Review of Health Services for Children Looked After and Safeguarding in East Riding of Yorkshire

Children Looked After and Safeguarding
The role of health services in East Riding

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Provider services included:	Humber NHS Foundation trust (HFT), Hull & East Yorkshire Hospitals NHS trust (HEYHT), Northern Lincolnshire & Goole NHS Foundation trust (NLaG) , York Teaching Hospital NHS Foundation trust (YTH), City Health Care Partnership (CHCP)
CCGs included:	East Riding CCG
NHS England area:	Yorkshire and Humber
CQC region:	North East
CQC Regional Director:	Malcolm Bower-Brown

Contents

Summary of the review

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

Where the findings relate to children and families in local authority areas other than East Riding, 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 NHS healthcare and the exercise of functions of NHS England and Clinical Commissioning Groups.

- The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.
- The focus was on the experiences of looked after children and children and their families who receive safeguarding services.
- We looked at:
  - the role of healthcare providers and commissioners.
  - the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
  - the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.
- We also checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, Working Together to Safeguard Children 2013.

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 60 children and young people.

Context of the review

The East Riding is one of the largest unitary council areas in England, covering 930 square miles, 90% of which is classified as agricultural land. This makes up around 17% of the whole of the Yorkshire and Humber region. The East Riding had an estimated population of 338,700 in 2010; over half live in rural communities, many of which are small, scattered and geographically isolated.

72,000 children aged 0-19 live in the county, making up approximately 21.5% of the population. The majority of school age children are white British (95.8%). Approximately 13% of children under 16 are classed as living in poverty, mainly focussed around Goole. Overall rates of teenage conceptions are lower than the regional or national average, however rates of births to teenagers are significantly higher than the national rate, concentrated in a few localities, most notably Bridlington and parts of Goole.

The East Riding has an ethnic minority population of 4.9 percent (95.1% British or Irish white). In their report, ‘Migrant workers: impact on local areas and services’ (2006), the Audit Commission estimated that approximately 3,000 economic migrants were living in Goole, the third largest settlement.

Generally the East Riding appears affluent; however this masks significant economic and health inequalities, challenges from its rurality in relation to communication links, loss of economies of scale in service provision and the lack of ‘local’ employment.

Furthermore, six wards have areas of high deprivation, these are: Bridlington South, Bridlington Central and Old Town, Goole South, Goole North, South East Holderness and Minster and Woodmansey (Beverley). Eight LSO[1] areas are in the 10% most deprived nationally.

Most of East Riding of Yorkshire (EROY) residents are registered with GP practices that are part of the East Riding clinical commissioning group (CCG) with 293,196 registered patients (85% of the local authority residents). Planning and commissioning of young people's health services is led by the CCG. NHS England North Yorkshire and Humber Area Team has responsibility for commissioning primary care and health visiting and South Yorkshire and Bassetlaw Area Team commission specialist services including Tier 4 CAMHS and inpatient perinatal mental health services on behalf of Yorkshire and Humber Area Team

Acute hospital services for children and their families are provided by trusts in neighbouring authorities; there are no acute hospital providers based within the county. Urgent care is also accessible at county wide minor injuries units: at Goole provided by Northern Lincolnshire & Goole NHS FT, at Beverley provided by Hull & East Yorkshire Hospitals NHS trust (HEYHT) and at Bridlington provided by City Health Care Partnership (CHCP).

Community based services (health visiting and school nursing), school based immunisations and sexual health services, child and adolescent mental health services (CAMHS), forensic services, adult mental health and adult and child substance misuse services are provided by Humber NHS FT (HFT). Sexual health and contraception services are provided by CHCP.

The last inspection of health services for East Riding's children took place in December 2011 as a joint inspection, with Ofsted, of safeguarding and looked after children's services. Recommendations from that inspection are covered 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.

[1] LSO –Local super output area –a sub-ward in a local area

What people told us

We spoke to six young people who had left care and to six foster carers.

- All of the young people told us how the support of the looked after children health co-ordinator continued to be the most important health service in making a difference to them.

"She's known me since I was a baby. I have a really good relationship with X, she's always been there. I can always ring her. "

"She sorts things out, I think she's top, she'll always do it for me."

- Young people told us about their experiences of other health services:

"Health support for care leavers with babies is massive and children's centres are really good with lots going on."

One young person felt the continuity of support from the same school nurse for years had been important – *"she was good but she had to leave when they changed things round."*

- Each of the young people had had some involvement with CAMHS, they told us :

"You've got to be settled to get help from CAMHS. By the time you get help you've got through things on your own. "

"Waited 18 months for an appointment; then they said got to do an assessment; that takes months then they have to write it up before you can get the help, then there's a waiting list all over again".

Another – *"only waited 6 months; but it's ridiculous, they cut you off after a certain number of sessions so you haven't really had any help, then they make excuses".*

"Gave up on CAMHS and went to MIND".

"It's a waste of resources just pushing us round the system and not really helping".

"Went to one appointment; got fobbed off, didn't like it, didn't go back".

- Foster carers told us:

"The (school nurse) who did our foster child's health review recently seemed very thorough and child centred. She made sure to give him chance to say what he wanted by seeing him on his own, then seeing us on our own. ".

Experienced carers talking of their concerns about their perceived lack of psychological support for a seven year old who had experienced a significant number of placement changes in less than a year. *"Whatever problems he had before have been made much worse. Every time he gets in a taxi he doesn't know where he's going. He doesn't know if he'll go to the same school after there's been a holiday. He's got no one to help him process information, no one in the world who has a relationship with him. He needs that help."*

"*The support offered was respite; we were told – if you can't manage, put him in respite – even though we knew long term the instability of accessing respite would make him worse". (*In respect of a 2 year old whose needs were escalating, the foster parents requested CAMHS or behavioural support on many occasions; they were told he was "too young" to receive psychological support. We were told by the trust that support in these cases is usually to parents and foster carers.

- We heard about:

Foster carers told us they had not been asked for their views or experiences of services.

The young people told us they did not feel they had much voice about health, for instance: "*They did a review (of the CAMH service) and some of us took part in a table session but we don't feel like we are really listened to about what's needed."*

Some young people we met were involved in writing and updating the local pledge for children in care – they didn't feel that the first version had made a difference to help from CAMH services:

There are good opportunities for young people in care to be involved in interviews for relevant staff. One young person we met had taken part in interviews for CAMHS staff – "interviewed a new worker a few months ago- he was really brilliant".

Communication – in particular young people felt that communication between the local authority and CAMH needs improving to ensure the services are working for them.

Foster carers we spoke to told us that they found CAMHS often unsupportive of the behavioural complexities presented by looked after children and that they feel "completely let down" by systems in this area. They said that they would have benefitted from CAMHS support and they felt that the lack of this support contributed to the placement breakdowns. One carer was told by professionals that LAC CAMHS were too short staffed to offer support for a 10 year old child who on placement had complex enuresis and smearing issues.

All the care leavers we met had a plan which included their health needs and for one young person this had included help to purchase glasses.

Care leavers' health summaries – the young people we met knew that there was an intention that they should receive a copy of their health history. Only one of those we met had a health care summary when they left care. Care leavers told us that they hadn't had information about how their health summary might be useful to them in future. We had heard that the looked after children service had intentions to design a more attractive health care summary format rather than a standard document. None of these young people had been consulted about this, but they told us that to them, the format was of little importance but having the information and an explanation of how it might be useful was important.

