pushed me to do that but they have done in here.”

“The OT does drama with me which helps me to understand my feelings by acting and stuff and talks about the way you behave.”

“Being here around other patients who are going through what I am going through has been really helpful for me. Because they know what it feels like and can understand me. They are the best thing about being here.”

“I internalise a lot of stuff and watch out for the staff’s body language so that I can see if they mean what they are saying to me or not.”

“I used to see my dietician from Leeds general however I don’t get to see them now that I am in here and I don’t like that. I know that it is because I have changed from a hospital to a secure unit but I think it would be better if I could still see them as I had built up a relationship.”

We heard from three young people within the Leeds Sexual Health Service.

One young person said *“The ‘walk in’ here (Leeds Sexual Health Service) is effective. You don’t need to book, not like at the doctors”*.

“The website is good but I came here because of word-of-mouth, friends told me about it”.

Another said, *“I like the walk in and having no appointment, this is best.I also get to see the same person here and they don’t judge you. There is just you and them. They give you practical help.”*

A third young person said – *“There are lots of places in Leeds you can get help staff here tell you about MindMate -that’s good.”*

“The college referred me to The Marketplace. I’ve had four counselling sessions there. They are really good and help you with coping mechanisms and that’s been helpful.”

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 Expectant women in Leeds have good access to community and specialist midwifery services. We saw evidence of a responsive and flexible peri-natal mental health service supporting women referred for additional, specialist mental health support according to a clearly defined pathway that meets national guidance. The peri-natal mental health team have good links with maternity, health visitors, infant mental health services, adult community mental health services and GPs. This ensures care for women and their babies is well planned and co-ordinated and identified vulnerable expectant mothers will receive targeted support to ensure not only their own safety also that the unborn child.
- 1.2 Communication and timely information sharing from maternity to health visiting is inconsistent. For example, although we were told there is a process within the antenatal pathway that health visitors are notified of pregnant women, we heard from health visitors that they are not always notified, impacting upon the health visitor's ability to complete a Family Health Needs Assessment during the antenatal period and deliver Healthy Child Programme antenatal visits. This means that the opportunity for early intervention and a joint approach to safeguarding of the unborn baby may be reduced. **Recommendation 3.1**
- 1.3 The well-established CAMHS infant mental health service provides a specialist early intervention service for families with children from 0-2 years; offering a wide range of psychoeducation therapies by qualified professionals. All case records reviewed in the service demonstrated comprehensive, explicit documentation with a child focus. This service supports strong parenting-child attachment and positive parenting; creating healthy relationship and healthy early years brain development.
- 1.4 Children under five in Leeds benefit from an integrated service Early Start, led by the local authority and involving close multi-agency intervention between health visitors and children's centre staff. This reduces duplication for the family and ensures the right support is provided at the right time, by the right practitioner to the child and family.

- 1.5 A comprehensive analysis of the needs of children under five years is not always undertaken within health visiting. Detailed family health needs assessments are completed at four of the five mandated healthy child programme contacts. However, in records seen of the family health needs assessments, the impact of the family circumstances on the child's health, development and well-being was not consistently captured. This means that the plan of care and interventions may not be based on a complete analysis of the child's circumstances and as a consequence children and their families may not be effectively supported.
- 1.6 Senior school nurse practitioners in Leeds are aligned to, and have allocated responsibility for school clusters where a number of primary schools are aligned to one or two secondary schools. They are supported by the central team of school nurses and school health practitioners to co-ordinate universal health services such as the healthy child programme and the national child measurement programme. This enables nurses to identify additional need and step up arrangements for more targeted support. Referrals for vulnerable children for multi-agency help with additional support needs are made to the local authority early help front door. Senior school nurses play a key role in the delivery of this targeted support, which enables local oversight and continuity and promotes good, locally based outcomes for children and families who are on the edge of safeguarding processes.
- 1.7 The school nursing service has a single point of access (SpA) system where decisions are made about how children and families can be best supported, either from within the service or through other local organisations. Referrals to other services are managed to ensure minimal delay in children and families receiving the most appropriate support. The school nursing service is central to the arrangements for health based early help in Leeds.
- 1.8 Referrals for children with additional support needs are made to the local authority early help front door. Senior school nurses play a key role in the delivery of this targeted support, either as lead professionals or as active participants in team around the family work co-ordinated through the school clusters. This enables good local oversight and continuity and promotes good, locally based outcomes for children and families who are on the edge of safeguarding processes.
- 1.9 School nurses carry out health needs assessments as part of the early help processes. In records we looked at assessments were child-centred and, in most cases, accurate with clear plans. In a small number of records, we noted that there was no clear analysis or plan, which means that the desired outcomes for children and young people were not clear to other practitioners who may access the records. This means the children and young people may not receive the support they need.

- 1.10 The school nursing service works well with the local authority to identify and meet the needs of children and young people who are home educated or those who have been excluded. Effective information sharing arrangements mean that the service is able to make contact with families and outline the service offer. This has resulted in a high take up of the service by families whose children are not in mainstream education and creates opportunities for vulnerable families or children with additional needs to be identified and support put in place
- 1.11 Children and young people in Leeds benefit from good access to social, emotional and wellbeing support through MindMate. MindMate is a dedicated mental health and emotional well-being website for young people, parents and professionals who work with young people. It offers tips and tools to support self-help and signposting to services in Leeds. It includes animations explaining what support is available for young people in Leeds and stories from young people in Leeds about how they have been helped and supported with their mental health needs.
- 1.12 MindMate Single Point of Access (SpA) provides open access for professionals to refer into when they are working with children and young people and identify they have a need for support with their emotional well-being and mental health. There are a variety of services available through MindMate such as CAMHS, drug and alcohol support, counselling and early intervention in psychosis. All referrals are triaged with risks considered resulting in access to the most appropriate service. When referrals do not meet the threshold for a specific service MindMate ensures alternative action is taken, rather than redirection back to the referrer causing further delay. This ensures that children and young people receive the most appropriate service to meet their needs and that they do not experience barriers to gaining support.
- 1.13 Flagging on Primary Care systems is not robust for children in need of early help. This means that GPs may not always be aware of the child's vulnerabilities and may not respond effectively to risk and consequently safeguard children and young people. This gap has been identified and the Named GP has been proactive in liaising with strategic leads for safeguarding to formulate a strategy to mitigate the risks associated with this. We heard about a safeguarding template devised by the Named GP that is being used across both patient record systems across primary care. We were told how this has also helped to identify those children and families that are in receipt of early help.

- 1.14 There is a good local offer from the Leeds Sexual Health Service. This contraception and sexual health service for all ages was set up in 2015 to provide improvements in sexual health for communities across Leeds. The service is both centrally located and at hubs across the city operating open access drop-in and booked appointments with some sessions specifically tailored to young people. A range of mechanisms are used to promote the integrated sexual health service, for example through social media options such as Facebook and Twitter as well as the service website. This means that young people are able to easily access these support services and receive the help they need.

We heard about user consultation in the Leeds Sexual Health Service.

