Care Quality Commission

Review of Health Services for Looked After Children and Safeguarding in Cumbria

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

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

Where the findings relate to children and families in local authority areas other than Cumbria, 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 all aspects of 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. This includes the statutory guidance, Working Together to Safeguard Children 2013.

How we carried out the review

We used a range of methods to gather information both during and before the visit. This included document reviews, interviews, focus groups and visits. Where possible we met and spoke with children and young people. This approach provided us with a corroborated set of evidence.

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 84 children and young people.

Context of the review

The population of Cumbria is approximately 494,400 and includes 108,454 children and young people aged 0 to 19 years. The proportion of residents from black and minority ethnic groups is relatively low at 4.9 per cent compared to other areas of England. Given the size and the dispersed centres of population in Cumbria, children and their families often have to travel long distances to access health services.

Cumbria County Council comprises six district council areas including Allerdale, Barrow-in-Furness, Carlisle, Copeland, Eden and South Lakeland. Analysis of public health data indicates a mixed picture of health outcomes for children and young people resident in Cumbria. Health inequalities in Barrow-in-Furness are high, currently rated as the third highest area in England. In contrast both Eden and South Lakeland have high levels of health and wellbeing. Substance misuse is a significant issue in some areas of Cumbria. The rate of hospital admissions for young people with alcohol related conditions is relatively high, and the rate for young people aged 15-24 admitted for misusing drugs is almost double the average for England. Rates of teenage conceptions overall fall below the average for England, however rates in some localities are significantly higher. Cumbria has a higher rate of suicides and self- harm amongst young people compared to many other areas.

In March 2013, Cumbria had 627 children and young people who were looked after. The numbers of children who are looked after in Cumbria has increased since our last inspection and is higher than many other areas. In addition, 92 other councils currently place approximately 250 children in independent fostering and children's home settings in Cumbria. There are 472 children currently on child protection plans, denoting a significant increase since our last visit.

Planning and commissioning of young people's health services is led by NHS Cumbria's Clinical Commissioning Group (CCG). The CCG covers the whole of the county council area and is made up of 82 member GP practices, including a GP practice in North Yorkshire. NHS England area team (Cumbria, Northumberland, Tyne and Wear and Lancashire) has responsibility for commissioning local health visiting services, primary care and a range of specialist services including tier 4 CAMHs in-patient services.

Cumbria Partnership NHS Foundation Trust (CPFT) provides specialist health services for children and young people who are looked after and care leavers. The trust is also responsible for the delivery of health visiting services, school nursing, child and adult mental Health services (CAMHs), specialist young person's substance misuse (DASH), sexual health and adult mental health services. Greater Manchester West Mental Health NHS Foundation Trust provides specialist adult substance misuse services.

University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBFT) provides maternity services and emergency services at Furness Hospital and maternity services at Westmorland General Hospital. North Cumbria University Hospitals NHS Trust (NCUHT) provides maternity services and emergency services at Cumberland Infirmary and West Cumberland hospital. Urgent Care/Minor Injury Centres are provided at 6 locations across the county.

A joint Ofsted and CQC safeguarding and looked after children's inspection (SLAC) was carried out in April 2012 and found that local health safeguarding arrangements and the provision of health care for looked after children and care leavers was inadequate. Progress against recommendations from that inspection is included 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

We heard from

A foster carer who said she had received very good information and advice from a speech therapist, and that she had regular support from a health visitor when the young child first came to live with her.

A foster carer who highlighted the need for greater vigilance and easier access to therapeutic support for the child he is caring for, who is presenting with some historical emotional difficulties as he moves into a new developmental stage of childhood.

A care leaver told us she valued highly the support she had received from her GP and specialist nurse in helping her to better understand and manage her long term condition. This she felt had transformed her life. However, she also reported a poor experience of the care and treatment provided by her hospital consultant and a lack of recognition of her vulnerability when she was discharged.

A parent told us she experienced difficulties in getting the help she needed for her daughter initially, but reported good support from the school nurse who enabled her to access CAMHs services. She said:
"You need to be assertive to get the help you need".