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. All women who become pregnant are encouraged to self-refer through a centralised telephone system which leads to a high rate of early bookings. Immediate triage and advice is followed up with appointments at one stop clinics at Beverly which provide information on a wide range of services and midwifery care. We heard it is a well-known and popular system. Women are also introduced to children's centre staff who run many of the antenatal sessions and this encourages early engagement and support for mothers and babies. Information following booking is provided routinely to the health visiting teams.

1.2. The majority of pregnant women in the East Riding have antenatal care from community midwives from Hull and East Yorkshire NHSFT (HEYHT) with Hull Royal Infirmary also the major centre for hospital- based care for mothers and babies. In the north of the county women may give birth at Scarborough District hospital, a smaller number of women in the west of the county may use York hospital and in the south, Goole district hospital provides a community midwifery service and ante-natal clinic.

1.3. The complexity of maternity care and other service provision in East Riding and the cohort of women who move between providers present additional challenges for communication and information sharing to ensure all women and babies receive timely, well co-ordinated help. Information sharing in relation to vulnerable women is, in most of the county, largely dependent on individual midwives rather than a systematic approach. The complexity of provision needs robust systems and integrated information technology but different processes and widely disparate IT systems remain barriers to the delivery of early help and effective safeguarding (recommendation 6.11).

1.4. Arrangements to identify and address pregnant women's vulnerabilities are well secured and regularly updated by midwifery services at Bridlington hospital. The midwifery service provided by HEYHT recognises that whilst many concerns are picked up, there is no common pathway to ensure there is a consistent response with all appropriate agencies involved. Individual midwives work hard to try to coordinate and share information about risks to mothers or their babies, often spending significant time without a clear result. Working without an agreed framework for identifying and addressing vulnerabilities risks important information being missed or lost (recommendation 2.1 & 2.2). However, the extensive span of the service, lack of IT and very limited (2 days per week) role of the interim named midwife also results in a lack of quality assurance of assessment and early help work (recommendation 3.1).

1.5. Many young children and their parents benefit from a range of early help services through health professionals working with the county-wide children's centre network. Specialist support for mothers and mothers- to-be is more variable. The majority of pregnant women in East Riding receive maternity care from the large midwifery service provided by HEYHT. A specialist consultant-led substance misuse clinic is available to mothers-to-be but the lack of specialist midwifery care for women who misuse substances is a significant gap in assuring the welfare of mothers and unborn babies in this large service (recommendation 2.1). We saw a case of a new mother whose history of substance misuse presented risks to herself and her baby. She was discharged home over a weekend without any notification or discussion with her drug and alcohol workers so that they could ensure the right support was in place to protect them.

1.6. The addition of a family nurse partnership in Goole and Bridlington brings valuable additional capacity to support young parents in those areas. In the north of the county teenage mothers are supported by a specialist teenage pregnancy midwife working to clear guidelines and standards of care. Teenage mothers to be living in other parts of the county may be given the option of specialist support but this isn't automatic, which risks some young people not getting the help they need. We saw cases where midwives were trying to support very vulnerable pregnant teenagers who needed a more tailored service.

1.7. We saw limited recognition by some mental health practitioners of the safeguarding needs of children in families affected by mental illness In cases we reviewed some practitioners were not recording the full demographic details of children involved with the adult with mental health needs; neither were they consistently assessing the impact of the parental mental health on the children, despite clear prompts on the assessment record. We looked at care plans and relapse plans and these did not always consider the needs of the children in the family despite there being good, ongoing reference to the relationship between parent and child in the electronic and paper progress notes (recommendation 5.4).

We saw an example of prompt, sensitive work to safeguard child A, an unborn baby when a heavily pregnant woman with a history of mental health complexities returned to the area. After a swift multi-disciplinary child protection response a perinatal mental health plan was put into place including community midwifery and health visiting support. The mother's mental health remains stable as she cares for the 4 month old and her first child. The family is supported by universal services with health visitors briefed about the signs of mental health relapse.

However, this is an example where the important contribution of adult mental health is not part of the on-going child protection core group despite past evidence of risks to her children should her mental health decline.

1.8. We found that women with perinatal mental health needs experience some inequity in the services they are offered dependent on where they live in the county. There is no inpatient mother and baby unit in county, mothers needing this care need to travel a considerable distance to Nottingham or Leeds. We heard they may also stay on a psychiatric ward in-county during their pregnancy (recommendation 7.4).

1.9. Most women are introduced to their health visitor at an ante natal visit and this helps to identify any emerging concerns and avoids delay in any subsequent offer of support. Effective post natal discharge arrangements then ensure that women receive a prompt midwifery visit when they return home. Subsequently, young families receive support from the *Healthy Child Programme*, delivered through a combination of visits and clinic appointments offered by health visitors and nursery nurses. Capacity in the health visiting service is increasing in line with national targets helping to balance case loads, however, despite monitoring arrangements we saw an example of an uncovered health visitor sickness absence which had left a vulnerable family for a period without the regular support they needed.

1.10. We saw some close partnership working between health practitioners, social care and schools helping improve outcomes for children, including an example where the GP and health visitor undertook a joint home visit to encourage a mother to agree to full immunisation of her child. Where a need for specialist intervention such as play therapy is identified, many children experience delays in being able to access this support (recommendation 7.3).

1.11. The drug and alcohol service recognise their role in a '*Think Family*'[2] approach in safeguarding children in families with whom they work. They share information well and recognise and act upon thresholds where escalation is needed. However, appreciation of the impact on children of parental substance misuse is not always reflected in planning and monitoring by other agencies (recommendation 6.3) and in one case we referred back, this had left three children exposed to risks.

[2] A multi-agency programme established to improve outcomes for families where parents have mental health needs

1.12. The well-established specialist mental health post provided by HFT CAMHS service and based in the youth offending service is a strength; it helps many young people access help for a range of health needs, including emotional issues which may be contributing significantly to their offending behaviour. We saw positive feedback about the flexibility and empathetic approach which helps young people engage and benefit from the support.

Child B had a series of low level offending and anger issues. Having lost a close relative in a fire, the bereavement hadn't been dealt with. At the young person's request the YOS mental health worker supported the first visit to the grave and we heard this has subsequently been very cathartic.

1.13. Across the three MIUs we visited, we found that more attention is needed to ensure that each unit is able to support the health care and treatment of children in accordance with practice guidance and standards. In particular we identified safeguarding concerns in respect of waiting areas which are not child-appropriate and supervised and inadequate attention is given to ensuring that staff are suitably trained for their work with children (recommendations 4.1, 6.2 and 6.3).

1.14. Health services in the county are seeing an increasing number of young people who self-harm. Young people who need treatment following a significant incident of self-harm are directed or transferred to one of the major hospitals, mainly Hull Royal Infirmary (HRI) or Scarborough District hospital where they are usually admitted to a paediatric ward for a period of observation, which is good practice.