There is a two hour slot each day from Monday to Thursday specifically for the young people service. Recently some consultation was undertaken with young people to establish whether this was the most suitable for them or any changes were needed. Young people fed back that they want to continue with the existing arrangement of the after school/college slot as this meant they could access a service without it being obvious to their family.

- 1.15 A team within the Forward Leeds substance misuse services deliver training to children and young people in schools and within the community on the risks of substance use, and how to access guidance and support across all ages. This helps to raise awareness and understanding and reduce risk to children and young people from substance misuse.
- 1.16 Adult mental health practitioners are not effective at identifying safeguarding needs of children associated with adult clients. Whilst we saw evidence of good liaison with social care when a child was already allocated a social worker and there were safeguarding concerns, referrals to social care in cases where a child may require early help were absent. This means that opportunities to provide timely support to children and young people within vulnerable families may be missed. **Recommendation 5.1**

2. Children in need

- 2.1 Discussions around domestic violence and abuse was evident in health visiting records seen. This was also the case when partners were present and discussions were carefully structured around the impact on infant brain development and emotional wellbeing. This demonstrated well thought out practice to ensure important messages were shared with parents to be and new parents.
- 2.2 Within the Emergency Department at St James's Hospital young people aged 16 to 18 have their safeguarding risk assessed through the use of a general adult focus pro forma. This includes some generalised safeguarding questions. Whilst we did see some good practice in identifying safeguarding risks there is an over reliance on individual practitioner professional curiosity. This means that the particular safeguarding risks and vulnerabilities related to young people may not be fully considered and as a consequence young people may not be effectively safeguarded.
- Recommendation 3.2**
- 2.3 There are robust processes in place to ensure that children and young people who attend the Emergency Departments due to self-harming behaviour are appropriately assessed by CAMHS prior to discharge, allowing any subsequent care plan to be instigated. This means the children and young people are appropriately supported.
- 2.4 Within the Emergency Department at Leeds General Infirmary a qualified nurse reviews all attendances of children and young people up to the age of 18 to ensure that any safeguarding or child protection concerns have been identified and acted upon. This means that vulnerabilities can be identified at the earliest opportunity, community practitioners are alerted and children and young people are kept safe. Effective arrangements are in place to respond to young people attending Emergency Departments due to substance or alcohol misuse through prompt referral to Forward Leeds so young people are able to quickly access support and advice.
- 2.5 Children with emotional and mental health needs are well supported through the CAMHS commissioned service. For example the school nursing service have recently received training from CAMHS to deliver three to four short term contacts to children on a 'mental health first-aid' basis as part of an emotional mental health initiative . This means that children and young people receive help at an early stage and can access this within school.

We heard about an example of good information sharing and multiagency working in CAMHS.

A 17 year old presented at CAMHS and it was established that she would benefit from medication. The young person's mother persistently did not attend the CAMHS appointments, which prevented the young person from accessing medication. The young person was also made homeless. The CAMHS practitioner made a referral to social care as she was concerned regarding neglect as medication was not allowed to be issued without a responsible adult present. In addition, contact was made with a number of voluntary services to support the young person regarding homelessness and social issues such as benefits and education and employment.

- 2.6 Children and young people who are experiencing severe mental health issues are supported well by the Little Woodhouse Hall inpatient unit. We heard of a very high number of patients who make positive progress and achieve improved functioning following inpatient treatment with a very small number needing further treatment or transfer to a different setting. This means that children and young people are supported during their recovery journey to reintegrate into their communities safely.
- 2.7 Safeguarding risk assessment within the Leeds Sexual Health Service is strong. A dedicated risk pro-forma based on the 'Spotting the Signs' tool is used effectively for children and young people under the age of 18. This supports early identification of safeguarding risk and means that needs can be met.
- 2.8 Safeguarding risk assessments are routinely completed by Forward Leeds practitioners with consideration to the impact on the child; however, these are not always updated following the receipt of additional safeguarding information. Consequently practitioners may be making decisions not based on current information and risks to children and young people may not be fully understood and consequently not met. **Recommendation 6.1**
- 2.9 There are good arrangements within Forward Leeds for transition between young people substance misuse services and the adult service. Flexible and individual approaches ensure that those young people that are vulnerable are safeguarded and their needs continue to be met.
- 2.10 Children and young people in Leeds whose parents use drugs and/or alcohol, and are engaged with Forward Leeds substance misuse service are effectively safeguarded through robust processes and practice. We saw evidence of good multi-agency liaison and information sharing. For example, the attendance of a Forward Leeds practitioner at the FDSH daily domestic violence 'front door' meetings. This helps to provide a co-ordinated response to meet the needs of children and young people.

- 2.11 Young people attending the Leeds Sexual Health Service benefit from the presence of a youth worker post. We heard about the support the youth worker was able to give an individual young person to help them engage with the service. This resulted in them accessing regular appointments within the young person's clinic.
- 2.12 Multi-agency working and information sharing between adult mental health services and a number of key children's health services is underdeveloped. We were unable to see any evidence of liaison with CAMHS and school nurses despite where it was identified that the child of the adult in treatment was known to, or would benefit from, their intervention. A multiagency approach to information sharing is integral to managing risk and safety of vulnerable children and young people and this is a missed opportunity to undertake joint working to safeguard and support children and young people. **Recommendation 5.2**
- 2.13 The voice of the child and the child's lived experience is not well documented by adult mental health practitioners. Evidence was seen of good observational case notes pertaining to the parent's presentation and mental health concerns, however there was limited consideration of the impact of the parent's ability to appropriately care for their child. **Recommendation 1.1**
- 2.14 The Intensive Community Service adult mental health team have effective arrangements in place to support adults who are acutely unwell to remain in their home environment as opposed to being admitted as an inpatient. This has been particularly instrumental in keeping families together reducing the need for children to be removed from home whilst their parents recover.

A good practice example from The Intensive Community Service adult mental health team.

In one case seen positive intervention and robust safeguarding enabled an acutely unwell mother to remain at home with her children whilst receiving treatment for her psychosis. The mother was experiencing psychosis and has expressed that a voice was telling her to hurt her two children who lived with her. There was good identification and documentation of risk and protective factors. Despite the service user posing high levels of risk, it was clearly documented that she had previously had an episode of psychosis and had engaged well with services and responded well to treatment. There was continual and robust monitoring of risk and good, daily liaison with social care, which ensured that the children were safeguarded whilst the woman received treatment. The need for the children to be removed and for their mother to be hospitalised was avoided.

3. Child protection

3.1 Within midwifery, appropriate arrangements are in place to respond to identified safeguarding risks and to safeguard the unborn child. The recording and sharing of concerns on communication forms and oversight provided by the safeguarding team mean that practitioners who come into contact with vulnerable women are able to access up to date and essential safeguarding information. In addition, there is also an LSCB pre-birth protocol in place to ensure that there is effective protection of the unborn baby.

3.2 The arrangements within midwifery to identify social vulnerability in expectant women are weak, with no formal opportunity for midwives to review social risk throughout the pregnancy. We did not see evidence of any robust risk assessment to explore Child Sexual Exploitation (CSE) even in cases where this was potentially easily identifiable. This means that risks are not identified and young people may not be safeguarded.