We met a group of young people being supported by DASH the young person's substance misuse service. They expressed concerns about transition arrangements post 18 and would like to continue to receive support from the DASH team up to the age of 25. They really appreciated the help given by their locality DASH worker including support for attending GP appointments. They told us:
"GPs don't notice you unless a worker is there".

A young mother on a post natal ward told us:
"I was really scared but the midwives explained everything and told me how they could help me. I went to the special ante natal clinic and everyone was very nice, it helped. I have already met my health visitor and I wouldn't change a thing."

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 Children who attend the Emergency Department (ED) at Cumberland Infirmary are able to wait for treatment in a dedicated paediatric waiting area and are usually seen quickly. Paediatric notes used by NCUHT include the use of the paediatric early warning score which supports clinical practice in ensuring prompt and appropriate care is given. However the building layout at Cumberland Infirmary does not provide sufficient clinical oversight of children and young people whilst they are waiting with their parents. This runs the risk that changes in young peoples’ wellbeing or behaviours may not be spotted quickly enough.

1.2 The waiting area at Furness hospital enables good observation of children waiting to be seen. A recent report highlighted the need to ensure young people requiring resuscitation do not have their care compromised by a lack of appropriate facilities. UHMBFT are currently working to improve their care arrangements including ensuring all staff have up to date paediatric resuscitation training. Both acute trusts do not currently have staff trained in paediatric care working in their emergency departments at all times. Additional expertise is deployed from the paediatric wards on occasion to aid clinical assessment of children within the emergency department. A number of actions have been taken since the last inspection to strengthen capacity, however, there remain gaps in the coverage of appropriately trained paediatric nursing and medical staff in Emergency Department and Minor Injury Units. (Recommendation 7.2).

1.3 Young people who attend emergency departments following an incident of substance or alcohol misuse are not consistently referred on to universal or early help services and therefore there may be delays before those with increasing problem behaviours are followed up by local CAMHs/DASH workers. This means that opportunities to provide early support may be missed. When cases of young people or parents who misuse drugs or alcohol are referred on, hospital staff do not consistently receive feedback on actions taken. This is an area where information sharing needs strengthening as a number of these young people and their parents are at high risk of re-presenting. (Recommendation 5.1).

1.4 NCUHT's teenage pregnancy pathway to support expectant teenage mothers is currently only available in draft format. (Recommendation 9.1). We saw good examples of how the teenage pregnancy midwife in Carlisle had positively impacted on the welfare of a pregnant teenager with good outcomes for both the mother and baby who is now living with the maternal grandparents and actively engaging with the local "Young Mums" group. Positively young people in Carlisle who are pregnant can access their ante natal care at a dedicated young people's centre.

1.5 NCUHT's specialist substance misuse midwife offers good support to mothers who misuse drugs or alcohol. In one case seen the pre-birth plan was comprehensive and helped to relieve the anxiety of the mother and labour ward staff caring for her during and after the birth through good joint planning between the specialist substance misuse midwife and local substance misuse services. The specialist midwife on the West Cumberland hospital site supports a high risk consultant-led clinic targeted to pregnant women who misuse substances. It is positive to note that the good practice in this area is being sustained. The specialist substance misuse midwife post at Furness hospital is currently vacant which impacts on the level of specialist support currently available to mothers with substance misuse problems.

1.6 There is now a strong sense of health visiting, school nursing, specialist and adult mental health teams coming together in a shared and coherent manner to identify and meet the health care needs of vulnerable children and their families. Joint working between health visitors and midwives is improving, although in a few cases seen, information sharing was not always timely or effectively managed. Regular peri-natal meetings involving midwives, health visitors and adult mental health staff are enabling stronger multi-disciplinary working.

1.7 We found health professionals in a range of settings are not sufficiently aware or recording children and their families' identity, faith and ethnicity. Best practice was seen in the work of local CAMHs services where exploration of their or their parents' cultural heritage or faith is considered in building awareness of all aspects of a child's life. (Recommendation 7.1).