1.15. As well as those who are admitted to hospital overnight after self-harming, minor injuries units are seeing many others who may be discharged home after assessment. We followed the experiences of some of these children and found that there is insufficient help available to respond to early indicators of concern and avoid self-harm escalating. The capacity of school health is stretched and its focus on children already in the child protection system impacts on nurses' availability to support individuals and to target groups at an early stage. Not only school nursing professionals but others who work with vulnerable young people told us how resource and capacity pressures in school health mean that school nurses are not readily available to children and young people for pro-active early intervention and health promotion (recommendation 1.3).

1.16. Children in the East Riding who need urgent care are treated at an A&E department at an out of county hospital or in one of the county's minor injuries units (MIUs). The MIUs have in house electronic records systems which are updated regularly with details of children with child protection plans. This enables these children to be identified if they present at one of the MIUs. Each MIU can also identify repeat attendances at that hospital but there are no IT links between the plethora of different emergency care provision in and around the county. This risks children being taken to different sites with multiple presentations but this not being identified (recommendations 6.5, 6.6, 6.11). Risk is mitigated by all attendances at any emergency care provision being notified to the child's GP and health visitor or school nurse.

1.17. We found the MIUs we visited were inconsistent in their arrangements to identify children who are at risk and to ensure they receive the help they need. We saw effective paediatric liaison and “virtual” practice monitoring at East Riding Community Hospital (Beverley MIU) but at Bridlington and Goole, arrangements for liaison with community services are less robust. Without a paediatric liaison presence in these services, notification is reliant on IT system-generated tasks being actioned and there is no follow up audit to check that this takes place (recommendation 6.6) other than for attendances by out of county children at Goole which are screened by a safeguarding specialist nurse who follows up cases of concern.

1.18. Practice in relation to information gathering, making checks and clinical triage was variable across the three MIUs we visited. At Bridlington, we saw no expectation that practitioners would look back at the history of a child, or ascertain recent history from the parents as best practice would dictate. Assessment detail, routine recording and clinical checks also lack necessary detail (recommendations 6.6). We referred a recent case to management where we identified that neither clinical triage nor potential safeguarding issues had been properly addressed. At Goole, we saw some comprehensive assessments of the child on admission, including details of both parents, although a more robust system is needed to ascertain who has parental responsibility. A note is made of who is accompanying the child to the department. The clinical triage notes are comprehensive and indicate if the presenting injury or condition is consistent with the explanation offered.

1.19. General sexual health and contraception services (CASH) are available around the county though young people do not have access to dedicated clinics. Since our review we heard that a new weekly clinic session may be available for young people in the Hornsea area. Bridlington is an area of significant health inequalities including a high rate of teenage pregnancy. However, the location of the sexual health and contraception clinic at the hospital deserves review given access difficulties and the very low attendance of young people at this clinic. The environment is also poorly suited to its purpose and unconducive to encouraging attendance by hard to engage groups.

1.20. The C-card scheme which is very successful in many areas of the country has not been adopted in East Riding; this limits the effectiveness of CASH services in establishing and continuing their engagement with young people. We were however, impressed by the small specialist nurse adolescent out-reach service that can provide targeted advice and interventions. We heard about effective liaison with other professionals and a high involvement in safeguarding work with vulnerable children. The very experienced practitioner we met had good understanding of consent issues and vulnerability. All of these issues should be considered in the child sexual exploitation strategy.

2. Children in Need

2.1. We have seen many examples of health professionals working very co-operatively across a range of disciplines to support vulnerable children about whom they have concerns. However, we have also seen a number of examples across several services where indicators of risks to children have not been identified or not been recognised for their significance. As a result, risks to individual children have not been fully investigated and addressed promptly.

2.2. Some cases seen highlighted a lack of a shared view in implementing local multi agency guidance leading in some cases to delays and a lack of clarity about professional roles and responsibilities in relation to decision making and the management of risk. We also saw in records of several children and families that the use of terminology in respect of child protection and child in need processes was sometimes confused which contributed to health staff being uncertain about roles and next steps. It is important that all agencies in team around the child (TAC) arrangements are clear about roles, communication, planning about what needs to change and the escalation route when these changes are not achieved or risks increase.

Child C was known to have a very difficult life at home over many years such that she met the threshold as a child in need. Health staff did not have clear roles as part of a child in need support plan. In the last year she presented at local emergency care provision on numerous occasions as a result of self-harm, telling staff about past abuse and her fears about life at home. Health staff responded appropriately in making safeguarding referrals. Health professionals continued to have concerns about the child although these referrals were closed and there was no formal framework in place.

Workers in CAMHS and the youth services convened a professionals meeting following which CAMHS asked the named nurse to escalate the concerns and during our review this escalation was completed. CAMHS, psychiatrists, the targeted youth service, A&E and MIU and the GP were involved with this child during this period.

Our case tracking identified areas for improvement in multi-agency working. Some relevant information that had not been dealt with appropriately and hence not acted upon. Some recording was unclear as to what action had been taken. Information sharing, for instance about self-harming behaviour, non-attendance at appointments or family disclosures was not sufficiently timely or comprehensive.

2.3. This is one of several cases seen where safeguarding work was managed outside formal frameworks as health professionals felt levels of risk and parental behaviours indicated that a more focused child protection response was required. In this case, health professionals continued to try to secure improvements and raise their concerns but despite multi-agency concern about the level of neglect, risk or violence, no shared view was reached on how to improve the child's situation. . We also saw in records that the use of terminology in respect of child protection and child in need processes was sometimes confused which contributed to health staff being uncertain about roles and next steps.

2.4. We saw several other cases involving children with child in need status where there was a lack of clear planning about the roles of health staff as to what was expected and what difference this should make to the children concerned (recommendations 1.2, 6.2, 6.3). Amongst our case sampling we identified this case where a child did not receive the protection of a clear plan despite child in need status:

The substance misuse worker for a mother who used drugs raised safeguarding concerns to the social worker for E a child who was a child in need. In response they were told a letter of expectation would be sent to the mother about the requirements for her co-operation.

No copy of any letter was sent to the substance misuse worker and the worker didn't chase it up. As a result, the worker remained unclear about the detail of their role and expectations about the parent's engagement.

2.5. Children of parents whose own difficulties impact on their parenting ability are particularly at risk of harm and health services have a crucial role in identifying and supporting these children. They may be suffering hidden harm through neglect, or for instance, taking on caring responsibilities beyond their years. These issues are not sufficiently considered in some case work we saw. In one case the impact on all three children in a family was not considered with the eldest, an 11 year old child, especially invisible. Appropriate professional curiosity about how the mother's own needs was impacting on care of all the three children was also lacking in the universal services professional involvement in this complex case (recommendations 6.2 and 6.3).

2.6. Although most health services now have a policy on non-attendance to appointments which is sensitive to re-engaging people where they fail to attend or avoid appointments (DNA), we saw a case that had slipped through the net. We also saw good examples of the use of the DNA policy in CAMHS, where the approach taken depends on the risks identified in the individual case. In the case of child C, CAMHS had regularly and diligently notified the child's school safeguarding lead and called a professionals meeting.

3. Child Protection

3.1. We saw from cases that most health practitioners are clear about thresholds and how to make referrals where they have safeguarding concerns but they do not always clearly articulate the risks of harm to the child in these referrals. The safeguarding referral template is not fully helpful in directing health practitioners to do so and health practitioners would benefit from further training on this. This would help ensure that children's social workers, who are not health experts, receive clear information about the implications of the issues being raised with them (recommendation 6.2).