Recommendation 3.3

We did not see evidence of any robust risk assessment within midwifery to explore CSE even in cases where this was potentially easily identifiable. In one case seen, an expectant teenager disclosed a relationship with an older male with a conviction of a sexual offence. Despite this being disclosed at booking, no CSE risk assessment was completed.

3.3 Effective professional challenge to children's social care was evident in health visitor records seen. A social worker at a review child protection conference wanted to step down from a child protection plan to child in need. This resulted in other professionals also challenging and the child protection plan remained in place.

3.4 Health visitors and school nursing staff have good access to the trust's safeguarding team and to the clinical team leaders for advice, guidance and direction, as and when this is required. Within school nursing we saw that whenever safeguarding advice is sought it is clearly documented and referenced to concerns shown in the child's journal. This is good practice as it ensures decisions are properly accounted for and contributes to keeping children and young people safe.

- 3.5 The electronic record keeping system in use in the school nursing service has been developed to incorporate templates for safeguarding. These templates help practitioners to carry out assessments of risk; the algorithmic nature of the templates enables practitioners to consider different potential scenarios and make more accurate assessments of those risks, for example risks of CSE. The use of the templates enables school nurses to gain a better picture of the risks to young people, identification of potential safeguarding issues and keep children and young people safe.
- 3.6 In records we reviewed in the school nursing service we saw that ‘voice of the child’ was evident in assessments and reports. When children and young people have a greater opportunity to express their wishes and feelings and have these taken account plans are more likely to be personalised and effective.

Good practice example from school nursing – voice of the child

In records we reviewed in the school nursing service we saw that the ‘voice of the child’ was evident in assessments and reports. In one record of a contact with the children’s social work duty and advice centre, for example, we noted particularly strong description from the child of an incident when they were physically assaulted by a parent and how this made them feel at the time. This demonstrated a good level of empathy and engagement by the practitioner to whom the disclosure was made and enabled the children’s social care recipient of the referral to have greater understanding of the child’s lived experience. The records show that a social work team visited the home that day and took immediate steps to ensure the child was safe.

- 3.7 We saw a number of measures within the Emergency Departments to keep children safe. For example, although there is no designated paediatric areas within the adult Emergency Department at St James Hospital, we saw evidence of how young people are kept safe during their time in the department. Arrangements to safeguard those children and young people who do not wait for assessment or treatment are robust. Alerts received for missing children, young people are screened, and a flag is added to the patient’s electronic record. This is good practice. This means that if the missing individual presents for treatment staff are instantly aware of their risks and vulnerabilities and they can be safeguarded appropriately.
- 3.8 Staff at St James University Hospital adopt a “Think Family Approach”. Effective arrangements are in place to identify families where vulnerabilities such as mental health, substance misuse and domestic violence are factors. Obtaining names and details of patient’s dependants and wider family members enables effective information sharing with other professionals, and creates opportunities to safeguard children and family members effectively from further harm.

Good practice example in the 'Adult' Emergency Department at St James University Hospital.

In one case examined a 39 year old female attended the Emergency Department via ambulance stating that she had suicidal ideation. There was evidence in the patient record that clinical staff had ascertained that she was a mother of five, and that her mental health had deteriorated following the birth of her fifth child. The clinician leading her care had documented the names of her partner and the names, ages and schools of all the children. Referrals to GP, adult mental health and the children's school nurses and health visitors were made along with a referral to social care requesting support for the family. The potential risk not only to the patient, but the wider family unit was clearly considered.

- 3.9 We heard how some children who are referred for urgent care at Leeds General Infirmary via GPs are not always safeguarded effectively as GPs are not following the policy to inform the service of the referral. This means that the hospital is unaware that the child has been referred for treatment and cannot follow this up if the child does not attend. We were advised by the local area that work is taking place between LTHT and the CCG safeguarding team to address this as part of learning from a serious case review. Options are being explored to ensure that a safe and sustainable process is embedded within primary care with clear lines of accountability.
- 3.10 There was a variable use of flags and alerts on records. The identification of vulnerable children and young people within the Emergency Departments and the Forward Leeds service is strengthened through the use of electronic flagging. Within the infant mental health service, a safeguarding flagging system was used appropriately, highlighting vulnerable children. This means that children and young people with specific safeguarding vulnerabilities and risks can be easily and quickly identified.
- 3.11 However, within CAMHS children and young people with known risk or vulnerability factors are not readily identifiable by CAMHS practitioners or managers as the alert function within the electronic patient records system is not fully utilised. This means that clinicians may not always be alerted to the fact that a child or young person has specific risks or is accessing statutory children's services support. Consequently the needs of children and young people may not be identified and met. **Recommendation 4.1**
- 3.12 In community specialist CAMHS although risk assessments were completed at the point of entry into treatment in some cases we examined there was no further review for over 18 months. Currently there is no flagging system to highlight out of date assessments so practitioners may not be considering all aspects of risk when planning interventions. As a consequence the needs of children and young people may not be fully met and treatment may no longer be appropriate. **Recommendation 4.2**

- 3.13 All service users accessing Forward Leeds with children receive a home visit within 6 weeks of initial assessment. This incorporates a check on the safe storage of substances and is repeated on a regular basis. This gives the opportunity for practitioners to check that the child is safe in the home environment.
- 3.14 The potential risks of medication prescribed for adults being accessible to children was not always considered by adult mental health services. Although home visits are routinely carried out, we saw no evidence in the cases viewed, of the safe storage of the adult's medication being explored. This is a missed opportunity to safeguard children. **Recommendation 5.3**

Adult Mental Health service example – area for development.

In one case we saw that the service user had, whilst experiencing psychosis given her children her anti-psychotic medication. Despite this being an identified risk, the service user was issued with a seven-day prescription without appropriate measures in place to ensure that the children were appropriately safeguarded. The potential risks of medication being accessible to children was not always considered by adult mental health services.

- 3.15 The Front Door Safeguarding Hub (FDSH) is the name of the Leeds children's social work services front door arrangement. It has two functions; provide a duty and advice function to directly receive contacts from practitioners and to offer support through professional discussion and identify an appropriate response. The second is provide a daily co-ordinated and consistent response to domestic violence cases. The FDSH has good engagement and participation from health through provision of a full-time CCG safeguarding nurse. The health post facilitates sharing of health information and effective liaison, which promotes the safeguarding of children and young people.