1.8 Local schools are being encouraged and supported to strengthen their offer to vulnerable children, with school nurses providing support and effective gatekeeping to address areas of increasing concern such as self-harming behaviour. School nurse records seen provide a clear picture of children's views and wishes. Practice in this area has been strengthened since our last inspection visit and denotes sensitive and person-centred work. School nurses provide an important link and advocacy role as evidenced in this case.

Child A was referred to the school nurse by the school who was becoming increasingly concerned by her behaviours and lack of engagement in education. The school nurse provided key information about A's health condition, failure to take medication, and on-going risk taking behaviours, including her unwillingness to engage with DASH and CAMHS. The school nurse completed a comprehensive risk assessment which informed a referral to children's social care and housing. Children's social care services are now being provided to child A and her family as a child in need.

1.9 We found an improved understanding of '*Think Family*'[1] approaches with some adult mental health professionals reporting they are now being asked for their professional advice in relation to the impact of parental mental illness on children. There is potential to further strengthen links between children's social care and adult mental health teams in all localities. Hospital discharge arrangements from adult psychiatric wards are generally well managed, with appropriate scrutiny of the impact for children. The young carers work undertaken by the in-patient unit in the north of the county is helpful in enabling children and young people to have a better understanding of their parent's mental illness and to prepare for their discharge home.

1.10 There are growing numbers and delays in most localities in relation to adults waiting to access primary mental health services. Risk management could be strengthened through a review of risks to those waiting who are pregnant and who are parents or have parenting responsibilities. (Recommendation 4.2).

1.11 There is now increasing awareness of families where domestic abuse is a feature, with good engagement of adult mental health services in MARAC work. Maternity records seen in both acute trusts provide a clear picture of risks and of actions that are required to ensure children remain safe. This denotes improved practice, with care taken to ensure women are seen alone.

2. Children in Need

2.1 Paediatric liaison staff employed by CPFT working in both acute trusts generally perform well in screening for risk and advising community and primary care professionals of children and young people's attendance at emergency departments or their admission to hospital. However, they have limited capacity within the current staffing establishment. In UHMBFT this is currently being reviewed given evidence of a marked and sustained increase in levels of incidents flagged. The capacity of paediatric liaison staff located at NCUHT has recently been reduced and we saw examples of notifications which would have benefited from prompt follow up and early intervention. (Recommendation 6.1).

2.2 Causes for concern are treated as incidents and named safeguarding professionals oversee the progress of investigation and of actions taken. This means a stronger shared focus on actions being taken to keep children safe.

2.3 Consideration is given by both acute trusts to the ward environment that is most appropriate to meet young people's health and wellbeing needs. For example, we saw sensitive practice in Furness hospital where a young pregnant teenage mother who had experienced domestic abuse, was placed on the paediatric ward with input from gynaecologists whilst further medical investigations took place.

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

2.4 A few cases seen of the work of midwives in UHMBFT and NCUHT highlighted inconsistencies in adherence to trust safeguarding policies and gaps in the supervision of midwives. Further work is required to embed local systems for assessing risk and multi-agency working. (Recommendation 8.1).

B has a well-recognised mental health condition. She experienced a delay from the point of her initial booking to risks being identified. Her care was not managed in line with NCUHT's perinatal mental health pathway. Four months later B's mental health deteriorated which then required an urgent crisis response by the community mental health team and children's social care. Following the baby's birth, B failed to attend a mental health appointment or to take her child for medical examination which resulted in the child being discharged. There was a further two month delay before the GP and health visitor were informed that her case had been closed. These incidents were not reported to the named safeguarding professional in line with the trust policy.

2.5 We also saw examples of better practice where additional safeguards had been put in place as illustrated in this case seen in the work of NCUHT.