3.2. Some staff take prompt action to escalate their concerns or to chase the outcome of referrals made but this is not consistent. We saw persistence in pursuing some referrals where health staff believed that their concerns were not being heard. In some cases this still failed to ensure that outcomes for these children were improved. We also heard that recent sampling of referrals confirmed that health practitioners are generally applying appropriate thresholds. However there has been no joint work to date on evaluating the quality of referrals by service or team, identifying exemplars and delivering training to improve referral quality to best inform decision making (recommendation 6.1, 6.2 and 6.10).

3.3. Midwifery services are vigilant in tracking families who move repeatedly, working across boundaries with named midwives and heads of midwifery services in other areas to safeguard unborn babies. Midwives make referrals to social care when they identify risks to an unborn baby, but in records of cases we saw, decisions and risk management of the case then passed to a social worker rather than through a CAF and team around the child approach which would ensure multi agency consideration (recommendations 2.1 and 2.2).

3.4. Health professionals demonstrated tenacity in securing the engagement of families of concern, refusing to accept non-attendance at appointments or avoidance of home visits. However, we also saw examples where insufficient action was taken when families continuously avoided the involvement of health professionals. Documentation about contact efforts was also variable, with actions not always being recorded with sufficient clarity.

3.5. Despite an "in principle" agreement for health provider safeguarding teams to have "read only" access to East Riding council's client information system two years ago, this has not been achieved. This can inhibit and delay effective sharing of information about children's known vulnerabilities or safeguarding risks, and about the support that they may be receiving (recommendation 6.11).

3.6. We heard about some improvements to safeguarding arrangements that were too recent to be seen in case work, for instance practice in ensuring there has been an acknowledgement of a safeguarding referral is still not clear and embedded county wide. As a result, some health practitioners follow up to ascertain whether their referral has been received, others assume that action will be taken. There is an inherent risk that some referrals may therefore be "lost" to the system and we have seen evidence of this, too. Not all health staff ensure that they know the outcome of a referral, which would be good practice. Unless referrers know the outcome of their referral, they are unable to use this to review or escalate if they believe their concerns have not been heard (recommendation 6.1).

3.7. Arrangements for ensuring that all the appropriate health staff contribute to multi-disciplinary assessments and planning are also inconsistent with the result that the important perspectives of some health disciplines are not reliably contributing to risk assessment arrangements. We did see examples of good practice in some pre-birth child protection work where cases demonstrated the positive impact of effective, timely multi-agency working around vulnerable women.

Regular multi agency meetings include midwifery in the north of the county which ensures midwives are notified of any pregnant women remanded in custody. We saw the effectiveness of this system where the mother to be had not disclosed any risk factors to this point of her pregnancy (36/40). A referral from the police highlighted the risk to child I, the unborn baby, from the mum's partner, a registered sex offender. Discussions with social care were immediate resulting in a pre-birth assessment and appropriate joint working to protect the baby.

3.8. Midwifery also contributes to multi agency safeguarding through representation at twice weekly meetings with social care, police, education and housing. This whole system approach to cases with cross agency vulnerabilities helps identify risks and safeguarding of vulnerable children.

3.9. The important role of health practitioners who work with adults in vulnerable families is insufficiently reflected in child protection arrangements. As an example, staff in adult substance misuse and sexual health services told us that they never receive requests for information as part of s47 enquiries and are not always invited to child protection meetings where they have an involvement in a case (recommendation 6.2). There are risks that where services such as adult substance misuse are involved with a family but not included in liaison between professionals, other practitioners may put too much faith in information given by the client which may be unreliable and we saw examples of this resulting in incomplete awareness of escalating risk factors. We also heard that where a professional is unable to attend one meeting they are often missed off for invitations to future meetings, particularly core groups.

3.10. The role of health practitioners in child protection plans is not routinely clearly specified. This makes it difficult for health practitioners to be confident that they are delivering what is going to best protect that child and how they most effectively inform child protection conferences of changes in risk factors or parental non-compliance with the plan (recommendation 6.2 and 6.10).

3.11. We saw examples where child protection plans included letters of expectation, for instance requiring continual engagement with a service such as substance misuse. This can be helpful provided the details are also set out in a care plan in such a way that the service concerned can assess compliance or non-compliance. In some cases the worker has been left unclear when and what to feedback to the social worker and case conference. We also saw examples where letters of expectation had not been shared with the health practitioners responsible for monitoring compliance, with the consequence that this measure was not effective in increasing protection for the children.

Unborn baby J was assessed as at risk and made subject to a pre-birth child protection plan in mid-November. The conference decided that a letter of expectation for the mother's co-operation would be put in place.

The baby was born and discharged on 6 December with the child protection plan in place. Despite chasing, the health visitor has not received the letter of expectation and is therefore unable to monitor compliance effectively as part of her role in the child protection plan.

3.12. We found that practitioners in the adult substance misuse service are clear on how to make safeguarding referrals and routinely do so when they identify concerns. They share information promptly and appropriately prioritise attendance at child protection conferences and core group membership. In some cases, they should more robustly challenge when they recognise other professionals are not responding effectively.

3.13. The important role of Humber NHSFT 's (HFT) adult mental health (AMH)services in safeguarding and child protection requires a robust programme of audit (recommendation 5.4) to ensure full and consistent application across the county . AMH managers we met told us that they make referrals to children's social care but we were unable to assess their quality as we saw no copies on records other than a write up of a multi-disciplinary team meeting which had been sent to safeguarding. We heard about two cases where some concerns had been reported to safeguarding but no follow up or further involvement had resulted and AMH staff were unaware of any outcomes.

3.14. Two way partnership working between AMH and other professionals is often insufficient. We heard that AMH practitioners are not routinely members of child protection core groups, even when they are closely engaged with the parent (for instance case of child A). We also found that there is no consistent process in place by which social care invite AMH to participate in pre-birth professionals' meetings where they are working with the parent. We saw some good practice with joint visits taking place with health visitors and appropriate sharing of information, however, this was limited. Partnerships of this nature are essential to ensure that information about parental mental health and resultant parenting capacity is known to multi-disciplinary teams around the family (recommendation 5.4 and 6.3).

3.15. From the cases we saw, multi-agency arrangements to improve identification of young people who are at high risk of harm as frequent runaways or as victims of child sexual exploitation are in place but that arrangements within individual provider services to ensure understanding and identification of children who may be suffering sexual exploitation will benefit from enhanced joint working and skills in recognition of indicators of risk.

3.16. Alternative arrangements for child protection meetings, such as video conferencing, standing dates for meetings or use of venues local to the children concerned could help to improve attendance and the range of contributors to risk assessment and decision making. Attendance or provision of reports to child protection meetings is given a high priority by most health staff although the location of all initial child protection conferences at Beverley has a considerable impact on many health staff. This presents particular challenges to those working in more remote locations and to part time staff, even more so as they frequently receive only very brief notice, not only of strategy meetings but also core groups. We saw how this impacts on full attendance of all those who could make a contribution. We heard about a conference report format developed by the named GP and now modified to improve the consistency of GP's written contributions to conferences.

