

Review of health services for Children Looked After and Safeguarding in Warrington Borough Council

Children Looked After and Safeguarding The role of health services in Warrington Borough Council

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

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

About the review

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

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

How we carried out the review

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

We tracked a number of individual cases where there had been safeguarding concerns about children. This included some cases where children were referred to social care 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 93 children and young people.

Context of the review

Warrington Borough Council is one of the fastest growing areas in England. The Council has a population of approximately 210,867 people, including 48,826 children and young people. Recent data indicates 10.9% of nursery and primary schools children and 9.2% of secondary school pupils are eligible for and claiming free school meals. These figures are lower than the average for England.

Children and young people from minority ethnic groups comprise 10% of all children living in the area. The largest minority ethnic groups are of Indian, Pakistani and Polish heritage. The proportion of children and young people with English as an additional language is 12% in primary schools and 4% in secondary schools.

The health profile of Warrington's children indicates a mixed picture of health inequalities and outcomes. Childhood vaccination levels are better than the average for England. The childhood mortality rate is similar to other areas. The emotional health of looked after children, captured within strengths and difficulties questionnaires (SDQs), indicates that levels of concern are similar to other areas in England. The rate of under-18 conceptions per 1,000 females aged 15-17 years is also similar to the national picture. In contrast, the rate of emergency admissions to hospital due to self-harm and for alcohol-related mental health and behavioural problems for under 18's is relatively high compared to most other areas of England. The hospital admissions for young people aged 15-24 caused by unintentional or deliberate injuries is also significantly higher than the England average.

The majority of Warrington residents are registered with a GP practice that is a member of NHS Warrington Clinical Commissioning Group (CCG). A total of 26 GP practices operate in the area.

Acute hospital services are commissioned by Warrington CCG and provided by Warrington and Halton Hospitals NHS Foundation Trust. Our review included visits to the Trust's Emergency Department (ED), paediatric ward and maternity services.

Specialist Child and Adolescent Mental Health Services (CAMHS) are commissioned by Warrington CCG and provided by the 5 Boroughs Partnership NHS Foundation Trust. In-patient care (tier 4 CAMHS) is commissioned by NHS England and provided by the 5 Boroughs Partnership at Fairhaven Young Person's Unit in Warrington. We did not visit this service.

Adult mental health services are commissioned by the CCG and provided by the 5 Boroughs Partnership NHS Foundation Trust. The 5 Boroughs Trust also provides mental health services to the neighbouring councils of Halton, St Helens, Knowsley and Wigan.

Health visitor, school nurse services and contraception and sexual health services are commissioned by Warrington Borough Council's Public Health Department and provided by Bridgewater Community Healthcare NHS Foundation Trust. This Trust provides the Children in Care specialist health service in Warrington. The Bridgewater Trust also delivers community health services in the neighbouring councils of Bolton, Halton, St Helens and Wigan.

Young Persons Substance Misuse Services are commissioned by Warrington Borough Council's Public Health Department and delivered by the Council's Youth Services. Adult substance misuse services are also commissioned by Warrington Borough Council Public Health Department and provided by Change Grow Live known locally as Pathways to Recovery.

Warrington has a relatively high number of children in care compared to other similar English Councils. At the time of our visit, 342 of Warrington's children were looked after, including small numbers of unaccompanied asylum seeking children. In addition, 228 children were placed by other councils in the area.

The last CQC safeguarding and looked after children's inspection took place in January 2011 as a joint inspection, with Ofsted. The overall effectiveness of the safeguarding services and capacity for improvement was judged as adequate. The outcomes for looked after children were judged as adequate. Progress against 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

Although we were unable to meet with an established young person's group during the review, we captured feedback from some people we met during our visits to specific services. Most of the feedback we received was positive, and indicated good awareness of and support from frontline local health services and partner agencies.

One mother spoke highly about the care she had received from her midwife. She told us her worries and concerns were dealt with promptly. Both parents said they felt well-informed, particularly at the time of the emergency caesarean section. They commended the nurse allocated to them who subsequently came to the ward to see how they were, which they felt demonstrated a caring approach. This mother reported being asked sensitively about domestic abuse during both pregnancies. The only area this mother felt could be improved was the levels of staffing at night.

Another new parent reported she had felt anxious through her pregnancy and that she valued having continuity of care from the same midwife. She reported that the offer of antenatal classes had not been suggested until late in her pregnancy.

A mother of a four month old baby reported positively on the support she had received from her health visitor, stating she had given helpful and consistent advice. She said there was good signposting to the local children's centre, which she had taken up.

A mother of a 13 year old child told us the service provided by the local Child Development Centre was brilliant. She said her daughter received fantastic support from the physiotherapist and speech and language therapist, including at school. The mother also commended the social and leisure support her daughter received at the Warrington Play and Sensory Centre and the activities provided during school holidays at the Pyramid Centre. She said:

"There used to be hardly anything for disabled children, now there is lots to do".

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 The paediatric emergency department (ED) at Warrington Hospital is a small dedicated department that treats all children and young people under the age of 18 years. The location of the children's waiting area means that it was not directly observable by nursing staff. This carried the risk that a child with a deteriorating condition may not be identified promptly. On the day of our visit, a floor standing electric fan in the area presented a potential hazard to small children as it would easily be pulled over. The layout and safety of the children's waiting area would benefit from further review.
(Recommendation 8.1)
- 1.2 It is positive that, although older teens could opt to wait in the adult ED reception, they were still seen and treated in the paediatric area. Paediatric documentation, including a safeguarding risk assessment, was routinely used; and helped reinforce staff recognition of their statutory responsibilities for older children. However, the child protection risk assessment checklist sat outside of the paediatric clinical assessment and record template and had to be manually pasted into the template. Adult documentation asks only for the next of kin and does not probe about parental responsibilities or whether there are children living within the household. This is a missed opportunity to identify the potential for hidden harm. ED and safeguarding senior staff recognised the opportunity to strengthen practice in these areas as part of the current review of the IT system.
- 1.3 Warrington and Halton Hospitals NHS Foundation Trust had a clear process for identifying risks posed by adults who were under the influence of alcohol or drugs. Arrangements for young people misusing alcohol or drugs had been recently strengthened. The new automatic referral pathway provided prompt access to the young person's substance misuse service. There were early signs that this approach was leading to improvements in levels of engagement. Significant work was still required to sustainably reduce the number of such presentations. It was of concern to us that the Trust managers we spoke to did not seem to be aware of the new pathway.
(Recommendation 6.1) *This has been drawn to the attention of Public Health Warrington as the commissioner of the young person's substance misuse service.*

- 1.4 Paediatric liaison arrangements delivered by Bridgewater Community Healthcare NHS Foundation Trust were well-established and ensured effective information-sharing about children and young people attending the ED, neo-natal and paediatric wards. Work undertaken by the paediatric liaison workers provided effective quality assurance in following up any child health concerns or gaps in safeguarding risk assessment that may not have been appropriately identified by busy frontline clinical or nursing staff. However, formal contracting arrangements with the community health provider ended in April 2016. The Trust was in the process of developing its own internal paediatric liaison role. The model of future delivery and timescales for transition had yet to be formally agreed. Action needs to be urgently progressed to secure a timely and seamless handover.
(Recommendation 3.1)
- 1.5 GPs told us that the notifications they received from the ED when adults with children in the household attended for treatment provided only basic details such as “head injury”. Contextual information about the cause or circumstances was limited, which in turn impacted on the effectiveness of their decision-making in reviewing risk and prioritising follow-up checks. Areas such as this would benefit from further review as the Trust firmed up its new paediatric liaison arrangement. **(Recommendation 3.1)**
- 1.6 Health visitors and school nurses reported daily receipt of all hospital notifications, with an appropriate duty system in place to ensure prompt follow up of urgent issues. Health visitors and school nurses were working to strengthen systems for information sharing and communication with GPs. They recognised current constraints given their dependence on paper records, with read only access to Systm One, the electronic case management system used by a number of GP practices in the area. Health visitors were matched to local practices so that GPs had a named contact.
- 1.7 On 1st February 2016, Warrington introduced a new multi-agency safeguarding hub (MASH) to provide a single point of entry for referral of concerns about children and their families. Health professionals engaged in this work included named safeguarding professionals from Bridgewater Trust. At the time of our visit, health input was arranged on a 6 week rolling cover basis. The MASH systems were still at an early stage of development and would benefit from continuity of health oversight to help embed new arrangements and promote learning across the wider health sector. Whilst links with health visiting and school nurse services that the Trust directly provided were working well, the interface with and awareness of other providers and teams was variable. This included CAMHS, GPs and adult mental health and adult substance misuse services.
(Recommendation 4.1)