- 3.16 We heard from practitioners in the FDSH how the move away from a specific thresholds document to an emphasis on professional conversations and a focus on restorative practice is driving forward good relationship building, professional challenge and effective understanding of risk. The view of managers within FDSH is that this is leading to more effective joint working and a focus on how best to meet the needs of children and young people. However, there is disparity between the FDSH belief and practitioners feedback. Despite the local area moving away from “thresholds” and considering referrals on a case-by-case basis, practitioners within most of the health teams we spoke to continue to refer to thresholds and reported that they feel that referrals are not always accepted due to “thresholds” being high. In addition, some health professionals described referrals as rejected when non-statutory social care intervention had been offered. This lack of understanding of referral processes may result in practitioners not appropriately sharing their concerns and subsequently children and young people may not be safeguarded. **Recommendation 1.2**
- 3.17 There was good awareness across health services of the process to escalate concerns and of the local conflict resolution policy. School nurses utilise the policy to effectively raise issues of professional disagreement and effective professional challenge to children’s social care was evident in health visitor records seen. Practitioners within the Leeds Sexual Health Service are fully aware of the conflict resolution policy and how to escalate concerns if a referral is not accepted by children’s social care. It was reported that this has been used in the past but more recently there has been improvement in communication with children social care and so it had not been necessary to follow the policy.
- 3.18 There were differences in understanding across services that we visited about the process for referrals to social care and the documentation of this. For example, within the health visiting service referrals made to children’s social care were made via the telephone and not always followed up with a written referral. Health visitors were told not to follow up with a written referral but did not challenge this. School nurses were clear about the arrangements for making a child protection referral and about their responsibilities for conveying accurate analysis of their concerns. However, the written contact form outlining the referral was not stored on the electronic record system so a shared record of the decisions made was not available to each practitioner. Not retaining copies of safeguarding referrals and evidence in the records of the concerns practitioners have shared means the record is incomplete and there is uncertainty about the extent of the information passed on the point of referral. This inhibits quality assurance of the impact on the child and family and performance management by the provider organisation and in addition this does not support accountable decision making. **Recommendation 1.3**

- 3.19 We saw a similar situation within Forward Leeds substance misuse service. Whilst practitioners within Forward Leeds are vigilant in considering safeguarding risks to service user's children and referrals to children's social care are monitored closely by the service, the recording of analysis of risk and impact; and discussions with social care is too variable. Practitioners did not always articulate their concerns and their analysis of risk to inform the telephone discussion/referral. Consequently children and young people may not be appropriately safeguarded. **Recommendation 6.2**
- 3.20 Safeguarding referrals are not routinely copied into the relevant safeguarding team. This means that there is limited opportunity for safeguarding practitioners to monitor the quality of referrals and collate management information. This does not support learning and improvement to enable better protection of children and young people. We were advised by the CCG that a plan is in place to implement a process to enable this to happen within the provider services. **Recommendation 1.4**
- 3.21 Health practitioners routinely participate in child protection strategy meetings. For example, we heard how midwives and Forward Leeds practitioners participate in child protection conferences. Whilst urgent strategy meetings are held at the FDSH other strategy meetings are held in local venues, including hospitals. This facilitates health input into decision-making and this is good practice.
- 3.22 School nurses attend child protection conferences and submit reports to support their attendance. Such reports are detailed, make use of chronology information and show good analysis to illustrate a child or family's strengths, protective factors and risks. This means that a comprehensive account is provided to help inform decision making and contribute to keeping children and young people are kept safe.
- 3.23 Referrals and contributions to child protection proceeding in examined in one GP practice lacked focus on the voice of the child and the child's lived experience. In a number of cases seen in this practice information pertaining to the adult was well documented however there was poor documentation seen of the child's presentation and the impact of risky parenting.
- 3.24 Adult mental health practitioners' involvement in child safeguarding processes is significantly underdeveloped. The service was not able to identify any referrals made to children's social care. We were informed that it is not working practice to retain a copy of the completed referral form. This means that completed referrals are not evidenced and cannot be audited. Practitioners are not able to re-evaluate risk, reflect on risk and consider a joint working approach for children and families. **Recommendation 1.3**

- 3.25 In the adult mental health service we were unable to see robust evidence in documentation of contributions to child protection processes and of discussions and actions from meetings. This means that there is a lack of clarity as to whether practitioners have been involved in these processes. In addition records may be incomplete and information may not be shared effectively with future practitioners reviewing the records. As a consequence important information may not be shared with other professionals and children and young people may not be appropriately safeguarded.

Recommendation 5.4

- 3.26 There is effective information sharing with GPs of domestic violence and abuse concerns from the daily risk and coordination meeting and multi-agency risk assessment conference (MARAC) meeting. We heard that in the two years since a health representative from the CCG safeguarding team has been part of the daily meeting, a threefold increase of referrals from GP practices into the MARAC has been seen. This means that risk can be identified sooner and children and young people kept safe.

4. Children looked after

- 4.1 Initial health assessments data provided by Leeds Community Healthcare NHS Trust the shows the number carried out within statutory timescales exceeds national targets. This data indicates that over 90% of children consistently receive their health assessments within 20 days. However, this figure does not include those instances where the health team receive notifications from the local authority more than 10 days after the child is placed into care. If these children are also accounted for, the numbers consistently fall below national targets. We are advised that the children looked-after health team make creative use of clinic time to try to ensure children experience no delay, however, as the data shows, this is not always possible. **Recommendation 4.3**
- 4.2 We are advised that the numbers of children looked- after who receive their review health assessments (RHA) within statutory timescales exceeds national targets. Our review of data supplied by the trust shows that over 90% are consistently completed within timescales for each of the age ranges where RHAs are carried out by health visitors, school nurses and specialist nurses. This means that children do not experience undue delay in having their health needs met.

- 4.3 Local policy is for strengths and difficulties questionnaires (SDQ) not be routinely carried out prior to or during initial health assessments as they are less likely to help build a picture of a child's emotional resilience at a time when they are new to care. However, during the period before the first statutory looked after children review, SDQs are carried out and subsequently taken account of during review health assessments. This helps practitioners to better understand the emotional resilience needs of children and young people.
- 4.4 In our review of cases in the children looked-after service we found that the quality of information recorded in both initial and review health assessments is variable. The depth of analysis of information provided during the assessment is inconsistent and in most cases the records simply show a factual narrative of the information obtained. This limits both the extent to how effectively the record is an accurate reflection of the child's needs and the extent to which other practitioners who might use the record can gain a good understanding of the child's needs. This lack of analysis is evident in the way that health action plans are documented. Most assessments do not show health action plans that are sufficiently specific and in some cases, health 'issues' are not accurately identified or are recorded in vague terms. This does not enable health needs to be fully explored and outcomes to be properly understood. As a consequence a comprehensive health plan may not be drawn up and the health needs of children and young people not addressed. **Recommendation 4.4**
- 4.5 The forms used for health assessments contain a number of sections with templated text. In most records we looked at it was not clear whether the templated text was being alluded to by the assessor or had been disregarded. We acknowledge that efforts have been made to significantly reduce bureaucracy by including prompt questions but the lack of clarity makes the records, and as a result, the assessments, difficult to understand. **Recommendation 4.5**
- 4.6 Initial health assessment are not always informed by information from primary care. One GP practice visited reported that they are not asked to contribute to health assessments but will receive a copy of the completed assessment. This means that when a child comes into care important health history may not be considered as part of their health assessment process and their health assessment may be incomplete. In addition, health information may not be added to the child's record at a later date. We heard from the local area how initial health needs assessments are informed by information from primary care where there is a shared record. There is inconsistency for those whose GPs do not use the shared record. Consequently this cohort of children may not be having their needs fully assessed and are potentially further disadvantaged compared to their peers. **Recommendation 4.6**