4. Looked after Children

4.1. The children looked after (LAC) health team has been affected by a raft of personal and organisational challenges in the past two years, during which time capacity to deliver their responsibilities has been challenging and, at times, has had a negative impact on the quality of service provided to children in care in the East Riding. The interim manager and staff have worked hard since summer of 2013 to overcome particular challenges to the ensuring core aspects of the service to looked after children were delivered.

4.2. We heard how the LAC health team's recent relocation into a health setting was felt to be improving access to other health professionals.

4.3. The previous inspection recommended that action should be taken to improve the timeliness of initial health assessments (IHAs). There has been some improvement but too many children entering care still experience late IHAs, and it remains unacceptable that the identification of health needs is delayed in this way. Since the previous inspection new arrangements have been established for IHAs to be done by a small cohort of GPs recruited to undertake these assessments. This has helped to improve timeliness and consistency. The IHA's we saw illustrated that there is more to be done to address the variable quality; several lacking a full reflection of the health complexities known and understood by other health professionals working with the child.

4.4. The IHA should inform each child's health plan, identifying the health support each child needs and setting out actions to be taken. Progress should be reviewed and revised after each assessment. We saw health plans that are not SMART and not always effectively identifying and securing the health services children need. Foster carers also told us about their experiences of the perceived ineffectiveness of arrangements in meeting the children's health needs. Plans we saw are very variable in quality, generally lacking measureable actions or clear timescales. In some cases the plans do not serve as a vehicle to ensure all of the child's health needs will be met in the period until the next review (recommendation 5.3).

4.5. Issues such as these in assessment and health care planning contribute to the unreasonably long waiting times for looked after children to access therapies that are essential for their well-being and development. Meanwhile, we heard, these needs often increase. We heard about a three year old child who when placed with foster carers had a known need for speech and language therapy (SALT) yet the foster carer described how she has chased this support through various channels including the paediatrician and health visitor. It will be six months after this placement before the child will be seen for the first time. Another foster carer of a seven year old child with needs for SALT had had a similar experience but with no success in accessing a service (recommendation 7.3).

Child K, aged 6, became looked after in August 2012, and his initial health assessment identified a number of health needs. Before becoming looked after, he was receiving SALT but this didn't continue and due to poor recording and changes in foster carers it is not possible to identify why the SALT was stopped.

When placed with his current, experienced foster carers in 2013, it was his 10th placement in less than a year. The need for CAMHS support had already been identified at that time, and remains outstanding, whilst his distress increases.

K's annual health review was delayed by over 2 months due to delays in the receipt of paperwork. The review competently identified his developmental and health needs but the health plan did not include services or targets to meet them though the nurse did undertake some actions outside the health plan.

4.6. The records we saw showed that most health reviews are stand alone events, variable in timeliness and quality and not reliably informed by the previous review or other health professionals' involvement. We saw reviews and health plans that could have greater impact if all available information, such as annual or specialist strengths and difficulties questionnaire (SDQs) outcomes, or updates from specialists were drawn together in advance, so that all needs including emotional well-being are considered at the time of the health review. The child's own GPs do not routinely contribute their knowledge of the child before the review. This is also a missed opportunity to enrich the quality of information used to inform assessments and reviews and contribute to the improvement of a child or young person's health (recommendations 5.2 and 5.3).

4.7. Assessments and reviews we saw are age appropriate, though they are not fully comprehensive, for instance not always reflecting the voice of the child. Screening for substance misuse (DUST) or other vulnerabilities is not incorporated into the process and very few looked after children access drug treatment programmes. These are missed opportunities to provide appropriate interventions (recommendations 5.2 and 5.3)

4.8. Positively, we heard good evidence of some older children in care engaging with their health reviews through the flexibility and approachable nature of the LAC co-ordinator who employs a range of techniques to reach or keep a young person motivated. The mental health YOS worker and the looked-after child health care co-ordinator for care leavers also work co-operatively to support young people. In relevant cases the mental health YOS worker routinely provides progress reports to inform a looked-after child's health review.

4.9. We heard how the views and expert knowledge of foster carers about the children in their care could contribute much more to ensuring the well-being of these children, yet they feel they are seldom listened to and their views come last in any discussion about the needs of the child. Carers are not routinely provided with copies of children's health plans as this is dependent on parental consent and a young person's consent. This may impact on the carer's contribution to ensuring their foster child's health needs are met.

4.10. There are weaknesses in services to support the emotional wellbeing of children in care and care leavers. Despite a dedicated resource of a CAMH team for looked after children, some children who are looked after are not always receiving timely effective help from CAMHS due to waiting times to access some therapies. We also saw how the referral and assessment process can introduce delay into some children and young people being seen quickly. We also saw good examples of how CAMHS intervention had made a significant and positive impact on the lives of children and young people, helping them through placement moves and building positive esteem.

Child L is a young boy for whom opportunities to identify underlying issues and offer earlier help were missed for several years. As his issues escalated his mental health has reached a crisis point and a CAMHS specialist has been working with L and family. Professionals understood that a new referral to CAMHS was needed because L has recently been placed in foster care as a result of his increasingly violent and threatening behaviours towards his family and others.

At the time of our review, informal agreement about the most appropriate placement to meet his needs had not been possible and health managers were trying to convene a panel to ensure all L's needs and the risks are fully considered.

4.11. We heard many examples of children being unable to access help from CAMHS until they have greater stability of placement yet psychological help could be instrumental in achieving that stability. One young person told us "You've got to be settled to get it but you're never settled because you need it. Then it starts all over again, you're not settled so you can't have it". This was also reflected in cases we saw and in the experiences of foster carers with whom we spoke (recommendation 7.3).

4.12. Some foster carers are receiving support to sustain potentially fragile placements, for example, a pre-placement planning meeting between birth and foster parent helped prepare the foster parent for the needs and challenging behaviour of a child prior to placement. A CAMHS psychologist continues to work with both adults to help secure the placement.

4.13. Foster carers do find the support of health visitors invaluable and told us that this is often the main source of help in securing urgently needed services. We saw an example of good work where the health visitor liaised across agencies in supporting a 12 week old baby presenting with substance withdrawal complexities and provided a good package of health support for the foster parents. We also saw an example of a foster carer being well supported by a school nurse and a social worker and being signposted to appropriate sources of advice and guidance including sexual health.

4.14. Most looked after children have good access to primary care, they are promptly registered with GPs and dental checks and immunisations are arranged for almost all looked after children. Foster carers feel very well supported by GPs and dentists who give priority to appointments for looked after children. As we saw however, not all GPs practices have systems which enable them to identify children who are looked after which is a concern in relation to the GP ensuring that the particular needs of a looked after child are met (recommendation 7.2). Young people told us of difficulties in registering with a GP if they change their location when they leave care. *"While you're in care it's easy to get a GP but you often move when you leave care. Then it's hard to get signed up with a GP here, a lot of them are over capacity so had to wait two months to get a GP when I moved."*

4.15. Many young people who are care leavers have experienced previous distress and research recognises that they may need help for their mental health and emotional well-being at this time particularly. Up to the age of 21 a looked after children's co-ordinator works well with the Pathway team to try to mitigate the difficulties experienced by many care leavers (recommendation 1.4). The period of transition and establishing adult life is an especially difficult one for young people who fall outside the threshold for adult mental health services yet have emotional support needs which impact on their future prospects.