- 1.8 Midwives employed by Warrington and Halton Hospitals Foundation Trust were flexible in offering clinics at a range of times, including evenings and weekends, and in various venues including GP practices, to facilitate early engagement with the service. However, midwives did not routinely seek information from GPs to inform the social needs section of maternity assessments. We were told that some GPs were proactive in raising concerns or supplying information to the community midwife; but overall this area of joint working was under-developed. **(Recommendation 8.2)**
- 1.9 Pregnant women were always seen alone at the first appointment, and asked about domestic abuse. This issue was not explored at other points in the pregnancy unless the midwife or other professionals had identified a particular concern. Guidance from the Royal College of Midwives highlights the need for routine enquiry into domestic abuse throughout the pregnancy and postnatal period. Routine questioning at other points during the pregnancy would help to strengthen vigilance in this area as domestic violence is known to be an issue that can emerge or escalate throughout pregnancy.
- 1.10 The local Cheshire Constabulary advised the named midwife of their attendances at domestic abuse incidents where pregnant women were involved. Such notifications ensured midwives were kept well-informed about any increase in risk that pregnant women were exposed to. Midwives were also routinely advised of attendances of pregnant women at ED for reasons of domestic abuse or other safeguarding issues. The Trust had a strong focus on the safety and security of babies whilst they were in hospital, with evidence of effective management of risk during a recent rehearsal of systems to prevent a baby from being abducted.
- 1.11 The joint liaison meeting proactively enabled a comprehensive child-centred approach to be taken to the protection of unborn and new born babies.

Good Practice: *The joint liaison meeting held at Warrington Hospital has been in place for a number of years. Its role and impact was highly effective in promoting a structured multi-agency approach to safeguarding the health and wellbeing of pregnant women and their unborn babies. A decision-making as well as information sharing group; it included a range of health and social care professionals and enabled proactive sharing of both hard information and soft intelligence.*

As a consequence, casework was secured by a strong early intervention and protection focus, where timely joint response to concerns had effectively prevented escalation of risk. Children's social care readily accepted referrals from the joint liaison meeting where it was highlighted parents were not engaging with the help provided, or where additional targeted support or intervention was required to try and effect change. Practice in this area denotes a high standard of ownership and shared accountabilities for the protection of unborn and new born babies.

- 1.12 Case transfers from midwives to health visitors were usually made by giving a print-out transfer summary to the woman to share with their health visitor. In cases where this was not deemed appropriate- where vulnerabilities were identified, or there was some doubt that the mother would pass on such information; handover was made via paediatric liaison or directly between the midwife and health visitor. Work was in progress to continuously improve performance in antenatal visit coverage by health visitors and enhance handover arrangements.
- 1.13 Midwives and health visitors had a good focus on perinatal mental health issues, with effective use of screening tools to promote recognition and support for women prior to and following the birth of their babies. The recent development of the *'Time for Me'* an art therapy group commissioned by the CCG and Public Health for women with post-natal depression, denoted a creative and empowering approach to meeting maternal mental health needs. The introduction of joint parent craft classes between midwives and health visitors was a positive new development in strengthening parental confidence and capacity. Health visitors made referrals for parents to psychological services (IAPT), however, they were not advised of the outcome of these or whether parents had engaged. This was an area to strengthen to promote good shared recognition of other partner agency's work. (**Recommendation 1.1**)
- 1.14 *'Kooth,'* an on-line bookable counselling service for young people aged 11 to 18 years was commissioned by the CCG to provide individual advice and support in a safe, confidential and non-stigmatising way. This counselling service is available to any child regardless of status or eligibility for CAMHS. Case studies indicated effective engagement with and follow up support for young people who felt hopeless about their family situation, with good usage of the service outside office hours. Feedback from young people indicated that this was a valued source of support in helping them deal with a range of issues including loss, bullying, anxiety or feeling scared. In addition, public health has established a *'Happy, Ok, Sad'* website that helps young people be more aware of a range of emotional and mental health issues and signposts them onto local services which may be able to assist them. These on-line developments positively recognise young peoples' preferences in relation to accessing information and help at a time and pace that they feel is right for them.
- 1.15 The school health service was working to strengthen its focus on the emotional health and wellbeing of children and young people. A pilot programme had been commissioned by public health and supported by the CCG during 2014-15 to help build the school nurse team's expertise in this area. The CAMHS service provided additional training in the use of brief interventions and supervision for frontline staff engaged in running the drop-ins. Work in progress at the time of our visit included actions to evidence the impact of early intervention and enable better tracking of outcomes for young people accessing the drop-in service.

- 1.16 School nurses were commissioned to undertake a range of duties, for example the National Child Measurement Programme (NCMP), immunisations and Personal and Social Health Education (PSHE) in schools. The service offer also included school health entry questionnaires at reception age. Plans to extend this to support the transition of children from primary to secondary schools, were in development. A strengthened focus on the safety and wellbeing of young people at this transition point should help to address young people's concerns about anxiety or bullying which were a feature in a number of referrals to specialist CAMHS, which following assessment, did not meet the team's threshold for response.
- 1.17 We found school health capacity to support the early help offer was on occasion constrained by high and competing demands given their increasing public health priorities combined with their ongoing involvement in time-intensive statutory work. No single assessment tool was being used by school health staff to identify the needs of children and young people when they presented at school drop-ins unless they had an identified self-harm need. *These issues have been drawn to the attention of Public Health Warrington as the commissioner of the school health service.*
- 1.18 Good attention was paid to promoting young peoples' awareness of sexual health services. Positive practice included the targeting of information via secondary schools which detailed all local health services where young people could access advice and support. The integrated sexual health service had been working closely with the school health team to share skills and strengthen their 'drop-in' offer. An enhanced drop-in service had been recently been offered to schools to provide advice and support with issues such as safe relationships, pregnancy testing, chlamydia and gonorrhoea screening, c-card or emergency hormonal contraception advice. The school health offer was agreed at the school health delivery plan meeting at the beginning of each academic year.
- 1.19 Young people had access to a broad range of specialist sexual health services which were flexible in their hours of opening; combining drop-in clinics as well as appointments. Sexual health services were delivered from bases which were easily accessible, including having clinics at locations such as young people's supported accommodation.
- 1.20 The integrated sexual health service made effective use of local intelligence in targeting individuals, groups and communities where risks of teenage pregnancy or sexually transmitted diseases were relatively high. The service had also forged a number of creative partnerships with other local professionals to strengthen the early help offer. Sexual health practitioners were able to identify whether a young people attending the service had previously accessed the service in another area given the recent introduction of an electronic case management system. This helped strengthen vigilance of risks to young people vulnerable to sexual exploitation (CSE).

- 1.21 Risk assessments in use in sexual health services were holistic and included commentary about the young person's risk of CSE and other vulnerabilities. A separate risk assessment for young people under the age of 16 year assessed Fraser competency and required practitioners to routinely complete details about the young person's capacity to consent. Practitioners were expected to review any previous records to inform the current assessment of risk. Practitioners also routinely asked adult attendees about Female Genital Mutilation (FGM).
- 1.22 Work had taken place with local GP practices to raise their awareness about the role they could play in the provision of early help. One of the GP practices we visited held a weekly whole staff meeting that included safeguarding as an agenda item. Areas of concern discussed about an individual child or family were recorded in a separate safeguarding file. This practice also had a robust 'Did not Attend' (DNA) policy for all children under the age of 18 years. Each month a report was generated that identified all non-attenders. Information of concern was shared with other agencies as appropriate.
- 1.23 The other GP practice we visited had re-introduced quarterly meetings between the lead GP and link health visitor to strengthen information sharing about vulnerable families. The practice nurses' monthly meeting reviewed and discussed vulnerable families. Health visitors and community midwives were also invited to contribute to these meetings, but did not regularly attend.