- 4.7 We found variability in the evidence of voice of the child across the different services we visited. Some examples within health visiting demonstrated strong voice of the child and child focused practice, whereas in others it was absent. In most children looked after cases we looked at the 'voice of the child' was evident in both initial and review health assessments. An example seen of a review health assessment of a young child was child focused, had the child's voice evident throughout and included a clear analysis and impact of needs, with SMART actions to improve outcomes. The voice of the child was not consistently captured in children's records. This variability did not always ensure practice was child focused rather than parent or practitioner focused. This means that we were not assured the child or young person's voice was always heard in the work undertaken by professionals. **Recommendation 1.1**
- 4.8 Consent to share information is not always properly recorded in health assessments despite the template overtly prompting the practitioner to record whether it has been obtained or withheld. This can lead to uncertainty about whether or not information about a child's health can be legitimately shared with other practitioners who need to know and this can also lead to delay. As a consequence the needs of children and young people who are looked after may not be met and their information may also be shared inappropriately. **Recommendation 4.5**
- 4.9 As part of the strategic review of children looked-after health services at the end of 2017, health needs assessments for children with special educational needs or disabilities are intended to be linked closely to the assessments carried out for education health and care plans. In the samples we looked at, we did not see this integration of assessments in practice. However, we acknowledge that this is a recently implemented initiative and it is too early to assess the impact.
- 4.10 The majority of children looked-after receive continuity of care from the specialist looked after children's health team when placed out of area as they remain the responsibility of this team. This responsibility extends to within an 80-mile radius. Of necessity, some health assessments and ongoing communication occurs through telephone or video link contact. Whilst there are benefits of continuity of care to the child or young person from a familiar professional who understands their needs this may also delay children and young people making contact and building a relationship with practitioners in their 'new area'. In addition practitioners in the 'new area' are likely to have a greater knowledge of and contact with local services and support.
- 4.11 Specialist children looked-after nurses hold cases and are allocated children and young people from the age of 13 as part of their case load, where they remain until they leave care. This ensures that young people can have their health interventions planned and co-ordinated dynamically without having to wait for the next health assessment and it promotes good continuity of care.

4.12 Young people approaching the end of their period of being looked after are seen by the specialist nurses for a leaving care assessment. In some cases, the nurses will maintain informal contact with the young person beyond the age of 18. This supports young people to better understand their own health needs as an adult and make independent decisions. As some young people refuse the offer of a written health summary in the form of a letter, there should be a clear audit trail in the health record indicating that the offer was made and refused, detailing the information given on how to access the health summary should the young person wish to do so at a later date

Recommendation 4.7

4.13 Children who are looked after benefit from access to the CAMHS 'Therapeutic Social Work Team'. CAMHS provide two psychologists who offer direct work with young people ranging from assessment through to care planning and treatment, in addition to supporting the social workers within the therapeutic team. The team also provide training to other social workers who may benefit from the clinical expertise meaning that young people who are looked- after receive therapeutic intervention to support their complex needs.

Management

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

5.1 Leadership and management

5.1.1 There is a good system in Leeds to regularly review the effectiveness of safeguarding arrangements the CCG has in place, and those of the providers that they commission. The Safeguarding Children and Adults at Risk Committee meets bimonthly, and monitors safeguarding practice and arrangements. This enables areas for development and improvement to be identified and actions followed up, promoting the effective safeguarding of children and young people.

5.1.2 There are good arrangements in place to provide assurance to the CCG that providers are compliant with evidence based and locally agreed safeguarding children practice standards in the form of an agreed reporting schedule. The recent review and revision of the key performance indicators to include narrative giving detail of safeguarding activity should further strengthen assurance.

- 5.1.3 Leadership provided by safeguarding professionals across Leeds is good. The CCG safeguarding team provide visible and active leadership. Practitioners in a number of services spoke positively of the accessibility of safeguarding specialists to advise on safeguarding concerns. Partnership working across health is promoted by a Safeguarding Health Advisory Group which brings together the CCG and provider organisations. This is an opportunity to share reflective learning, identify safeguarding issues and areas for improvement in safeguarding practice.
- 5.1.4 The Designated Doctors for safeguarding children are proactive and influential in the city's safeguarding leadership. They lead on improvement work co-ordinated by the partnership. For example, they developed a large-scale training event for fabricated or induced illness (FII) that was attended by multi-agency practitioners. This has also evolved into the development of specific guidance for the partnership on identifying and managing FII. The Designated Doctors support the CCG to facilitate a range of learning activities and have contributed to single agency practice reviews with lessons learnt disseminated to health practitioners across Leeds. This demonstrates a culture of learning candidly from significant incidents to improve the safeguarding of children and young people.
- 5.1.5 The Named Doctors in LTHT provide safeguarding expertise and operational support to medical and other clinical colleagues. For example, they lead weekly peer review meetings with paediatric clinical colleagues, an important part of the medical quality assurance processes in Leeds.
- 5.1.6 The CCG safeguarding team have undertaken extensive work to raise the profile of safeguarding children across GP practices in Leeds and to engage GPs in safeguarding work. For example, work has been undertaken with practices to support GPs to submit high-quality reports to child protection conferences. This has involved an audit of the quality of reports and provision of individual face-to-face training to specific practices. We heard of some improvement but it is recognised that this is an area of challenge and further work is needed. Another example is the pilot undertaken with eight practices within one consortium to increase awareness of safeguarding within the practices and to support practice improvement. Although not yet reaching all GP practices in Leeds this improvement work supports the early recognition of safeguarding risks and effective information sharing which means that safeguarding risks can be recognised sooner and appropriate support put in place to protect children and young people.
- 5.1.7 The Named GP for safeguarding has well embedded and effective working relationships with the CCG, designated professionals and other strategic leads for safeguarding across the local area. The CCG have invested in additional safeguarding posts to increase capacity and resources in the safeguarding team with two additional named nurse posts. This has enabled additional support for safeguarding work within primary care and the work of the Front Door Safeguarding Hub.