C has learning difficulties and earlier this year became pregnant. The midwife appropriately carried out a risk assessment and met with the health visitor who completed an assessment of her needs using the common assessment framework (CAF). Despite initial reluctance and suspicion from C, her partner and family, the CAF identified the need for additional support and a referral was made to children's social care. A pre-birth plan was agreed with professionals and the family, and good progress was made in meeting the agreed goals during the ante-natal period. Joint visits by the health visitor and social worker involving the expectant parents and wider family focused on how to effectively meet the needs of a baby. A short while after being discharged from hospital the baby's grandparents became concerned that C was not taking their advice around handling the baby safely and feeding. A professionals meeting was called with C's social worker, the baby's social worker and the health visitor who then collectively carried out a home visit. A clear plan has again been agreed with C, her partner and grandparents that includes attendance at parenting classes and a further assessment of C's parenting capacity.

2.6 Joint working with children's social care is improving following the establishment of the county triage team (multi-agency safeguarding hub). However, some health professionals reported they do not receive timely feedback on the outcome of referrals made. The triage team is seen to be increasingly effective in enabling stronger shared approaches to the management of risk and decision-making, as evidenced in this case.

D a young woman with concealed pregnancy presented at Furness hospital. Her baby was safely delivered and she said she wanted to go home. Midwives were concerned and used the triage team to find out about the young person and whether there were any concerns they needed to be aware of prior to discharging her. The feedback they received from the triage team was timely and meant that her discharge was not delayed. Community midwives were informed and appropriate post-natal care was provided.

2.7 UHMBFT community midwives have recently implemented a 'vulnerable families 'log which enables community midwifes to have basic information identifying all of the high risk families in case they should present at their maternity units. It is intended that these cases are included in the new safeguarding supervision arrangements currently being rolled out.

2.8 Overall, we found an improving though mixed picture as to the extent to which the Common Assessment Framework/Team around the Family approach is fully supported by community health and midwifery teams and of its effectiveness in strengthening parenting capacity. Lapses in CAF review arrangements in some cases contributed to a lack of shared direction and did not support sufficient checks of the effectiveness of preventative actions taken. Midwives in both acute trusts are not consistently completing a CAF for all teenage pregnancies as required by their trust policies. This means that some teenage parents may not be receiving timely support in enabling them to be equipped for their parenting responsibilities. (Recommendation 7.3). Positively, health visitors and school nurses are increasingly involved in local CAF arrangements, including acting as lead professional where appropriate.

2.9 The work of the specialist Family Nurses denotes positive outcomes are being achieved for most young people, including reduction in risk-taking behaviours, good birth weights and low attendances at emergency departments. Young parents are being positively supported to return to education or find work. However, Family Nurse capacity continues to be stretched in relation to local demand in some localities.

2.10 In a few cases seen safeguarding work was managed at a child in need level where health professionals felt levels of risk and parental behaviours indicated a more focused child protection response was required. In these cases, health professionals were persistent in raising their concerns. For example in one case seen, work continued to be managed at a CAF level where the outcomes for children at a number of levels were poor. There was not a shared multi-agency view about the level of neglect, risk of violence and sufficiency of safeguards. In another case, a child was on a child protection plan, but health professionals considered that the young person could not be effectively helped so long as they remained in the care of their parent. (Recommendation 6.2).

2.11 Local health and social care services are very stretched in meeting the diverse needs of adolescents in crisis, some of whom are previously unknown to services. (Recommendation 3.1). This includes young people presenting in a psychotic state, young people who are threatening serious self-harm or who are at high risk of suicide, including those with eating disorders and those misusing substances. Action is being taken to improve access to specialist CAMHs advice and support including out of hours, however, coverage remains limited in some localities. Pathways to manage the care of young people who self- harm require development. (Recommendation 6.4). These issues were highlighted as areas for improvement at the last inspection.

2.12 The quality of risk assessment work undertaken by CAMHs professionals once the case is allocated is of a good standard on those cases seen, with good use made of observations and feedback from the young person to inform their treatment plan and ongoing review. Multi-agency working is enabling a more flexible and individually tailored response to young people as illustrated in this case example.