2 Children in need

- 2.1 The Local Children Safeguarding Board (LSCB) had a clear priority to strengthen the leadership and contribution of midwives, health visitors and school health services in Child in Need arrangements. We found that practice continued to be an area for improvement as levels of activity had not increased in line with expected progress, and required a stronger shared direction and impetus by local health partners. For example in midwifery supervision notes, we saw a case where a mother in her third pregnancy was low in mood and was at risk of being made homeless. The midwife had asked the health visitor to undertake a joint visit and was working to implement a common assessment framework (CAF) having recognised the family's need for longer term support. However, this was not achieved, and was noted as a missed opportunity for joint working. **(Recommendation 2.1)** *This has also been drawn to the attention of Public Health Warrington as the commissioner of health visiting services.*

2.2 Warrington LSCB had made positive progress in strengthening local systems for the identification and management of children and young people at risk of neglect. The LSCB partnership had positively driven forward a comprehensive training programme to encourage all staff to use the Graded Care and Signs of Safety assessment tools. This aimed to support a stronger individual and collective agency response to harm reduction. However, the use of such tools was not sufficiently embedded in the work of frontline health professionals. This was an area for immediate action. **(Recommendation 2.1)** *This has also been drawn to the attention of Public Health Warrington as the commissioner of the health visiting, sexual health, school health and adult substance misuse services.*

2.3 Warrington Hospital ED had good systems for the identification and management of domestic abuse and ensured all incidences where there were children in the family were referred to the MASH. We found examples of effective joint working between ED lead clinicians, children's social care and the police with young people in a distressed state.

Case Example: *A 15 year child was brought into ED by the police. She reported that her Mum and step father had physically abused her and threatened her with a knife. She had threatened her step-father with a knife also. The ED doctor promptly contacted children's social care as the young person did not require admission and they were concerned about her safety when she was discharged. The young person was refusing to return home and suggested another relative may be able to care for them. However, the police were aware of offences within this household that made this an unsuitable option.*

The police and ED doctor listened sensitively to the young person and eventually a further safe option was identified with the police taking her to the home of another relative who lived out of the area. Persistent work by the ED staff and police meant the young person did not need to be admitted to hospital or end up detained in a police cell.

2.4 Women who reported domestic abuse were encouraged to seek help from an independent domestic abuse adviser (IDVA) who visited the hospital 2 days a week. The cases we tracked demonstrated midwives worked hard to secure the engagement of women and robustly followed up any failure to attend appointments. Information was gathered about the woman's partner and/or father of the baby as routine good practice. Multi agency risk assessment conferences (MARAC) worked well with good feedback to relevant health professionals of the outcome of discussions and of actions being taken to safeguard children and young people at risk of domestic abuse.

- 2.5 Young women under 19 years who met the criteria for the Family Nurse Partnership (FNP) were referred to this service which was available across the borough council area. Family nurses reported effective joint working with the teenage pregnancy midwife and children's social care where, without intervention, outcomes for new babies and their families were likely to be poor. This was clearly evidenced in the cases seen and demonstrated the benefits of this targeted, intensive support programme in meeting the needs of Warrington's young parents who themselves had experienced a poor start in life.

Case Example: *The teenage pregnancy midwife notified the family nurse about a young pregnant woman who disclosed a history of self-harm and depression. She had an unhappy childhood and been bullied all the way through school. She was living at home with her father in poor housing. Her partner also had a troubled childhood. He had been on a child protection plan, used drugs and also reported mental health issues. Risks were carefully tracked throughout the pregnancy with good information sharing and joint working with other relevant agencies. Both parents were supported to talk openly about issues of control and dependence within their relationship and how they needed to prepare to be good parents.*

Following the birth, concerns were raised by the ward midwife about parental engagement and stimulation; with further observations and guidance given to parents prior to the baby being discharged from hospital. A parenting assessment was undertaken by children's social care which evidenced strengthening of parenting capacity, with good attachment and care routines established. Post-natal mental health screening was undertaken and no risks were identified. The mother did not self-harm throughout her pregnancy. Although still requiring anti-depressant medication, she was more emotionally resilient, coped well with caring for her baby on her own, and had been able to secure a part time job. The family were helped to move to more suitable accommodation, and to access the local Children's Centre and Homestart programme. The father benefited from Pathways to Recovery for his drug misuse.

This case, which could easily have become a child protection issue, was being effectively managed at the child in need level.

- 2.6 We saw limited evidence of direct liaison between midwives, health visitors, school nurses and adult mental health or substance misuse professionals on individual cases outside of the joint liaison meeting or formal child protection meetings. Professionals working with parents acknowledged this was an area to strengthen, recognising risks to children within the household may fluctuate and the need for all to remain vigilant to early indicators of relapse or increases in risk affecting the whole family. Close contact by all professionals in these circumstances is critical to further enhance local systems for intervention prior to or following children being removed from a child protection plan. **(Recommendation 5.1)** *This has also been drawn to the attention of Public Health Warrington as the commissioner of health visiting and adult substance misuse services.*
- 2.7 The *Think Family* approach was well-established in work undertaken by the Pathways to Recovery service. The substance misuse assessment tool in use was comprehensive. It promoted robust safeguarding practice including asking questions about child sexual exploitation (CSE) and Female Genital Mutilation (FGM). All new service users were followed up to check whether they had children in their care or living elsewhere, and whether they were subject to common assessment framework (CAF) or had been identified as children in need or were on a child protection plan.
- 2.8 Home visits were prioritised where children were known to be present or if the client themselves had been identified as a vulnerable adult. Where safe storage boxes had been issued, routine and periodic checks were made to ensure children were appropriately safeguarded from harm. Home visits by the service's attrition worker were also undertaken if a client did not attend on two occasions. These approaches ensured an ongoing and effective focus on the safety and wellbeing of children.
- 2.9 The work undertaken by the Pathways to Recovery Hidden Harm worker to engage with prisoners with drug and/or alcohol issues in two local prisons prior to their release, was innovative. We saw effective use being made of the *'My Lifestyle and My Child'* tool to highlight the impact of parental substance misuse on children. This supported improved awareness of children's needs and sensitively enabled fathers to explore what good parenting looked like.

Good Practice Example: *The 'My Lifestyle and My Child' tool covered a wide range of areas – housing, health, diet, finances, substance use, psychological health and relationships. The parent was helped to openly discuss their needs and assigned a risk score from 1-10 (least to most problematic) in relation to the impact on their children. This was further reviewed as their release date drew nearer.*

Joint work set out what needed to change to effectively meet their parenting responsibilities; with clear analysis of risk and ownership for the negative impact of substance misuse on family life. It encouraged fathers to identify and commit to what they needed to do to strengthen their parenting capacity and of actions required to protect their children.

This work promoted new and creative ways of engaging with prisoners with a history of drug and alcohol issues abuse. Relationship building activities included recording the father's voice talking to his child/children to help each other's transition to the return of the parent to the family home.

- 2.10 In contrast, the stage of development of *Think Family* approaches within adult mental health services was under-developed. Although the assessment documentation in use in adult mental health services required routine enquiry about children and where they were living; some case work seen did not evidence sufficient awareness of risks to babies and children. In one case, where the GP had referred an expectant mother with a history of mental health issues, the adult mental health practitioner's assessment of safeguarding risks did not explore the risks to her unborn baby despite being advised by the woman of her previous admissions to psychiatric hospital and misuse of substances. (**Recommendation 9.3**)
- 2.11 Our review of child and adult mental health cases also indicated the need to strengthen joint working and information- sharing with GP's where both parents and children had mental health issues, or where children/young people were caring for their parents. In one case we tracked, the GP had not been given sufficient information about known risks. They had not been involved in multi-agency discussions about a young person who had recurrent admissions to hospital for self-harm, whose parent was also being treated by them for mental health issues. The outcome of this was that risk to the young person was not effectively managed and information about known areas of concern was not adequately joined up. (**Recommendation 7.1**)
- 2.12 Most sexual health case records had a clear focus on CSE, with good recognition of professional accountabilities for identifying and reporting risk as outlined in this case we sampled

Case Example: *A 16 year old young man attended the sexual health clinic as he had some concerns that he might have contracted a sexually transmitted infection (STI). He said he was unsure about his sexuality and in order to explore this, he had accessed an internet site where he made contact with a man for sex. He subsequently met a man in his 50's and sexual activity took place. The young man had come prepared and used a condom.*

He agreed for this information to be shared with the police including his partial recall of the car number plate used by the older man. This information subsequently informed discussion at the Missing Children, Sexual Exploitation and Trafficked (MCETO) meeting. Police welcomed this intelligence on an adult male coming into the area seeking sexual contact with young people.