- 5.1.8 There are some challenges in respect of safeguarding posts and capacity within provider organisations, which is having an impact on safeguarding practice assurance. For example within LTHT the Named Nurse for safeguarding children post is currently vacant and is being covered by the Head of Safeguarding Adults and Children. This is likely to result in a reactive and operational focus and compromises the capacity of the Head of Safeguarding to have oversight and undertake quality assurance of safeguarding practice within the trust. **Recommendation 3.4**
- 5.1.9 There is a lack of understanding in frontline practice across health of the local safeguarding referral processes and a lack of appreciation by local managers of this situation. The move from a specific thresholds document to an emphasis on professional conversations and a focus on restorative practice, is not well understood by practitioners nor what this means for their practice. This suggests that training and information sharing about revised processes that has previously taken place has not been effective. There is no collective view about which children need further social care intervention and no standard process followed. This also means that the escalation process for disagreement may not be effectively used. This situation may leave some children at risk of significant harm. **Recommendation 1.2**
- 5.1.10 A multi-disciplinary and multi-agency weekly safeguarding meeting, facilitated by the Named Doctor, takes place within the Emergency Department at LTHT where any identified adult or child safeguarding concerns, including those picked up by the 'on duty' safeguarding liaison nurse are discussed, in order to share information, identify opportunities for learning and follow up any outstanding actions. We were told that The LCH safeguarding team representation ensures information is shared with relevant services. This forum could be further strengthened by the inclusion of child and adolescent mental health services representation. **Recommendation 3.5**
- 5.1.11 The Designated Nurse for children looked-after is currently employed by a provider (Leeds Community Healthcare NHS Trust) and not by commissioners. This creates potential conflicts of interest with the Designated Nurse representing both the provider and the commissioners at strategic meetings. This is illustrated in the completed NHS compliance tool, used to benchmark practice across looked after children work. This was updated in November 2017 and highlights an 'amber' level of risk in relation to the roles of Designated Nurse, Designated Doctor and Named Nurse. Despite this being a long-standing issue we were advised that there are no current plans to alter the service structure to address this conflict. We heard how the current Designated Nurse for children looked-after is also the LCH Head of Safeguarding and covering the vacant operational children looked-after Named Nurse post, (called locally 'operational manager') resulting in her carrying out three senior roles across three layers of leadership. CQC has concerns about the level of independence when a senior leader has strategic responsibilities for the commissioning and provision of the same service. **Recommendations 2.1, 2.2**

- 5.1.12 We learned that Leeds Community Healthcare NHS Trust have been working with the CCG driving improvement in relation to initial health assessments of looked-after children. Three years ago, a Commissioning for Quality and Innovation (CQUIN) target was agreed with commissioners. The CQUIN system makes a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of patient care. There were a number of agreed exclusions in place; late notifications, unaccompanied asylum seeking children, appointment refusals/ did not attend. The following year a quality indicator was put in place due to improved performance. The agreed exclusions remained. We were advised that the CCG will continue to monitor and gain assurance in 2018/19 through the quality indicator reporting process however there will be no exclusions. With the removal of exclusions the data will provide a comprehensive picture of performance and enhance the focus on the needs of this vulnerable group of children and young people.
- 5.1.13 Due to current CAMHS management vacancies, operational oversight of frontline practice has been compromised. For example, attendance at Child in Need and Child Protection meetings is not monitored and there is no oversight of whether reports are submitted to articulate risk and CAMHS intervention. CAMHS service leads are aware of the impact however, at present, there is one manager across three CAMHS teams which is insufficient. **Recommendation 4.8**
- 5.1.14 Young people approaching transition into adulthood are effectively supported regarding their mental health via the dedicated CAMHS transition team. The service holds 'Interface' meetings every four months with a range of adult transition stakeholders to deliver presentations and share both good and challenging practice. This encourages positive working relationships and also promotes child centred care enabling smooth transition between child and adult services.
- 5.1.15 Young people suffering from eating disorders who are approaching their 18th birthday face difficulty in gaining support if they are progressing well in treatment within CAMHS. Criteria for adult eating disorder teams is strict meaning that if a young person has managed to gain weight they may, by virtue of their own progress, no longer meet threshold for the adult service, despite their ongoing difficulties and high likelihood of relapse in the absence of ongoing support. **Recommendation 5.5**
- 5.1.16 Operational oversight of children of adult service users in adult mental health services is weak. Practitioners and managers do not have a clear picture of the number of children attached to adults in treatment and any potential associated safeguarding concerns. Record keeping around children's details was often incomplete and information contained within records was contradictory. The use of alerts was inconsistent which further inhibits the ability to carry out audits of safeguarding practice and subsequently improve standards. As a consequence children and young people may not be safeguarded. **Recommendation 5.6**

- 5.1.17 Young people accessing substance misuse services support receive a flexible service to meet individual needs on a case-by-case basis. Young people who are particularly vulnerable, or would benefit from further short term intervention past the age of 18 years are kept in the young person's service to reduce risk from exposure to a different style of working in adult services and exposure to service users who may pose a risk.

5.2 Governance

- 5.2.1 Multiagency quality assurance of safeguarding referrals is good. Monthly meetings around quality assurance of referrals at the FDSH are represented by all health services and social care, and co-ordinated by the CCG. Learning is fed back to individual practitioners completing referrals. There is a monthly quality assurance process across the health economy as part of a subgroup of the Leeds Safeguarding Children Partnership (LSCP), formerly the Leeds Safeguarding Children's Board. This includes a review of a sample of referrals. There is feedback to practitioners on good practice and areas for improvement and development.
- 5.2.2 The quality of safeguarding referrals and systems and processes for assurance within health services is variable and needs further development. There appears to be an overreliance on the central assurance processes and we did not see quality assurance of safeguarding referrals within services. For example in the Emergency Departments the quality and standard of onward referrals are not being reviewed or audited, and the safeguarding team are not carrying out any audit of the referrals made. Quality assurance of referrals is not in place within the Leeds Sexual Health Service, although we heard that referrals are copied to the safeguarding team by practitioners to enable quality assurance. We did not see evidence of this. Within CAMHS and the Adult Mental Health Service there are no quality assurance processes in place to monitor the quality of either referrals to children's services or reports/contributions to child protection proceedings. The current lack of quality assurance and audit within health provider services in respect of referrals reduces the opportunity to identify areas of good practice and areas for improvement at an operational level. It inhibits manager's ability to gain valuable insight into clinical practice, to ensure a consistent standard is being achieved and to identify areas for improvement resulting in improved practice to safeguard children and young people. Audit and quality assurance can support organisational learning and identify trends. **Recommendation 1.5**
- 5.2.3 The Named GP, together with the safeguarding team, has developed an audit tool to audit record keeping across primary care. We heard how the team has audited the completion of GP's report writing and presentation of evidence to Child Protection Conferences, improving the standard of defensible documentation and record keeping across primary care in Leeds.

- 5.2.4 The standards of safeguarding practice in the school nursing service are monitored through a regular, scheduled audit programme. These include audits for the quality of documentation and for attendance at child protection conferences. An example of a recent audit examined showed that case files had been reviewed against a number of trust-wide core and qualitative standards, as well as service specific standards relating to the effectiveness of care planning and meeting needs. Areas for improvement had been clearly identified. This is accountable oversight and ensures safeguarding practice is maintained and improved.
- 5.2.5 The completion of the safeguarding children checklist on the Emergency Department electronic system is variable. In some records seen, there was evidence of detailed narrative, to accompany the yes/no response to safeguarding prompts, that articulated the risks and vulnerabilities associated with the patient. Other Emergency Department patient records lacked pertinent detail, which means that their vulnerabilities may be overlooked and children and young people may not be safeguarded as robustly. There is no guidance for completion of the form or standard to which practitioners should comply. The inconsistent completion of the safeguarding children checklist does not allow for oversight of safeguarding practice and identification of areas for improvement where practitioners could be supported through further education and supervision.
- Recommendation 3.6**
- 5.2.6 The Leeds Sexual Health Service has a weekly multi-disciplinary team meeting where cases discussed are identified through an automated process. This includes all cases under the age of 16 years, Female Genital Mutilation (FGM) cases, vulnerable adults and any case where there is a clinician concern. This ensures that there is robust oversight of cases and review of practice to ensure needs of children and young people are met effectively.
- 5.2.7 Health providers in Leeds have not yet met the national requirement in relation to implementing and embedding the child protection information sharing (CPIS) system. This means that children and young people are not benefiting from this information sharing process. We were advised that the local area has a plan to implement CPIS in the near future.
- 5.2.8 In a number of services we saw health practitioners are being supported by training and evidence-based tools to discuss domestic abuse with their client groups. Within the Leeds Sexual Health Service there is routine enquiry about domestic abuse for all attendees as part of the risk assessment tool. This is good practice and enables early identification of risk. Work is taking place in GP practices across Leeds to implement routine enquiry. Within health visiting discussions around domestic violence and abuse was evident in records seen.