4.16. Since the 2011 inspection which made it a recommendation, some young people who have left care have received summaries of their health history. The LAC health team now record the reason for any young person who is not provided with a leaving care summary. Of six young people we met, only one recalled having had received any form of care leavers' health summary. It is important that young people who are leaving care have information to manage their own health needs including understanding how the health summary might be used (recommendation 5.2).

4.17. Although we saw no performance information about outcomes, we heard that young people in care who become parents can access a good range of support, with children's centres offering support services around the county.

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

The findings of this review indicate that arrangements for safeguarding children and ensuring the quality of health care provided to children who are looked after require increased focus. Local managers identified some additional pressures including increased complexity of need and risk levels, and a number of changes in local commissioning and partnership arrangements that are still in the process of being worked through. Many professionals are proactive and fully committed to their work, keen to identify opportunities to improve. We also heard about and experienced complacency by some isolated professionals in terms of the extent of safeguarding risks within their work.

5.1.1 The CCG and NHS England area team (AT) are working to develop safeguarding arrangements aligned to changed requirements and responsibilities. The AT has in place a memo of understanding with the CCG setting out a robust accountability framework for safeguarding. The AT is also at an early stage in starting to build a vision about how it wants to develop the services for which it has responsibility, in consultation across the region. A regional safeguarding forum is established but at an early stage and did not yet see evidence of impacts on practice locally.

5.1.2 During the shadow arrangements for the transfer of duties from PCT to the CCG and AT and pending the opportunity for wider review, existing local arrangements for the designated roles and for GP training continued without interruption. Through this period of significant change this provided helpful stability. However, the major changes which have altered the commissioning landscape and increasing services challenges require urgent review of the role, capacity and accountabilities of the designated and named professionals for safeguarding and for children who are looked after across East Riding of Yorkshire (recommendation 1.1).

5.1.3 As a result of a succession of issues, leadership and staffing of the looked after children's health service has undergone an extensive period of instability. This period has impacted on the effectiveness of the strategic capacity of the designated professionals. The operational difficulties also compromised the quality of service to children, which are described in our findings. As the staffing position worsened during 2013, interim staff struggled to maintain a level of service that the organisation would aim to deliver. It is to the credit of these staff that from a difficult position in summer 2013 they have established new systems and enabled the core business of assessments and reviews to continue. The appointment of a new designated nurse for looked after children to take up post in January 2014 offers the opportunity to plan service development to comply with statutory guidance and drive quality health care for children in care.

5.1.4 The designated doctor for looked after children is an appropriately qualified senior paediatrician who is enthusiastic and committed. Newly located in CHCP following the transfer of all paediatricians, the role is not yet secured by an agreed role description with evaluated workload. The extent to which current very limited capacity is sufficient to discharge the full role including its strategic responsibilities requires resolution to ensure service quality and development. Limited quality assurance of health assessments is undertaken and some training has been provided for the GP's who undertake health assessments, but this is work in progress and both aspects require attention as shown in the cases we saw. There is also recognition that much more needs to be done to support GPs to develop their awareness of the health needs of looked after children and improved confidence in paediatric assessment would help improve the quality of their referrals to paediatricians (recommendations 1.1 and 7.1).

5.1.5 Capacity and design of the roles of all named professionals is also an area that would benefit from further scrutiny to ensure all key aspects of their role in safeguarding children are effectively delivered (recommendation 1.1). Given the significant size and complexity of some health organisations, it is unclear how the current capacity of their safeguarding leadership is sufficient to bring about the necessary improvements and effectively oversee and develop practice, quality assure work, update guidance and maintain a grip on risks. As an example, the named nurse for HFT has responsibility for 3000 staff across all community services, forensics, child and adult mental health, child and adult drug and alcohol services, with two supporting posts which also cover adult safeguarding across these services.

5.1.6 Although newly in post, the acting named midwife in HEY has started to strengthen safeguarding arrangements and develop a more strategic approach. However, the temporary, part time nature of this named midwife role is a barrier to developing robust safeguarding practice and quality assurance. Capacity of 15 hours is over-stretched for responsibilities including the work of over 200 midwives working across the county as well as in inpatient services. Coupled with the lack of IT, this results in there being no direct oversight of individual community midwives management of safeguarding for vulnerable women (recommendation 3.1).

5.1.7 The named GP for safeguarding has a close working relationship with the designated nurse. We heard that he demonstrates leadership and commitment to the role, being a source of regular advice to other GPs and having a high profile amongst his peers. Training, supervision and support for the named GP needs to be put into place to develop the skills and knowledge necessary for the role (recommendation 7.1).

5.1.8 The CCG has started to develop its arrangements for monitoring performance data with an early scorecard approach. Further development is needed to drive the quality of safeguarding and service delivery and to monitor outcomes for looked after children (recommendations 1.2/ 5.1). We found that inconsistencies in the manner in which data about safeguarding training is presented makes it difficult to assess compliance. Case examples also suggest that core safeguarding training is not ensuring that all staff have the required competence and skill set for some areas of work (recommendation 6.5 and 6.10).

5.1.9 Performance management, quality assurance and managerial oversight within individual service areas requires significant development, as demonstrated in many of the cases we reviewed. Services for looked after children require much greater oversight and partnership working to improve their quality and timeliness. We heard about on-going difficulties of late receipt of information from social workers, and the exchange of documents by internal mail adding delays at each end of the processes. There is scope for greater use of technology to improve timeliness and performance management.

5.1.10 Case records across health do not always reflect the practice and actions of the worker and there is little evidence of management audit or oversight of case recording practice in a number of services. Following this review we heard that strengthened arrangements were immediately put into place in health visiting and school nursing services. Bridlington maternity service however, was a particular example of good practice with managerial evaluation and learning on each case record, promoting continuous improvement.

5.1.11 Both health and social care have experienced unprecedented challenges and changes since the last inspection. A number of the difficulties experienced by children, their families, carers and professionals that are highlighted in this report can benefit from the new partnerships working together to secure improvements.

5.1.12 The county has a comprehensive raft of strategies addressing the health and well-being of children and in particular of looked after children and these are a valuable blueprint. The Health and Wellbeing Board's strategy acknowledges children's emotional well-being as the main strategic priority of improving children's health. The CCG has embarked upon a re-commissioning of CAMH services for 2014 and we heard about proposed specification improvements that could contribute to improved services. We found this to be a priority area for improving outcomes (recommendation 7.3). Health support and transition arrangements for care leavers who fall outside adult mental health service criteria also remains an area for improvement (recommendation 1.4).

5.1.13 As the JSNA[3] recognises, the current analysis does not include details about the profile of the looked-after or vulnerable children population or specific cohorts within it, which is a barrier to effective planning and commissioning. Improvements in the quality and detail of health care plans and monitoring of their delivery would also contribute to better intelligence for planning and commissioning through the ability to aggregate requirements for services.

5.1.14 As the earlier sections of this report demonstrate, frontline health services continue to experience high demand; in some areas resources are being diverted into the management of high risk cases, with limited capacity to scope, deliver and sustain preventative work.