- 2.13 Children 13 years and younger presenting at sexual health clinics were routinely referred to children's social care in line with statutory requirements; and also to paediatricians if there was a clinical need. However, essential details of the sexual partners of young people were not consistently captured on child health records seen. Records could be strengthened through the routine inclusion of a description of the young person's demeanour and presentation, and consistently recording the young person's voice within the consultation. We found limited usage of CSE assessment tools by school nurses as part of their ongoing dialogue with young people. *This has been brought to the attention of Public Health Warrington as the commissioner of school and sexual health services.*
- 2.14 The sexual health service was an active member of the Missing Children, Sexual Exploitation and Trafficked (MCSETO) forum. The service was notified of young people to be discussed at meetings and shared relevant information about young people who had previously accessed sexual health services. These young people were then flagged on the patient record system as being known to be at risk of CSE, with guidance for frontline staff about what actions to take, and who should be informed. In addition, the manager created an interim code on the patient record system for any young person discussed at MCSETO who had not yet attended a clinic. This ensured they were immediately identified as 'at risk'. This approach evidenced robust safeguarding practice contributing to the continuous strengthening of the local multi-agency response to CSE.

- 2.15 Health and social care staff were working to proactively reach young people with learning disabilities or mental health needs who were at risk of grooming or sexual exploitation, or who may be engaged in sexually harmful behaviour, but had not yet attended a sexual health service. Young people with learning disabilities who continued to be at risk of sexual exploitation on reaching 18 years were appropriately flagged as vulnerable adults.
- 2.16 The referral pathway to CAMHS for children and young people who self-harmed and presented at Warrington hospital was well-embedded and complied with NICE guidance. CAMHS provided timely assessment of young people attending ED or who were admitted to the paediatric ward following an incidence of self-harm. The CAMHS team provided daily support to paediatric ward staff for young people whilst they were awaiting discharge or who required admission to a specialist mental health service.
- 2.17 CAMHS professionals wrote up their assessments in the paediatric ward nursing or medical notes, but did not share a copy of their care plan. Ward staff said they would have welcomed this and also further training in helping them promote a more holistic response to young people with complex needs. Ward staff used a generic risk assessment to promote environmental safety. They recognised the need to strengthen and tailor their approach to promote early recognition of risk for young people with high or complex mental health needs, whilst also ensuring the diverse needs of all children and young people and visitors on the ward were effectively managed.
(Recommendation 5.2)
- 2.18 Consent was sensitively managed and recorded on young peoples' CAMHS case records seen. This area had been previously highlighted for improvement in CQC's regulatory inspection of the 5 Boroughs Trust in August 2015. Therapeutic work was underpinned by sensitive and persistent approaches to engage the young person and their family.
- 2.19 Case recording, risk management and care planning was clear and well managed on CAMHS records seen, with appropriate escalation of concerns about young people who were not receiving the level of parental care required to support their recovery. However, further work was required to effectively involve and empower young people through the expansion of child/young person-centred approaches within care documentation. The potential of this approach was warmly welcomed by staff we spoke to.
(Recommendation 9.2)
- 2.20 The 'Skin Camouflage' service promoted by the 5 Boroughs Partnership Trust enabled a sensitive approach to be taken in supporting young people whose self-harming behaviour had led to permanent scarring and wounds. Young people were taught how to use special medical skin camouflage to cover their self-harm scars. This had led to improvements in their self-confidence and was valued by young people in aiding their recovery.

- 2.21 Whilst the CAMHS service generally met the required timescales for young people requiring emergency or urgent help; those designated as ‘routine’ referrals faced increased delays in access to services. Timescales from assessment to treatment were increasing. It was of concern to us to hear one referrer say that they had stopped making referrals to CAMHS as a consequence of delays in access to therapy. The work undertaken by St Joseph’s Counselling Service, a voluntary sector provider, was rated highly; but this service also had a long waiting list at the time of our visit. The CAMHS specialist service also continued to receive a number of referrals that impacted on the capacity of the CAMHS assessment and referral team. Cases reviewed demonstrated the need to strengthen the capacity and responsiveness of lower level emotional health and wellbeing services. **(Recommendation 1.2 and 9.1)**
- 2.22 The health visitor case records seen provided a good overview of the health and development of young children, and demonstrated vigilance to harm. Some school health records seen however only provided a partial picture of the young person’s needs and home circumstances. In one case where the parent of a young person had severe and enduring mental health needs; school health records denoted only a narrow focus on their emotional health and wellbeing. Further work was required to promote holistic assessments and care plans in relation to school health activity with children in need. *This has been drawn to the attention of Public Health Warrington as the commissioner of school health services.*
- 2.23 The transition pathway from child to adult services was working well for young people with clearly identified mental health needs or learning disabilities. Gaps in provision remained in Warrington, (as we see in most other areas), in the availability of ongoing support for other vulnerable young people, particularly young people with autism or attention deficit hyper-activity disorder (ADHD).
- 2.24 The audit and development work undertaken by the named GP with practice staff had been effective in increasing awareness and vigilance to children and families in vulnerable circumstances. In one practice, concerns identified by a health care assistant about an unaccompanied young girl during school time, resulted in further enquiries being made and escalation to the designated nurse and children’s social care. This incident led to greater vigilance by practice staff about the potential risks to young people who present alone. The practice was using learning from this incident to develop a ‘*Minors presenting Alone*’ policy to continuously strengthen practice in this area.

3 Child protection

- 3.1 Warrington children on child protection plans were not flagged on WHHFT's electronic case management system. In contrast, an alert system was in place at the hospital for children on child protection plans living in Halton Borough. Warrington Council was supportive of this action but there had been a delay in implementation. The lack of progress in this area had been identified on the Trust's risk register. The Trust needed to take immediate action to ensure a robust system was in place to support clear and timely recognition of Warrington children who were on child protection plans or who were looked after. This included having appropriate systems for keeping such data up to date. **(Recommendation 6.2)**
- 3.2 We saw evidence in two cases at ED of a lack of professional curiosity about the circumstances surrounding incidents that precipitated the child or young person's attendance. In both cases, the need to probe further into how injury or serious self-harm had occurred should have been obvious to the practitioner, not least, because both children were known to be at risk of harm.
- 3.3 The '*Did Not Wait*' Protocol in the ED was not sufficiently robust to ensure a consistent and appropriate response when children were removed by those who brought them prior to triage or treatment, or when pregnant women left before being seen. Whilst the protocol provided guidance on missing clinical interventions; it was less clear in relation to professionals' safeguarding responsibilities. Situations were dealt with on a case by case basis, and we saw an example where there was no evidence of any follow-up action taken by ED staff when a suicidal pregnant woman was brought by ambulance but did not stay to be seen. **(Recommendation 8.3)**
- 3.4 The MASH partnership was working to promote a systematic joint approach to the management of child protection, including securing the active involvement of relevant agencies in strategy discussions. It was recognised that the engagement of health professionals in the MASH work required strengthening so that they were routinely reviewing all health intelligence in advance of strategy meetings. Development work in progress at the time of our visit also included analysis of the level and quality of referrals made by health professionals. The LSCB had identified low referral rates from some professionals and was seeking further assurance that all agencies were appropriately using the joint agency assessment and referral form. Named safeguarding professionals in all provider trusts maintained a database of such referrals and were working to strengthen arrangements in this area.