E is a 17 year old male with increasing risks of self- harm. His GP referred him to CAMHS after he had made a home visit and prescribed some medication to help with anxiety. A CAMHS appointment was arranged for 3 weeks later. The next day E presented at the GP Out of Hours (CHOC) service with suicidal ideation. The service appropriately escalated his care to the Adult Crisis team who provided immediate support and advice. The CAMHS service made an urgent risk based appointment for E to meet with a practitioner the following day and a safety plan was agreed. The Crisis team and on call CAMHS continued to provide support until he attended his first appointment.

The CAMHS practitioner identified the need for his care and treatment to be continued post 18 and is working to ensure his transition to adult mental health services is effectively managed. E continues to attend joint adult and CAMHS appointments in preparation for the transfer of his care to adult mental health services.

E and his family are now receiving support through a child in need plan. The social worker has identified the potential impact of E's needs on his younger sibling who is also open to social care.

2.13 Achieving better outcomes for young people in these situations is hindered by a lack of timely access to specialist in- patient care (tier 4) provision resulting in some young people being placed inappropriately and for several days on paediatric wards which risks impacting negatively on the care of other children. (Recommendation 1.1). This is also resulting in sick children having to be diverted to other hospitals. In other cases, young people are being inappropriately managed on adult mental health wards. Paediatric nurses do not have the expertise or workforce capacity to effectively manage these young people. Adult mental health staffing levels may not be sufficient to provide the intensity of support required. Action is being taken in some areas, as capacity allows, through in reach from CAMHs professionals or the deployment of agency staff, but these are not satisfactory or sustainable solutions as highlighted in this case example.

F, a 15 year old girl attended NCUHT's emergency department following an incident of self- harm. In line with NICE guidance, F was admitted and when medically stable was placed onto the paediatric ward to wait for CAMHS assessment. She remained there for a further five days as a "place of safety" waiting for a decision and discharge plan prior to her returning home. Specialist CAMHS nursing support was not made available to F during her stay on the paediatric ward.

2.14 CAMHs has continued to experience a number of difficulties in attracting, recruiting and retaining suitably qualified and experienced staff; and although the situation is now improving, a number of key posts remain covered by locum staff. A more timely response to urgent cases is evident. However, their capacity is at risk of being diverted away from short-term focused pieces of preventative work which in turn is leading to an increase in the numbers of crisis cases. This is contributing to an increase in waiting times for those assessed for routine assessments or further treatment whilst efforts are made to ensure the initial 48 hour target for assessment of urgent cases is achieved. (Recommendation 4.3). In addition, there is increased pressure on the capacity of school nurses which in turn is impacting on their work to promote young people and their families' health and help them achieve safer lifestyles. Whilst recognising some of these issues are challenges that are mirrored nationally, the size of Cumbria and the distances some young people have to travel to access specialist health services places a high burden on these young people and their families; including when they are placed a long way from home.

2.15 We saw highly effective and tightly managed child and family centred work undertaken by a GP practice in Penrith with clear ownership by all practice staff including receptionists and administration staff of their safeguarding responsibilities. Regular monthly multi -disciplinary meetings involving a range of community health professionals ensures good tracking of individual children and their families, including children in need and children on child protection plans, with prompt follow up of concerns. Actions are centred in a shared drive to improve outcomes for children, their families and the wider community. Not all GPs have yet got such effective arrangements in place, but the named GPs continue to work closely with lead GPs and other safeguarding professionals in local surgeries to strengthen their focus on vulnerable children and their families.

2.16 The *'Love Barrow Families'* project is also beginning to create positive momentum in finding creative ways of engaging with the local community secured through stronger partnership working between child and adult health and social care services. It is still too early to assess the outcomes of this.

3. Child Protection

3.1 Systems local hospitals have for the flagging and management of alerts in relation to vulnerable children or parents are not robust. NCUHT's alert system to identify known concerns is not reliable or accurate. In Furness hospital we found gaps in alerting arrangements for a vulnerable young person who is looked after who had presented as a suicide risk on previous occasions. Both trusts are still experiencing difficulties in receiving timely information from Cumbria County Council about children who have been placed on or who have come off protection plans. There remain significant gaps in hospitals being made aware of the legal status of children. This means that hospital staff may not have all the relevant information they need to inform decisions about how best to manage the young person's care. (Recommendation 6.3).