5.1.15 Information systems which do not interface effectively or are stand-alone are barriers to effective information sharing to inform robust risk assessment of vulnerable children. The risks are compounded by the complexity of providers and out of county services. There has been very limited progress in extending IT compatibility; given the interface limitations, most current systems and arrangements to check risks are not fully effective. Health managers and safeguarding leads generally have very poor access to the social care records system which impacts on service's ability to make speedy checks to identify children who may be at risk. We heard that improved access had been planned but was still not implemented. In some areas of work this is a significant barrier, for instance the midwifery service at HEY has over 200 midwives but no current information system to enable its managers to have oversight of case work with vulnerable women and babies who are at risk (recommendation 6.11).

5.1.16 Safeguarding within the CASH service is also hampered by the lack of an effective integrated recording system which is accessible county wide. This means that staff cannot identify multiple attendances across sites, link people or operate performance reporting and oversight systems. We understand an electronic system is due for implementation in 2014 and with proper roll out and full activation this has the potential to deliver significant improvements to current safeguarding arrangements.

[3] JSNA – joint strategic needs analysis – annual public health report on the needs of the population

5.1.17 We heard how, with few shared systems, confusion about the interface of information sharing and consent protocols with child protection is a barrier to effective safeguarding by practitioners from different services. We saw examples where health staff withhold information (such as case history or details of current concerns held by other agencies) from other professionals if consent to share or seek information has been refused by a parent.. This is resulting in some cases where the service currently most engaged with a family is not fully informed about previous concerns or historical activity. This could adversely affect their own risk assessment work and result in risks to a child being missed (recommendation 6.12).

5.1.18 The adult mental health service has continued to operate two separate information systems despite integration many years previously. This is a barrier to effective joint working and creates inherent risks that child safeguarding issues may be overlooked. It also impacts on the effectiveness of managerial oversight and quality assurance of safeguarding practice.

5.2 Governance

5.2.1 There are shared arrangements for safeguarding accountability in the East Riding. The role of the lead nurse is vested in the director of quality & governance to whom the designated nurse reports. The designated nurse then works with safeguarding leads in provider services and also reports to the director of commissioning and transformation as the nominated lead to the local safeguarding children board (LSCB). The effectiveness of these governance arrangements in helping the CCG in discharging its statutory roles for children looked after and safeguarding are worthy of consideration.

5.2.2 Health is well represented on the LSCB and sub-groups. The important role of general practitioners is recognised through the named GP who has an advisory role to the Board. However, the named GP has been unable to attend, hence GP's perspectives have not been directly available to the LSCB over the past year. The LSCB scrutinises health partners' safeguarding activity and has focused on some key areas for audit.

5.2.3 However, our review demonstrates that a robust programme of quality assurance is not yet in place to provide assurance to the CCG and provider organisations on the quality and effectiveness of safeguarding practice across all health services operating within East Riding of Yorkshire (recommendations 1.2).

5.2.4 Whilst the health trusts have internal escalation protocols, there is no shared, jointly agreed escalation policy providing a consistent and supportive framework across health and social care for resolving professional differences about safeguarding thresholds. Issues are dealt with on a case by case basis. Health professionals are holding many complex cases of significant risk and we saw several that had been escalated by multiple professionals without securing clear planning or improved outcomes for the children concerned. This is an area of concern (recommendation 6.1).

5.2.5 All Trusts have safeguarding governance arrangements in place. Given the findings of our review it is not clear how effectively safeguarding practice, is being monitored and addressed. Mechanisms through which managers can assure practitioners' safeguarding competence require strengthening to enhance monitoring and assurance from the front line to the Board. This is especially important as most frontline staff across these services have significant involvement with children in the course of their work. Several improvements are due to be implemented since the review.

5.2.6 The safeguarding role of adult mental health and drug and alcohol services was highlighted in the CQC/Ofsted thematic review which included a neighbouring authority in 2012[4]. Child safeguarding arrangements in East Riding should be strengthened by further focus on culture change to ensure that all appropriate staff recognise their full role in on going safeguarding activity where children are affected by parental mental health issues. Our review found that some isolated members of staff demonstrated low expectations of the service's role and participation in children's safeguarding and formal child protection arrangements beyond making referrals to social care with limited involvement expected of adult mental health staff participating in child protection procedures. Although the trust has provided training and introduced systems and processes to support the "Think Family" model there is no ongoing audit to provide evidence and assurance to the trust board of its successful implementation. During the review we found evidence of gaps in practitioners considering the impact of parental mental health on children during assessment, planning and discharge (recommendation 5.4).

5.2.7 The *"Think Family"* awareness, training and performance in drug and alcohol services is regularly making a difference to children. Managers and safeguarding leads in the adult substance misuse service set clear expectations about practitioners' participation in child protection work and monitor their performance.

[4] *Report "What about the children" Ofsted 2013*

5.2.8 We saw little evidence of regular opportunities for young people, families or carers to be involved in the design of health services. However, young people had been invited to a meeting as part of a major consultation about CAMHS redesign, though a few felt they had inadequate opportunities to influence changes. Positively, we heard that this was being addressed in the new service specification. Overall, our feedback from young people and carers suggests they could contribute more to evaluations of service effectiveness. A number of services do have arrangements to collect feedback from families who have accessed their service. Our findings suggest there is also scope for all services to increase the reach and scope of opportunities for feedback (recommendation 6.8) to maximise young people's opportunities to influence the services they receive. We heard that the local Healthwatch has held some discussions about establishing a young people's Healthwatch group which could be a positive development but as yet young people have not been involved in this.

5.2.9 We heard about some changes to practice as a result of learning from national serious case reviews. However, many of the recommendations within the action plan from the local serious case review relating to the case which occurred in 2012 have yet to impact on practice and culture. Many of the findings, for instance, the need for improved joint working, recording practice, information sharing and mental health practice remain relevant in this review's findings suggesting that more robust action is required to improve the protection of children.

5.3 Training and Supervision

5.3.1 All providers are recovering from challenges in 2013 which affected safeguarding training. Difficulties in releasing staff to attend training remain an issue for some services. We found that levels of compliance remain variable. East Riding services provided by CHCP at Bridlington hospital are currently least compliant against Trust-set targets; we saw the need for improved safeguarding practice in the identification of potential risk to children attending the MIU operated by CHCP. Safeguarding practice at this MIU also reflected the need for improved assessment of safeguarding competence in addition to attendance at training. Practice concerns in a number of other cases and especially those we referred for management review underline the importance of monitoring training effectiveness and outcomes (recommendation 6.10).

5.3.2 Targeted sessions have helped NLaG's Goole MIU staff to reach compliance with the Trust's core safeguarding expectations (level 2) in response to CQC concerns earlier in 2013. Some of these MIU staff have also undertaken level 3 training which we consider to be more appropriate for roles in an MIU which provides care to a high volume of children.

5.3.3 Health staff who are not employed directly in children's services frequently need their skills to identify and contribute to the assessment of risks to children. In these services we suggest that Trust policies should be reviewed to ensure training to level 3 rather than level 2, this is a particular issue in AMH but is also the situation at Bridlington and Goole MIUs. Additional topical training at level 3 is available to staff in many services areas, for instance sessions on Hidden Harm or the impact of mental health on parenting are available. Attendance by adult substance misuse practitioners is encouraged and well taken up at these

5.3.4 Positively, some service areas have adopted training strategies with targets which are more robust than the minimum, for instance, the midwifery unit at HRI is delivering additional training to midwifery assistants and hearing screeners, recognising their important contact with vulnerable women and babies. HEY is making progress in ensuring all of its 200+ midwives are trained to level 3 though with about 55% compliance, arrangements to allow the release of staff more quickly need to be considered given the high levels of individual responsibility midwives carry (recommendation 6.10).