- 3.5 Good practice was evidenced in the work of ED staff in raising alerts about children and young people. ED practitioners completed pre-CAFS and made referrals to children's social care using the joint agency referral form. They routinely consulted with children's social care by telephone when concerns were identified and followed this up in writing through electronic or hard copy referrals. However, ED staff reported that they had not received notifications from the MASH of acceptance of their referral or feedback on whether cases had been followed up. MASH health professionals together with children's social care needed to ensure the outcomes of such referrals were routinely communicated to enable stronger vigilance should the child/young person or their parent re-present. **(Recommendation 4.1)**
- 3.6 Midwives routinely attended pre-birth safeguarding meetings, child in need, core groups and child protection conferences for the duration of their contact with parents and their baby. We saw evidence of their active recording of discussions, decisions and actions arising from multi-agency meetings on a standardised proforma. The process could be further strengthened through inclusion of the names and roles of other attendees. This record was placed in the women's health case file ahead of receipt of the formal minutes of the meeting. This approach ensured the wider midwifery team was kept fully aware and held the most up-to-date information and plan. Cases we reviewed set out clear directions to support maternity ward staff in keeping mothers and their babies safe.
- 3.7 Arrangements for the protection of unborn and new born babies were strong. The joint clinic for parents misusing substances supported good information-sharing and management of risk between the drugs and alcohol specialist midwife and Pathways to Recovery team members. A yellow patient alert record had been recently introduced by the WHHFT named nurse that supported a high level of vigilance about current concerns and potential future risks. Where vulnerabilities were identified by midwives, purple cause for concern sheets were routinely completed and put into case notes which immediately alerted the wider midwifery team and detailed safeguarding actions to take.
- 3.8 We saw a case where two midwives had escalated concerns to children's social care about a woman's capacity to parent effectively due to mental health issues. She had failed to attend ante natal appointments and although the midwife had put in place a comprehensive plan to support the delivery of a CAF, the mother had refused to engage. A decision was quickly made to hold an initial child protection conference. The outcome was that the unborn baby was placed on a child protection plan. Midwives felt confident about raising concerns and played an active role in promoting timely responses across the partnership to safeguard unborn and new born babies.

- 3.9 Discharge planning meetings were well-established and were chaired either by the midwife or children's social care. Details of these meetings were recorded on patient notes. Invitations to health visitors were sent via paediatric liaison to ensure attendance was maximised and to support effective co-management until the care of the baby was formally handed over.
- 3.10 The LSCB together with named safeguarding professionals tracked attendance and submission of reports by all health professionals to child protection conferences. Attendance by child and adult health professionals overall was good, with effective use made of the standard reporting template on all cases seen.
- 3.11 GP engagement remained an area for further development. Positive progress was seen in relation to their attendance at child protection conferences against agreed criteria. Their contribution to conferences could be further strengthened through the use of technology. The coverage and quality of GP reports was improving. GP practices we visited had appropriate systems for tracking the outcomes of meetings and scheduling reports for review conferences. The new named nurse for primary care provided the opportunity to trial new approaches to continuously strengthen primary care involvement.
- 3.12 Health visitors and family nurses routinely used chronologies to support their analysis and understanding of children's experiences as they moved in and out of the child protection system. The use and maintenance of chronologies by school health was more variable.
- 3.13 Safeguarding work undertaken by health visitors was of a high standard; with regular review of children's health and development combined with strong oversight of risks of harm to vulnerable children. Records were well-documented in relation to their approach with individual families and of their impact in enabling change; with good analysis of areas where parents were not consistently providing the level of safe and nurturing care required. Efforts were made to meet with parents/young people to discuss their reports in advance of the conference.
- 3.14 School nurses conference reports seen were comprehensive and contained relevant information about children's health and development. We were informed that school health staff routinely undertook a health assessment of all children and young people who were subject to a child protection plan. However, in two cases we reviewed, we saw no evidence of this. Work in progress to streamline their attendance at conferences and ensure participation by the most relevant community health professional should assist in identifying the areas where school nurses can have most impact.

- 3.15 Adult mental health managers had a clear expectation that team members would attend core groups and child protection conferences, and that they would submit written reports. We saw case examples of this. Managers were also clear that where a child was placed on a child protection plan, the parent's care plan would be reviewed with them to ensure it reflected and actively supported actions to strengthen parenting capacity. We did not see this in practice in cases we reviewed. **(Recommendation 9.3)**
- 3.16 The two GP practices we visited had appropriate flagging systems for identifying children on child protection plans. GP practices had a good understanding of the children in the practice subject to a child protection plan or child in need arrangements. Links had been made with the local authority to improve their identification of the needs of children in care who were registered with the practice. In one case we tracked, the receptionist had raised concerns with the GP about poor parental interaction with a baby who was on a child protection plan. The GP practice had recognised the important role receptionists play in identifying potential safeguarding issues, and had provided a higher level of training for this cohort of staff to support effective recognition and reporting of risk.
- 3.17 A significant programme of work had been undertaken under the leadership of NHS England, designated and named safeguarding professionals to strengthen the focus on and awareness of professional accountabilities for reporting female genital mutilation (FGM). Women presenting with gynaecological problems or recurrent urinary tract infections were now being routinely asked about FGM. We found frontline health professionals were alert to FGM and had a good understanding of their roles and accountabilities as evidenced in this case.

Case Example: *A woman presented to the midwifery service having no fixed abode. She shared a history of significant domestic violence that had been reported to the police, children's social care and the independent domestic violence advisor (IDVA).*

The woman disclosed that she had been a victim of FGM. The midwife followed the Trust's FGM pathway including alerting the consultant and the named safeguarding nurse/midwife. The woman's GP was informed as was paediatric liaison to ensure relevant others were aware of potential risks to the mother and her unborn baby. The case was also discussed a number of times at the joint liaison meeting given the wider challenges this woman experienced. The baby was safely delivered but both mother and baby required further medical care prior to their discharge.

- 3.18 Training and awareness raising sessions had been delivered to support health professionals' understanding and accountabilities for the delivery of the PREVENT programme. This was a feature of safeguarding practice in one case seen. The risk of radicalisation in relation to young people within the household was managed effectively.
- 3.19 The LSCB was working to more effectively engage young people in its work. Information leaflets about safeguarding have been developed for children and young people, tailored to the levels of understanding of children and young people. The Designated Nurse together with the engagement team from the CCG worked closely with members of the Children in Care Council to provide information to help young people understand what child protection meant for them. This was part of the wider LSCB activities to secure stronger engagement and feedback from young people in developing its work.
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4 Looked after children

- 4.1 The Children in Care (CiC) nurses were well-engaged with local authority children's social care and other agencies, including supported housing providers, in shared activity to promote the health and wellbeing of children who were looked after. Although the team's capacity had been strengthened since our last inspection, the team of two specialist nurses and a designated doctor/medical adviser were struggling to keep pace with the increased numbers of children who were looked after. A business case had been produced that outlined current capacity challenges experienced by the team. At the time of our visit, the outcome of this was not known.
(Recommendation 4.6)
- 4.2 The team administrator held a detailed spreadsheet of all children who required a statutory health assessment. Information-sharing was good, and changes in children's legal status or home moves were regularly updated. However, maintenance of this was very time-intensive. Planned work between the local authority, CCG and provider trust to promote a more efficient system had been put on hold.
- 4.3 Children in Care nurses provided training, ongoing advice and support as required, to local foster carers and children's home staff. The designated doctor provided training for fostering panel members on common adult health problems which could potentially impact on or be a barrier to parenting. At the time of our visit, they were in the process of auditing current procedures for children at risk of blood-borne viruses.