3.2 UHMBFT has implemented a rigorous system for checking alerts, taking child histories and ensuring any risks are formally logged and shared to enable appropriate follow up. The robustness of the system is checked through regular review and audit. This denotes significant improvement since our last visit and we understand plans are progressing to replicate this process in NCUHT. This will also require a 'culture of vigilance' to support effective use of the new system.

3.3 The use made of alerts to identify children on child protection plans or who are looked after is also not yet sufficiently robust. We found a number of gaps in safeguarding processes across a range of different teams and providers. These included cases in the Emergency Department at Cumberland Infirmary where frontline medical or nursing staff failed to check if a child was flagged on the electronic case management system. In one case although a child was quickly seen by a doctor, they had not noticed that there was an alert on the system and this resulted in a lack of exploration of other aspects of risk in relation to his presentation. NCUHT's emergency departments are not routinely carrying out or recording assessments to identify potential non- accidental injury (NAI) in line with NICE recommendations. (Recommendation 6.3).

3.4 The capacity of the named midwife in UHMBFT is over-stretched given that her responsibilities include all 3 hospital sites which are located at significant distances from each other (Recommendation 8.1). Although the trust has a clear and effective system for managing alerts in relation to the vulnerability of mothers or their unborn babies, there is some delay in these being placed on the mother's maternity record and transferred over to the baby's record following the birth. The maternity staff working in the Special Care Baby Unit at Furness hospital reported that they tended to implement their own records. This means that there is a risk that some key information from the labour ward may not be effectively used to inform on-going safeguarding arrangements. (Recommendation 6.3).

3.5 Staff working in the Primary Care Assessment Service (PCAS) had a 'Special Notes' alert system on their electronic records. This system is also used by GP practices and Cumbria Health Out of Hours (CHOC). However staff reported that they very rarely got any feedback on outcomes of referrals made from social care to enable them to update and amend records. This means that alerts could inappropriately remain on children's records and heightens the risk that social histories may be incorrect or lead to inappropriate action. (Recommendation 6.3). Care is taken to ensure women who have experienced domestic abuse are appropriately flagged on the PCAS alert system.

3.6 Systems for alerting sexual health staff about young people at risk of sexually harmful behaviour or child sexual exploitation, including those who are on child protection plans or who are looked after are weak. (Recommendation 6.3). Information sharing between the sexual health team and other specialist health teams and children's social care is not robust. (Recommendation 6.5). This means that there is not the degree of scrutiny required to enable effective assessment of the risk of harm to young women and men who attend for advice, support and sexual health checks as evidenced in this case.

G first attended sexual health services a year ago when she was 12 years old. She denied being in a sexual relationship, although it was known she previously had a sexual experience that was investigated by the police and that she used drugs and alcohol. Sexual health staff did not share this information with children's social care or DASH services. G did not come for the results of her tests and sexual health staff raised their concerns with the school nurse and named nurse for safeguarding children. She was followed up and later returned to the clinic and disclosed she had been sexually active. Sexual health staff reported their concerns to G's social worker who was about to close the case, but said they would visit. The sexual health worker was not informed of the outcome of this visit.

The young person re-presented 8 months later, saying she was sexually active, and that she no longer had a social worker. The sexual health team made a referral to children's social care. Children's social care said they would re-open the case and undertake an initial assessment. There was no feedback on the outcome of this.

Three months later, the young person re-attended. Risks to her safety and outcomes of the work undertaken by children's social care remained unclear.

3.7 Action is being taken to strengthen pathways of care for young people who have been sexually abused. However, joint approaches to preventing sexually harmful behaviour and addressing child sexual exploitation are still at a relatively early stage of implementation. (Recommendation 6.5).