5.3.5 CAMHS staff are also required to complete level 3 safeguarding training, with all mandatory training delivered at a summer school to ensure full reach, which is good practice. It is not clear how effectively this learning has been embedded in practice or how the impact of training on practice is routinely evaluated (recommendation 6.10).

5.3.6 Overall, performance in respect of staff supervision shows an improving position, but is not yet adequate across all health services. Most practitioners have good access to ad hoc advice and guidance and do receive an annual appraisal. This is not however, sufficient to ensure staff are fully supported and equipped in line with statutory guidance (recommendation 6.9).

5.3.7 Supervision policies and arrangements would benefit from review to ensure that they fully accord with Intercollegiate expectations in relation to formal, dedicated safeguarding supervision for staff in relevant roles by appropriately trained supervisors. For example, HFT has professional supervision policies in place and we saw arrangements for health visitors and school nurses where records of supervision discussions about specific cases are reflected in the case record. We found recording of supervision within case records not to be evident in adult mental health, substance misuse or MIUs however. In some services such as Bridlington and Goole MIUs, supervision is on request only.

5.3.8 We saw the start of positive impacts where trusts have targeted the development of supervision capacity and skills in some services. For example newly developed supervision arrangements in midwifery services at HRI have been supported by training of 24 supervisors, with implementation in place for December. However, in adult mental health it is unclear what training managers have undertaken in order to equip them to effectively supervise, to recognise good or sub-optimal practice and therefore to effectively practice manage safeguarding and child protection activity (recommendation 6.9).

Recommendations

1. ***East Riding CCG should:***

1.1 Review the leadership, capacity, accountability and skills for both safeguarding children and children in care to ensure that statutory requirements are met and the timely delivery of quality services for these groups is secured.

1.2 Ensure commissioning governance and assurance arrangements provide effective scrutiny of the experiences and impact of local health services in delivering improved outcomes for children and young people who are looked after.

1.3 Work with partners to ensure that children of school age receive the support they need to safeguard their health and secure improvement in their development including health promotion and advice.

1.4 Review arrangements to meet the health needs of care leavers and young people in transition who fall outside adult mental health services criteria.

2. ***East Riding CCG, HEY and YTH should:***

2.1 Ensure that a clear pathway is put in place to assess vulnerability in all pregnant women and to safeguard unborn babies who are at risk through robust CAF, child in need and child protection arrangements backed by quality assurance to support consistent good practice.

2.2 Review partnership arrangements to ensure that all unborn babies for whom safeguarding risks are identified have the protection of multi-agency involvement in early assessments as well as timely CP case conference decision making.

3. ***East Riding CCG and HEY should:***

3.1 Ensure that safeguarding in midwifery services is secured by robust safeguarding leadership with sufficient capacity for oversight and quality assurance commensurate with the scale and scope of the service.

4. ***East Riding CCG, HEY, NLaG, CHCP should:***

4.1 Review the environment and facilities of the urgent care and emergency care provision to ensure they provide appropriate facilities for children and young people, including waiting areas, and triage for children and young people who are in distress or have self-harmed. (also see footnote 6)

5. ***East Riding CCG and HFT should:***

5.1 Regularly report on child health outcomes for children in care, proactively identifying local trends, and robustly addressing risks to the health and wellbeing of children in care and care leavers.

5.2 Fully implement holistic health history summaries and information about taking responsibility for their health for all young people leaving care and ensure this is meaningful and responsive to their individual wishes and needs.

5.3 Ensure that all children in care have prompt and high quality, holistic assessments of their physical, emotional and mental health needs and regular reviews which are all supported by SMART health plans.

5.4 Ensure through a robust programme of training, supervision and audit that adult mental health practice is consistent in recognising and safeguarding the needs of children within families who are affected by mental illness, including at assessment, in care planning and on discharge.

6. ***East Riding CCG, NLaG, HEY, YTH , HFT, HCHCP should:***

6.1 Ensure that children are safeguarded through an agreed safeguarding children's escalation protocol and procedure to facilitate consistent effective resolution of professional differences and ensure appropriate support for children.

6.2 Ensure that robust arrangements are put in place to assure the quality of health professionals work in safeguarding children and young people across East Riding of Yorkshire, with particular attention paid to the quality of safeguarding referrals and their impact in working with children in need, and child protection to ensure that children for whom risks are identified receive prompt and effective support.

6.3 Ensure that all health professionals who work with families have awareness commensurate with their roles, of the impact and risks of parental mental health, domestic violence, alcohol or substance misuse and take account of this in their support for these children.

6.4 Ensure that opportunities to offer young people help through drug and alcohol support services are maximised, with clear referral pathways from health services, including children in care services, GPs and urgent care settings.

6.5 Ensure all children and young people attending minor injury units are cared for by appropriately trained staff with updated paediatric skills and assessed competencies.[5]

6.6 Review arrangements for paediatric liaison, including capacity and clinical governance arrangements to ensure that robust arrangements are in place across all emergency and urgent care settings so that risks to children are effectively identified and followed up.

6.7 Ensure that staff across all health disciplines including adult mental health, drug and alcohol services and sexual health services are fully engaged in robust, consistent information sharing about children and their families for whom risks or concerns are known.

6.8 Expand opportunities for listening to and learning from the experiences of young people and their families/carers, actively engaging them in service improvements

6.9 Ensure effective supervision arrangements are in place for all staff who are involved in safeguarding and child protection work in line with inter-collegiate professional requirements and that this is monitored by the LSCB.

6.10 Review the training programmes and supervision arrangements to ensure that they continuously promote, embed and evaluate the impact of training in increased practitioner understanding of the role of all health professionals to maximise their engagement and inclusion in child protection arrangements and planning.

6.11 Jointly review IT systems and the use of technology to maximise opportunities for timely information sharing, effective identification of risks and improved performance monitoring.

6.12 Review the application of consent and information sharing protocols and guidance and ensure that, all staff are aware of national guidance about their responsibilities for sharing information with other professionals where it is in the interests of safeguarding children who are vulnerable.

[5] Royal College of Paediatrics and Child health, 2012.

7. *NHS England and East Riding CCG should:*

7.1 Ensure that GPs including the named GP are properly equipped and competent for their respective roles in safeguarding, child protection and meeting the needs of children in care through robust development opportunities supported by monitoring and quality assurance.

7.2 Ensure that GPs clinical records clearly identify the looked after status of each child so that their particular needs can be acknowledged.

7.3 Review the commissioning of paediatric therapies, including CAMHS and specialist LAC CAMS and their effectiveness to ensure that children requiring early help and those who have specialist needs have access to timely, child centred assessment. Families should have access to a range of treatment including community based alternatives to in-patient care and to facilitate care close to home.

7.4 Ensure that mothers in all areas of the county who require perinatal mental health services have access to a range of suitable services to secure effective early intervention and support for the well-being of mother and baby.

Next Steps

An action plan addressing the recommendations above is required from the CCG within **20 working days** of receipt of the **finalised version** 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.