- 4.4 The work undertaken by CiC nurses was responsive to children and their carers' wishes about the preferred location for their annual health assessment. However, many review health assessments undertaken by school health staff still took place at school. This may not always be the preference of young people. Young peoples' consent was appropriately recorded on cases seen. Copies of health assessments were routinely sent to the GP and carers. Copies of the health action plans were not sent directly to young people. This was identified as an area of practice to strengthen. Young people were encouraged to '*Rate their Health Assessment*' and so provide feedback to the CCG on their experience. However, response rates have to date been low. **(Recommendation 4.4)**
- 4.5 The local area's performance in ensuring timely initial and review health assessments of children in care had continued to improve, and was excellent; with 99% compliance at the end of March 2016 compared to 92% the previous year. The number of children and young people receiving health checks and immunisations was also very good compared to other areas. This was a significant achievement given the current pressures on the local health visiting and school nursing workforce. Since 1st April 2016, a drugs and alcohol screening tool was being used to promote early identification of risks of harm to young people 13 years and older. Action was also being taken to strengthen identification of risk and support for young people in relation to sexual health and smoking cessation.
- 4.6 All initial health assessments (IHAs) were carried out by a community paediatrician in line with statutory guidance. Cases seen reflected a thorough approach in detailing medical checks and parental health history. Their focus on the emotional health needs of children and young people was weaker, however, and was an area that required further development. One unaccompanied asylum seeking young person's case we reviewed had gaps in relation to their ethnicity, religious and cultural needs. Although the assessment recognised both birth parents were deceased, the health plan did not appropriately consider further support required to meet the young person's emotional and mental health needs. Further direction and review of practice by paediatricians at the point of the initial assessment would help to strengthen awareness and embed good practice in follow up work to holistically address the health needs of unaccompanied asylum-seeking children. **(Recommendation 4.2)**

- 4.7 Cases reviewed by the CiC nurse demonstrated excellent multi-agency working and identification of emotional health needs and safety risks with improved outcomes for the child. Work undertaken by the CiC nurses was creative and persistent in reaching young people who were reluctant to engage. The review health assessments were comprehensive and outcome-focused. The voice of the child was clear and there was a good assessment of their emotional health needs. Similarly, we saw some well-considered, holistic, young person-centred assessments undertaken by health visitors and school nurses. However in some cases seen, key detail in review health assessments in relation to the child's faith, ethnicity, cultural needs and allergies was not consistently recorded. This had been identified as an area for improvement through the quality assurance work undertaken by CiC nurses. **(Recommendation 4.2)**
- 4.8 Some health plans were not sufficiently outcome focused or provided specific information about accountabilities for action, including timescales for following up areas of risk. This related more to cases seen where Warrington's children were placed out of area. In such cases, the CiC nurses provided challenge and followed up issues with relevant professionals until they were satisfied the required standards were achieved. In one case seen the RHA mirrored the previous year's record and had been completed over the telephone. The CiC nurse challenged the quality of the work and required the assessment to be re-done face to face.
- 4.9 Given heavy reliance on the use of paper records, CiC nurses were only able to take account of the previous review health assessment paperwork and not the child's full health record. This increased the risk of oversight being episodic, and was not a true reflection of the child's experience, or of progress being made in achieving the required outcomes **(Recommendation 4.3)**
- 4.10 Not all GP practices were sufficiently aware of or involved in the assessment and health plans for this vulnerable group of children. This was being addressed by the named GP and designated nurse for safeguarding. Training recently provided included an overview of their roles and responsibilities for looked after children with better levels of participation and engagement in identifying and tracking health concerns.
- 4.11 A CAMHS practitioner was located within the Council's permanence team and provided good oversight of young people with emotional or mental health needs. They ensured children with more complex needs were referred to the specialist CAMHS team for an urgent response. CAMHS professionals provided a comprehensive package of training and advice for foster care and residential care staff which was evaluated positively. Cases tracked evidenced good involvement by CAMHS in case consultation with other professionals, including in areas such as exploring concerns about CSE risks or previous trauma young people were exposed to.

Case Example: *A 16 year old young woman moved to England with her mother and younger siblings. The children were emotionally and physically abused by their mother and taken into care.*

She was referred to CAMHS due to fluctuations in her mood and previous self-harming behaviour. She disclosed she struggled with self-esteem and confidence having being constantly told by her mother that she was 'worthless'. She was fearful that she would be returned to her mother, deported, or end up as a care leaver without any continuing support or parental guidance.

Since being placed in foster care she feels safe, and her self-harming behaviour has markedly reduced. She has been referred to IAPT (Improving Access to Psychological Therapy) to help address the impact of her earlier traumatic childhood experiences. This service will continue to be available to her as she moves into adulthood.

- 4.12 CiC nurses were kept well- informed about children who attended hospital or who required medical intervention. From cases seen, however, there was limited sharing of work undertaken by CAMHS practitioners with the other frontline health professionals- such as health visitors or school nurses undertaking the review health assessments. Strengths and difficulties questionnaires (SDQs) were routinely used to identify risks to the emotional development or wellbeing of children, and CiC nurses were advised about children's individual scores. However, this information in isolation did not support holistic assessments or enable tracking of progress in relation to previous health plan actions. **(Recommendation 4.3)**
- 4.13 Health care support for care leavers was under-developed and was a priority area for improvement identified in our previous inspection. The timescale for implementing child health histories/passports had drifted. Current arrangements did not meet the expected standards set out in statutory guidance. The CiC nurses were working closely with the young person's personal advisers and aimed to strengthen their links with Children in Care Council members in co-producing a suitable person-centred format for capturing their health history and needs. **(Recommendation 4.5)**

Management

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

5.1 Leadership and management

- 5.1.1 The NHS England area team provided strong leadership and support to the local health economy. It was a key player in enabling stronger partnership working, standardisation of pathways, robust governance and sharing of learning within Warrington and the wider region.
- 5.1.2 Safeguarding strategic priorities were well-aligned to the needs of the local community, with a shared vision and ambition to achieve continuous improvement in outcomes for local children and young people. Leadership and commissioning for safeguarding children and families across a range of health, social care and public protection forums were strong in Warrington. The contribution of health professionals to partnership working was appropriately supportive and challenging in promoting the delivery of shared agendas.
- 5.1.3 The CCG had reviewed its professional roles and accountabilities for safeguarding children in line with the *Safeguarding Vulnerable Groups in the NHS- Accountability and Assurance Framework (2015)*. Local management arrangements and the deployment of designated and named professionals had been recently reviewed and met framework requirements. The designated nurse employed by the CCG provided good strategic leadership in safeguarding and children in care development work. Their capacity had been recently enhanced through the appointment of a new post of named nurse in primary care.
- 5.1.4 The CCG in conjunction with its LSCB partners had recognised strategic weaknesses within its health sub-group, and was working to transform its role and contribution. The CCG had also recognised the need to drive forward a stronger shared direction and pace in managing change to secure better outcomes for local children particularly in the areas of early intervention and meeting the needs of adolescents. Planned work in these areas should help to address the areas of drift/slow implementation of improvement activity at an individual provider and collective agency basis referred to in the earlier sections of this report.

- 5.1.5 The named GP had established excellent links with local practices. Together with the designated nurse and the recently appointed named nurse for primary care important additional capacity was created to effectively link the focus of primary care into a wider range of partnership and locality based activity. Both GP practices we visited had lead GPs for safeguarding with good engagement by practice managers in the management of safeguarding activity.
- 5.1.6 Whilst good attention was paid by the Council, LSCB, CCG and provider managers to meeting their statutory responsibilities for children in care; local intelligence about the impact of help in addressing child health inequalities and evidencing improved outcomes for this cohort of young people was relatively under-developed. The leadership provided by the designated doctor and specialist nurses for children in care promoted a shared understanding of professional standards and accountabilities for health assessments. However, further review of the capacity of the CiC team was required to help promote a consistently high standard of child and young person- centred work, including effective support for and recognition of the needs of care leavers. **(Recommendation 4.6)**
- 5.1.7 The pan Cheshire strategy for child sexual exploitation and missing children referred to the development of CSE champions. This approach was reinforced in the NHS contract for local health providers. However, whilst most health staff we spoke to had received CSE training, with appropriate use of CSE tools in some areas; overall we found joined up leadership and championing of this agenda at the frontline in health was not yet well-embedded. **(Recommendation 2.2)**
- 5.1.8 Recent changes within the 5 Boroughs Partnership and Bridgewater Community HealthCare NHS Trusts to align their service delivery to the Council/CCG boundary should further strengthen their focus on the needs of Warrington's specific communities. The restructuring aimed to provide better opportunities for building relationships and promotion of integrated working. It should also help address previous challenges in monitoring local trends and outcomes.
- 5.1.9 We found examples of innovative service design and practice that was making best use of the expertise and resources of public, community and voluntary sectors. We were particularly impressed by the creative commissioning and cross-generational partnership work in progress being led by Pathways to Recovery in conjunction with the NSPCC and Footsteps, a third sector organisation. This aimed to ensure the children of substance misusing parents were effectively protected including shared work with grandparents to help build the capacity of the whole family. The sexual health service was proactive in building partnerships with other agencies and professionals to target areas of risk and strengthen the early help offer. This approach was pragmatic and carefully considered to maximise the impact of the service within the context of reducing public health resources.