5.2.9 However, within midwifery effective arrangements are not in place to identify and safeguard women who are at risk of domestic abuse. Women are only asked once at booking if they are experiencing abuse; good practice seen in other areas inspected has been to repeat this routine enquiry at intervals throughout the pregnancy. In cases seen, we saw poor practice with the routine enquiry section being left blank or a single line through the risk assessment. Therefore, it was not possible to evidence that women were being asked, even at this single opportunity. It is well evidenced that domestic violence and abuse can commence or escalate in pregnancy. The lack of effective routine enquiry means the opportunity to identify and support women who are at risk (and in turn the unborn baby), may be missed. **Recommendation 3.7**

5.3 Training and supervision

- 5.3.1 We found that there was variability in compliance with appropriate safeguarding training for roles and responsibilities. For example, the LTHT training strategy sets out the requirement for midwives to undertake level 3 safeguarding training however, we heard that Band 5 midwives are only trained to level 2. This does not meet the requirements of intercollegiate guidance and the local training strategy. As a consequence some midwives may not have the appropriate level of skills and knowledge to underpin their work in safeguarding children and young people and the trust cannot be assured of the competence of their workforce. **Recommendation 3.8**
- 5.3.2 There is a well-established infant mental health service that is supporting professionals across Leeds to have a greater understanding of infant mental health, for example through training provided. We heard from the FDSH service manager how this is valued by social workers. Health visitors value the opportunity for reflection and respectful challenge from the infant mental health service
- 5.3.3 Challenges with compliance with Prevent training have been well recognised by the local area and the health economy have developed an e-learning package to run alongside face-to-face training. Local health organisations in Leeds are now on track to meet identified targets and have recovery plans in place. This will ensure staff are appropriately trained to recognise and respond to those people, including children and young people, who may be vulnerable to radicalisation.

- 5.3.4 We also saw examples where safeguarding training has been effective in raising the profile of safeguarding children. Although most staff at St James University Hospital (SJUH) emergency department are adult trained, 80% have completed level 3 safeguarding children training. The staff that we spoke with informed us that they felt more confident in identifying and managing risk presented by young adults as a result of attending the safeguarding training provided by the Trust.

Good practice example Emergency Department.

Safeguarding training has been effective in improving and developing professional practice. We heard how level three safeguarding training has been effective at improving clinical practice and has facilitated staff to effectively identify risk and vulnerabilities. In one case example, a 17 year old diabetic female was brought into St James University Hospital Emergency Department via ambulance as she had not self-administered her insulin for four days. It was identified by staff that this was potentially an incident of self-neglect, and that the young person needed to be safeguarded. Further exploration of the patient record found that she had been admitted on numerous occasions with Diabetic Ketoacidosis and had failed to attend a number of health appointments. We saw evidence of detailed referrals to social care and CAMHS having been made in order to ensure that a holistic package of support was in place for when the patient is discharged.

- 5.3.5 A range of training opportunities are available for practitioners across the local area. For example, a number of services across Leeds benefit from mental health training delivered by CAMHS professionals. This is provided to hospital Emergency Department and paediatric ward staff, social workers and school nurses. This ensures that children and young people who may be experiencing mental health crisis are supported effectively.
- 5.3.6 Managers and supervisors within CAMHS who support practitioners who may be dealing with complex safeguarding concerns have not received additional training to ensure that they are competent and confident to undertake this. Managers within the service are aware that this is an area for improvement.
- 5.3.7 Safeguarding training compliance within Leeds Sexual Health Services is good. Following a previous CQC inspection considerable work has been undertaken to ensure clinical and non-clinical staff in the service are trained at the appropriate levels commensurate with their roles and safeguarding responsibilities and in line with intercollegiate requirements. Access to safeguarding training enables staff to have the requisite knowledge and understanding to identify and respond appropriately to safeguard children and young people.

- 5.3.8 Understanding and response to concerns about Female Genital Mutilation (FGM) are good within the Leeds Sexual Health Service. Practitioners have good awareness of the LSCP FGM policy and referral pathway. Practitioners have undertaken FGM training and have good links with midwifery service. Any case of concern in relation to FGM is automatically discussed at the multidisciplinary team meeting, which ensures that risks are managed and appropriate support put in place to ensure children and young people are safeguarded.
- 5.3.9 Single agency training across Forward Leeds is delivered through an external agency who have mapped competencies in the intercollegiate guidance and devised bespoke training to meet the best practice recommendations.
- 5.3.10 A proportion of adult mental health practitioners are not compliant with appropriate child safeguarding training as per intercollegiate guidance. This means that they are not equipped with the most current research and practice to promote effective safeguarding of children. **Recommendation 5.7**
- 5.3.11 There were examples of good supervision arrangements in some services we reviewed. Group and 1:1 supervision is mandatory for all health visitors provided by the safeguarding team, clinical leads, and the infant mental health team. Supervision sessions were clearly documented in children's records. These sessions allow a shared opportunity for peer support and reflection and highlight good practice. In school nursing safeguarding supervision is also regular and scheduled. Monthly one-to-one supervision with clinical team leaders addresses all children on a nurse's caseload where there are concerns. This supervision arrangement means that school nurses are appropriately supported in their work to safeguard children and young people.
- 5.3.12 The supervision process within the LTHT has been strengthened with the safeguarding team practitioners providing supervision to specialist teams who care for vulnerable children and young people. Emergency Department staff confirmed that they felt supported with regular supervision, debrief sessions and access to adhoc advice and guidance including sessions facilitated by a psychotherapist.
- 5.3.13 We are advised that peer supervision takes place every three months between the children looked-after nurses, led by one of the team, with records made of the supervision in children's records. We heard how this arrangement encourages reflection and challenge. We did not see evidence of supervision in the records we reviewed. This means that an audit process is not available to provide assurance that supervision is taking place and there is no record to refer back to ensure any safeguarding issues or concerns are followed up. **Recommendation 4.9**

- 5.3.14 Records within CAMHS did not consistently contain evidence of supervision to demonstrate when a case had been discussed with peers or supervisors to promote positive outcomes in treatment. Through discussion it was apparent that most complex cases have a degree of additional scrutiny and oversight through clinical supervision, multi-disciplinary team meetings or the complex case forums, however, the absence of clearly documented record keeping makes it difficult to maintain oversight and accountability of actions which need to be undertaken. **Recommendation 4.10**
- 5.3.15 Supervision for adult mental health practitioners lacks focus on safeguarding children. The service was unable to demonstrate any evidence of supervision which included discussion around risks to children of adult mental health clients and support for practitioners to reduce risks. **Recommendation 5.8**
- 5.3.16 Supervision arrangements within the Leeds Sexual Health Service are good. Staff in the service are benefiting from regular, planned group supervision based on case discussion and peer review. This means that staff are well supported and challenged in their work with children and young people and safeguarding practices are subject to regular scrutiny and challenge.
- 5.3.17 Effective supervision arrangements are in place across the Forward Leeds partnership with 92% compliance. This means that staff are well supported in their work to safeguard children and young people.