3.8 The majority of maternity records seen in both acute trusts contained appropriate risk assessments and care management plans. Midwives had obtained relevant details of the father and routinely asked if the current partner was the father of the baby. This is helping to strengthen the focus on any potential risks to the unborn baby. However, the engagement of NCUHFT's midwives in child protection arrangements is not yet sufficiently embedded. We spoke to a mother who had recently delivered her baby. A pre-birth conference had taken place and there had been regular core groups throughout the pregnancy. She told us that her midwife did not attend these meetings and she had not seen any reports that she had written. (Recommendation 8.1).

3.9 Health staff in all 3 trusts informed us there continued to be significant delays in their being provided with minutes of strategy meetings or child protection conferences. In some cases there were delays in drafting pre-birth plans resulting in babies being born prior to safeguarding arrangements being jointly agreed. (Recommendation 6.7). This resulted in mothers and babies staying for a longer period in hospital until decisions were made about future care arrangements. More recent practice indicates pre-birth planning is more responsive to the vulnerability of the woman and to indicators of risk for the unborn baby, rather than working to the previous rigid 20 week timescale for referral.

3.10 We found health professionals now have a better awareness of their safeguarding responsibilities and are more regularly seeking advice from named professionals. They are taking prompt action to escalate their concerns or to chase the outcome of referrals made. Some staff highlighted that the capacity of their named safeguarding nurses was stretched given that they also covered safeguarding adults work. This is an area that would benefit from further scrutiny to ensure all key aspects of their role in safeguarding children are effectively delivered. (Recommendation 2.1).

4. Looked after Children

4.1 Specialist CLA health staff are not always notified in a timely manner of children being placed in care or in the area which results in delays in following up and scheduling appointments. (Recommendation 6.7). Close tracking, including daily monitoring and escalation to senior managers is undertaken to reduce risk, and performance overall is improving. Partnership working between children's social care and CPFT is becoming more effective and there is a high shared commitment to addressing statutory responsibilities in this area.

4.2 Information sharing, management of consent and co-ordination of health care for children placed in Cumbria by other local authorities is a challenging task given there are currently 92 different councils placing children in the area. Keeping on top of this volume of activity is a time consuming and demanding task. Current administration is very stretched in tracking children as they move in and out of care or between placements and areas. Specialist nurses are being drawn into administration tasks which impacts on their clinical capacity. We identified a few cases where the database is out of date or children's assessments are not up to date in one locality. (Recommendation 4.4).

4.3 Children placed by other areas in Cumbria are benefitting from the focused work undertaken by the specialist nurse who was appointed since our last inspection to provide a dedicated service for these children. For example, we saw some positive practice by the specialist CLA nurse in partnership with GPs to address the complex health needs of some young people placed by other councils in the area. However, we found that some adolescents placed by Cumbria in other areas are not receiving the level and quality of support they need and their personal safety, health and wellbeing continues to be of concern. (Recommendation 2.3).

4.4 The quality of initial health assessments recently undertaken by community paediatricians is of a very high standard. This means that they can also be flexibly used to inform future adoption medicals and so reduce delays in permanence planning for children. Recent health plans drawn from these high quality assessments are SMART and positively contribute to improving the health and wellbeing of children. Care is taken to ensure the process is undertaken in a comprehensive and inclusive manner. Records seen of earlier initial health assessments were not within the required timescales and were of variable quality. In these cases, senior managers need to be assured that the first review health assessment is sufficiently comprehensive to address these historical deficits. For example, we saw a case where there was a seven month delay before a young child whose parents misuse substances had their initial health assessment. The initial health assessment provided only scant details of their health and development.

4.5 Review health assessments and plans seen by inspectors varied significantly in their quality, impact, achievement of the required timescales and focus on outcomes. The adapted BAAF forms are enabling a more holistic approach in identifying children's health and development needs. However in some of the cases seen, health plans did not consistently reflect the findings of health assessments, and they were not sufficiently robust or tailored to wider actions being taken by partner agencies to reduce risk. Records seen of children with a disability did not sufficiently focus on their development or on actions to enhance their social skills and independence. The use of chronologies to assess risk and progress is not yet sufficiently embedded in practice or used to support reflection of the child's experience including the emotional impact of placement changes. In one case seen of a female aged 17, a number of concerns raised in her assessment about her emotional health and wellbeing were not transferred into her health plan. This means this young person may not have been able to clearly understand and access services available to support her. (Recommendation 4.5).