- 5.1.10 Specialist perinatal mental health services were not fully in place as set out in national guidance. Women with perinatal mental health needs were referred to the adult mental health recovery team and overseen by a psychiatrist with an interest in perinatal mental health. Further work was required to strengthen the offer to pregnant women and ensure effective partnership working between primary, community health, specialist mental health and secondary care providers. **(Recommendation 1.1)**
- 5.1.11 We found strong team leadership and morale underpinning the work of health visitors in the area, with full implementation of the Healthy Child Programme. There was recognition of the need to continuously improve local performance in coverage of ante-natal visits. Health visitor capacity to support high risk children and their families was well targeted and managed. Arrangements for the recruitment and development of newly qualified health visitors were well-developed. Although still relatively new, the Family Nurse Partnership (FNP) was developing well, with good evidence from cases seen of its effectiveness in preventing escalation of risk and in safeguarding children on child protection plans.
- 5.1.12 School nursing capacity was over-stretched, with one school health nurse we spoke to holding unsafe levels of complex work. We also found duplication of activity in the work undertaken by school nurses. There was potential to streamline processes more including responding to requests for information or meetings attendance to reduce the administration burden on this team. *This has been brought to the attention of Public Health Warrington as the commissioner of school health services.*
- 5.1.13 In our previous inspection we highlighted the need to ensure emotional and mental health services were effectively co-ordinated, had sufficient capacity, and were secured by clear pathways to CAMHS specialist provision. This remained an area for improvement. The capacity and skill mix of the Warrington CAMHS (tier 3) team was not fully established. For example one of the psychiatrists we met was being inappropriately pulled into time consuming case co-ordination work given vacancies in key posts which directly impacted on their clinical capacity. Further work was required across the range of commissioning and provider partnerships to ensure a comprehensive and well-integrated approach to addressing different levels and complexity of emotional and mental health need. **(Recommendation 1.2)**
- 5.1.14 Full paediatric nursing cover in Warrington Hospital children's ED was a real achievement. WHHFT had recently reviewed the capacity of its midwifery workforce against 'Birthrate Plus' the nationally recognised workforce planning tool for midwifery services. Additional midwifery posts had been appointed in recognition of identified shortfalls in capacity against recommended staffing levels.

- 5.1.15 At the time of our visit WHHT's safeguarding capacity was over-stretched with a post-holder responsible for both the named nurse and named midwife roles. Whilst the new named nurse post holder had made a positive impact in strengthening practice in some key areas, the joint role was unsustainable given levels of continued demand coupled with its growing safeguarding children development agenda. A business case for a named midwife was being drafted in recognition of organisational risks. This needed to be progressed as a matter of urgency. **(Recommendation 8.4)**
- 5.1.16 Engagement of young people and their families in shaping and reviewing the work of commissioners or providers was recognised by local leaders as an area for further improvement. Local sexual health services were giving priority to achieving the 'You're Welcome' accreditation. We saw some emerging examples of inclusive and creative work in shaping the delivery of services in line with young people and their families' views about what worked and what good practice looked like. The CCG had sought to learn from complaints and had involved children and families in strengthening its transition planning arrangements. It had started to involve young people from a local college, Young Healthwatch and families using Homestart to strengthen their awareness of and input to its work. There was potential to effectively build on these emerging approaches to achieve a stronger culture of co-production. **(Recommendation 2.3)**
- 5.1.17 Health case recording systems in Warrington were 'behind the pace' and inefficient compared to current practice in most other areas of England; with all the attendant risks in relation to reliance on paper records or a combination of paper and electronic. We found this created barriers to the timely and effective communication and information-sharing within and between the range of local health services and their partners. Providers were at various stages in their transition to electronic systems, though most reported full implementation by the end of the year.
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5.2 Governance

- 5.2.1 CCG leaders were actively discharging their roles and responsibilities for safeguarding children and adults. Safeguarding children was well-embedded in the day-to-day operations of the CCG, with regular reports to its Board and senior leadership team. The work of designated professionals was appropriately scrutinised. Designated professionals were providing good challenge and support, and made effective use of intelligence from a range of provider visits to assess the quality and impact of safeguarding work undertaken by frontline health services. Findings from multi-agency audits and contract reviews had helped to strengthen assurance that statutory and safeguarding children and adult requirements as set out in the NHS contract were being met.

- 5.2.2 Warrington health and social care leaders had taken seriously learning from its historical serious case reviews. Multi-agency learning reviews and actions plans had been appropriately developed and monitored with good engagement of and use of the expertise of the designated doctor in helping support improvements in clinical practice.
- 5.2.3 Good joint working arrangements had been established between Warrington CCG and Warrington Council's Public Health Department to help promote a 'whole system approach' and make best use of each other's resources and expertise. A Memorandum of Understanding was in place to support joint working in areas of shared interest. New joint approaches included CCG funding of places on a nationally accredited programme for schools to help young people with anxiety and depression.
- 5.2.4 Frontline health professionals spoke positively about their joint working arrangements with children's social care. An LSCB escalation policy was in place, and we were told that this worked well and rarely needed to be used. It was appropriately used by health professionals on a couple of cases seen. We also saw good engagement by named and designated professionals in helping to resolve any issues in a timely manner.
- 5.2.5 Named safeguarding professionals kept good track of and quality assured safeguarding activity at a number of levels including monitoring referrals to children's social care, attendance at, and the quality of conference or court reports. However, some frontline managers did not have a good working knowledge of levels of safeguarding children activity within their teams or, of local trends, and were not actively reviewing with their teams the outcomes of referrals made. Stronger management oversight would help in providing assurance that priorities were being consistently delivered and better inform the deployment of organisational capacity. **(Recommendation 2.5)**
- 5.2.6 The CiC nurses quality assured all review health assessments completed by the health visitors and school nurses using an agreed audit tool. They were working to strengthen recording of demographic information and equality and diversity issues having identified weaknesses in these areas from a recent case audit undertaken.

5.3 Training and supervision

- 5.3.1 The level and quality of training provided by the LSCB was a real strength, with positive engagement by all partner agencies in sharing their skills and expertise. The range of opportunities for learning and development was highly valued by frontline health practitioners, and was increasingly being used to help strengthen partnership working.

- 5.3.2 Whilst most staff working with children and young people at Warrington hospital had received levels of training in line with intercollegiate requirements, safeguarding children training coverage across its wider workforce was an area for further improvement. This had been identified as an area of risk for the Trust for some time. The midwifery preceptorship programme required updating and a stronger the focus on safeguarding children competencies. The Trust highlighted that its recent Child Sexual Exploitation Awareness raising day had positively helped in raising the profile of children at risk of abuse within the organisation.
(Recommendation 8.5)
- 5.3.3 The 5 Boroughs Partnership and Bridgewater Community Health NHS Foundation Trusts' safeguarding training provision met inter-collegiate requirements. However, some adult mental health professionals we spoke to did not have the required level of knowledge about their accountabilities for safeguarding children. The 5 Boroughs Trust had recognised the need to strengthen safeguarding training provision. A programme of work was planned to provide a more advanced level of training (level 3 of the inter collegiate framework) in recognition of the complexity of safeguarding children work and need for higher levels of expertise in this area.
- 5.3.4 Further training and stronger operational governance was required for staff working within the Pathways to Recovery service to ensure they were up to date in their use of safeguarding terminology. *We brought this to the attention of Public Health Warrington as the commissioner of adult substance misuse services.*
- 5.3.5 The training provided by CAMHS to school health teams was helping to strengthen their knowledge and capacity to support young people with a range of emotional health issues. However, there appear to be issues of professional confidence as well as capacity still to be addressed to enable school health to fully embrace all aspects of this role. *We brought this to the attention of Public Health Warrington as the commissioner of school health services.*
- 5.3.6 All sexual health staff had received appropriate training to enable them to discharge their safeguarding responsibilities and this was leading to some innovative practice.
- 5.3.7 The training provided to GPs met intercollegiate requirements, with a strong culture of learning and development in the two GP practices visited.