Recommendations

- 1. Leeds CCG, The Leeds Teaching Hospitals NHS Trust, Leeds Community Healthcare NHS Trust, Leeds and York Partnership NHS Foundation Trust, Leeds Sexual Health Services and Forward Leeds should work together to ensure that:**
 - 1.1 Voice of the child is consistently captured in the records of children and young people or where relevant the adult being cared for.
 - 1.2 The principles and process for making a safeguarding referral to children's social care is clearly and consistently understood and acted on by all health professionals and embedded in practice so that every available opportunity is used to identify children at risk.
 - 1.3 A process is implemented to ensure that when a written contact form outlining a referral to children's social care is completed this is then made available within children and young people's electronic record.
 - 1.4 Implementation of the plan to ensure a copy of each completed contact form is routinely copied into the relevant safeguarding team to enable them to monitor the quality of referrals and collate management information is expedited.
 - 1.5 The processes within individual services for quality assurance of safeguarding referrals to children's social care are strengthened to support organisational learning and consistent standards.

- 2. Leeds Clinical Commissioning Group should ensure that:**
 - 2.1 Ensure the role of designated nurse for children looked-after is designed and implemented in a way that enables effective challenge of the provider and as a result provision of a good quality service to children looked -after.
 - 2.2 Ensure that the operational oversight of looked after children work is carried out by a post holder who is separate from the designated role in accordance with national guidance (Looked after children: Knowledge, skills and competences of health care staff Intercollegiate Role Framework Guidance 2015).

- 3. The Leeds Teaching Hospitals NHS Trust should ensure that:**
 - 3.1 The process for consistent, effective and timely information sharing from maternity to health visiting, including pregnancy notification, is audited to ensure this is effective.

- 3.2 Young people who attend the 'adult' Emergency Department at St James Hospital benefit from improved assessment of risk through the use of an age appropriate assessment pro-forma.
- 3.3 The arrangements within midwifery to identify social vulnerability and risk in expectant women throughout their pregnancy are strengthened and that this includes a robust risk assessment to explore CSE. There is an assurance process that screening for CSE is embedded in practice.
- 3.4 The recruitment of a dedicated Named Nurse for safeguarding children post is prioritised.
- 3.5 The inclusion of child and adolescent mental health service representation at the multi-disciplinary and multi-agency weekly safeguarding meeting, at the Emergency Department at LTHT is considered.
- 3.6 A process is introduced to ensure consistent completion of the safeguarding checklist on the Emergency Department electronic system.
- 3.7 Arrangements are put in place within midwifery to effectively identify and safeguard women who are at risk of domestic abuse through the use of routine enquiry, on more than one occasion, throughout pregnancy and that this is appropriately documented in the risk assessment tool to evidence that women are being asked.
- 3.8 The safeguarding training undertaken by Band 5 midwives is audited against the LTHT training strategy and intercollegiate document requirement for midwives to undertake level 3 Safeguarding training and an action plan to address any shortfall in compliance is implemented.

4. Leeds Community Healthcare NHS Trust should ensure that:

- 4.1 A process is employed within CAMHS to ensure children and young people with known risk or vulnerability factors are readily identifiable by CAMHS practitioners and managers through using the alert/flagging function within the electronic patient record. Work is carried out with the local authority through the corporate parenting board to investigate the delays in notifications of children looked after to the health team.
- 4.2 A process is implemented in community CAMHS to review risk assessments and to highlight when these are due, considering the use of a flagging system to do this.
- 4.3 Work is carried out with the local authority through the corporate parenting board to investigate the delays in notifications of children looked after the health team.

- 4.4 Improve the quality of information recorded in both initial and review health assessments and the depth of analysis of information provided during the assessment Initial health assessments are of a consistently high standard and provide a clear focus on child /young.
 - 4.5 The use of the initial and review health assessment template is audited to ensure the templated text sections are being appropriately used, including the recording of consent to share information.
 - 4.6 A review is undertaken to assess the extent to which GPs are invited to contribute to initial health assessments and a process is implemented to ensure GPs are asked to contribute where this is not happening.
 - 4.7 For those young people approaching the end of their period of being looked-after who decline a written health summary, their health record reflects the information given on how to access the summary should they wish to do so at a later date.
 - 4.8 A process is introduced to ensure operational oversight of frontline safeguarding practice in CAMHS. To include monitoring attendance at Child in Need and Child Protection meetings and oversight of whether reports are submitted.
 - 4.9 A process is put in place so records within the children looked- after team contain evidence of safeguarding supervision.
 - 4.10 A process is put in place so records within CAMHS contain evidence of safeguarding supervision and actions which need to be undertaken.
- 5. Leeds and York Partnership NHS Foundation Trust should ensure that:**
- 5.1 A process is implemented, and subsequently audited, to improve the identification of safeguarding need in the children of parents with poor mental health by adult mental health practitioners, with referrals to social care in cases where a child may require early help.
 - 5.2 Multi-agency working and information sharing between adult mental health services and key children's health services particularly CAMHS and school nurses is strengthened.
 - 5.3 When home visits are carried out by adult mental health practitioners, the safe storage of medication is explored and this is recorded.
 - 5.4 There is oversight of the involvement of adult mental health practitioners in child safeguarding processes and meeting attendance and their involvement is robustly documented.
 - 5.5 Review the transition of young people suffering from eating disorders into the adult eating disorder team and the criteria in place.

- 5.6 The operational oversight of children of adult service users in adult mental health services, including the number of children attached to adults in treatment and any potential associated safeguarding concerns, is improved and the 'Think Family' model is promoted.
 - 5.7 Compliance of adult mental health practitioners with child safeguarding training as per intercollegiate guidance is monitored to ensure that compliance continues to improve and is sustained.
 - 5.8 Safeguarding supervision for adult mental health practitioners has a focus on discussion around risks to children of adult mental health clients and support for practitioners to reduce risks.
- 6. Forward Leeds should ensure that:**
- 6.1 A process is implemented to make sure risk assessments are updated following the receipt of additional safeguarding information.
 - 6.2 There is consistency in the sharing and recording of analysis of risk and impact, and discussions with social care.

Next steps

An action plan addressing the recommendations above is required from Leeds 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.