- 5.3.8 Appropriate arrangements were in place in the emergency department of Warrington hospital for peer review, with evidence of care taken to develop the competences of staff involved in safeguarding medical examinations. The designated doctor for children in care had recently undertaken an analysis of the competences of all health professionals. They aimed to use the findings to target training to areas where gaps were identified. Safeguarding supervision arrangements were being strengthened in the ED with the named nurse introducing monthly hour long drop-ins. These group supervision sessions were open to all practitioners and were a positive in promoting active learning and consistent responses to the identification and management of risk.
- 5.3.9 CAMHs, adult mental health and Pathways to Recovery staff had appropriate arrangements for the delivery of safeguarding supervision. Safeguarding supervision in sexual health service had been recognised as an area for further development and action was being taken to address this. However, whilst the CiC specialist nurses provided good advice and guidance to front line health visitors and school nurses, they were not receiving regular supervision of their work. **(Recommendation 4.7)**
- 5.3.10 Midwives reported good access to 'ad hoc' advice when managing complex safeguarding cases, with quarterly group supervision available. However, group supervision was voluntary, and monitoring for compliance was weak. Midwives did not have access to 1:1 individual safeguarding supervision or protected time to support their development in this area. Such opportunities for individual reflection would help to strengthen review and professional challenge of their work. **(Recommendation 2.4)**
- 5.3.11 Health visitors benefited from supervision delivered as a minimum 3 monthly in line with Bridgewater Trust's policy. New staff, or staff who required additional support, were able to access supervision on a more frequent basis. Whilst individual supervision records provided an overview of discussion about safeguarding risks, actions in some cases were not sufficiently clear to support effective review of the required outcomes. **(Recommendation 2.4)**

Recommendations

- 1. NHS England and Warrington CCG together with Bridgewater Community Healthcare NHS Foundation Trust, Warrington and Halton Hospitals NHS Foundation Trust and the 5 Boroughs Partnership NHS Foundation Trust should:**
 - 1.1 Ensure women benefit from effective joint working between local health services in the prevention, detection and management of mental health issues, with good access to specialist expertise in line with Department of Health guidance.
 - 1.2 Ensure children and young people benefit from a comprehensive, appropriately resourced, well-integrated approach to addressing different levels and complexity of emotional and mental health need, secured through robust, well-monitored '*Fit for the Future*' transformation plans.

- 2. Warrington CCG together with Bridgewater Community Healthcare NHS Foundation Trust, Warrington and Halton Hospitals NHS Foundation Trust and the 5 Boroughs Partnership NHS Foundation Trust should:**
 - 2.1 Ensure all frontline health professionals are actively engaged in leading and supporting children in need activity, and make appropriate use of shared assessment tools to continuously improve the identification of neglect.
 - 2.2 Ensure the role of CSE champions is effectively embedded in the work of all frontline health care teams with appropriate use of CSE screening tools to open up conversations with young people and strengthen vigilance to risk.
 - 2.3 Ensure the engagement of a wide range of children and young people in shaping and reviewing the individual and collective work of local health commissioners and providers.
 - 2.4 Ensure arrangements for safeguarding supervision provides a robust framework to support effective reflection and analysis of the experience of children, with clear accountabilities and timescales to support effective tracking of outcomes.
 - 2.5 Strengthen operational management oversight of safeguarding activity to provide assurance that safeguarding priorities and the required standards of practice are being consistently met.

3. Warrington CCG together with Bridgewater Community Healthcare NHS Foundation Trust and Warrington and Halton Hospitals NHS Foundation Trust should:

- 3.1 Ensure a timely and smooth transition of the paediatric liaison role to enable continued effective oversight of the health needs and safeguarding risks to children and young people presenting at Warrington Hospital.

4. Warrington CCG together with Bridgewater Community Healthcare NHS Foundation Trust should:

- 4.1 Promote wider awareness of MASH and ensure effective information-sharing arrangements are in place with other health partners including GPs, CAMHs, adult mental health and adult substance misuse services.
- 4.2 Ensure initial and review health assessments are of a consistently high standard and provide a clear focus on young peoples' voice, their emotional and mental wellbeing and identity, including their faith and cultural needs. This included strengthening the focus on the needs of young unaccompanied children.
- 4.3 Enable Children in Care nurses to have easy access to the child's full health record to enable them to rigorously review progress in tackling health risks and inequalities and capture of data about improved outcomes.
- 4.4 Ensure young people receive a copy of their health plan so that they are fully aware and helped to take a more active role in the promotion, management and provision of feedback about the impact of work to improve their health and wellbeing.
- 4.5 Progress planned work with young people so that they receive appropriate person- centred information about their health history and needs as they leave care.
- 4.6 Ensure designated, named professionals and specialist nurses for looked after children have sufficient capacity to address current strategic and service development gaps.
- 4.7 Ensure the Children in Care nurses benefit from regular supervision and reflection on their practice.

- 5. Warrington CCG together with Warrington and Halton Hospitals NHS Foundation Trust and the 5 Boroughs Partnership NHS Foundation Trust should:**
 - 5.1 Ensure regular communication/information exchange between midwives, health visitors, adult mental health and adult substance misuse services so that early signs of increased risk or relapse are promptly and consistently shared.
 - 5.2 Strengthen sharing of care practices and expertise between paediatric ward staff and CAMHS professionals to promote holistic care and robust management of environmental safety.

- 6. Warrington CCG together with Warrington and Halton Hospitals NHS Foundation Trust should:**
 - 6.1 Ensure hospital staff are aware of and make appropriate use of the referral pathway into the young person's substance misuse service.
 - 6.2 Ensure a robust flagging system is in place to support clear and timely recognition of Warrington children who are on child protection plans or in care. This includes having appropriate systems to keep such data up to date.

- 7. Warrington CCG together with the 5 Boroughs Partnership NHS Foundation Trust should:**
 - 7.1 Enhance local *Think Family* arrangements to ensure the experiences of children and the impact of parental mental health on their safety and wellbeing is fully embedded within frontline case management practice, with information of concern promptly shared with GPs.

- 8. Warrington and Halton Hospitals NHS Foundation Trust should:**
 - 8.1 Ensure review of the layout and safety of children in the ED waiting area to reduce risks of harm from a sudden deterioration in their health condition or hazards to children from equipment left in the area.
 - 8.2 Actively engage with and proactively share information with GPs in building a picture of the social circumstances and risks to pregnant women and their unborn babies and so help to promote consistent practice and targeting of early help.
 - 8.3 Review and promote wider awareness of its '*Did not Wait to be Seen*' protocol to ensure professional accountabilities for follow up of children or vulnerable adults are clear and robust.

- 8.4 Ensure the post of named midwife is urgently appointed to and so provide essential capacity to strengthen oversight of safeguarding practice and implement all actions to address areas of organisational risk included in this report.
- 8.5 Ensure all the workforce have good access to safeguarding children training in line with intercollegiate requirements commensurate with their roles and responsibilities for safeguarding children and young people.

9. The 5 Borough Partnership NHS Foundation Trust should:

- 9.1 Improve the performance of its local CAMHS service in ensuring a prompt response from assessment and treatment and securing effective reduction of its 'Did not Attend' DNA rates.
- 9.2 Expand child/young person-centred approaches within care documentation to effectively involve and empower young people in the management of risks and decision-making to support their recovery
- 9.3 Strengthen adult mental health engagement with child in need and child protection plans including ensuring regular review of the parent's care plan so that these reflect and coherently support actions to strengthen parenting capacity.

Next steps

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