4.6 We found significant improvements in the health and wellbeing of some young children following their placement in care. Prompt action is taken to ensure all children who are looked after are registered with a local GP. GPs in some localities are not routinely sent copies of all reviews and health plans. GPs are currently not part of the routine information gathering when preparing for initial health assessments and ongoing health reviews. The GPs we spoke to identified they would like to have a better understanding of their responsibilities in relation to children who are looked after and care leavers. (Recommendation 4.6).

4.7 In some cases seen health visitors, school nurses and, where applicable, the CLA specialist nurse attend the child's statutory reviews to advocate for and promote the health and wellbeing of the child looked after. This championing of the health of the child looked after child is proactively promoted and Independent Reviewing Officers are made aware of any new developments or outstanding health issues. Capacity problems in some areas mean however, that some health professionals are unable to be as fully involved as they would like.

4.8 The use of Strengths and Difficulties (SDQ) questionnaires to improve identification of the specific concerns of young people with emotional and mental health needs is improving, and scores in relation to the risk of harm are reducing. We found mixed practice overall in the extent to which they are used to inform health planning, including referrals to CAMHs, and they could be more creatively used at key points in the young person's development or journey through care. Three cases sampled in one locality did not have an SDQ in place. (Recommendation 4.7). Positive practice included a case where the SDQ completed by a foster carer for a young child had led to a professional discussion between the CLA health team and the social worker within CAMHS to provide behavioural support to the foster carer to enable her to better manage the young child in her care.

4.9 We were told that lack of administration and nurse capacity meant that forms are not being consistently sent out or followed up, with some school nurses not having sufficient capacity to ensure SDQs routinely inform the child's health assessment. Local CAMHs teams experienced difficulties in being able to access previous CAMHs assessments for young people placed by other councils in the area. This meant some key information was not known when making a decision about the urgency of the case. (Recommendation 2.3).

4.10 Outcomes for some care leavers continue to be poor. Care leavers are not always supported well in transitioning into adult health services and we found a mixed picture in relation their experiences and the effectiveness of support locally available. (Recommendation 4.8). Some care leavers' health records indicated drift in clinical oversight, insufficient focus on their emotional or mental health needs, lack of exploration of sexual exploitation or substance misuse risks, and poor engagement of some young people. This has led to delays and gaps in implementing effective joint actions across partnerships, including other council areas and health organisations, in identifying and meeting these young peoples' needs. (Recommendation 2.3).

H had his final health assessment and SDQ completed in 2013 and although assessments had identified outstanding health issues, including high scores to indicate significant concerns around his emotional health, no referrals were made to adult mental health services. This young man has a chaotic lifestyle and recently attended the local emergency department following an incident of self- harm. There is good joint work taking place now between his personal assistant and the CLA specialist nurse to try and identify a service to diagnose attention deficit hyperactivity disorder (ADHD). However, because of his age the paediatricians have refused to assess him and have referred him back to his GP.

4.11 Greater scrutiny is needed of risks to young people placed out of area to ensure their safety on their return to Cumbria as this case demonstrates (Recommendation 2.3).

J is an 18 year old with a history of self-harm, substance misuse and is vulnerable to sexual exploitation. Her last health assessment was eight months late and did not adequately focus on her vulnerability or make appropriate use of other documentation on her record to provide a comprehensive overview of her history and risks. Her health action plan did not sufficiently explore the complexity of her needs or safeguarding issues. There were no clear strategies to encourage her engagement and promote improved management of her health as a young adult.

4.12 Positive practice is seen in the case of K a young person placed in Cumbria by another council.

K an 18 year old, has a long term health condition and prior to her case being managed by the specialist nurse, her future looked bleak. She was living in unsafe and unsuitable housing, had repeat hospital admissions, was low in mood and was engaged in risky behaviour. The quality of pathway planning and support from her original placing authority was poor.

The specialist nurse took time to get to know and form a relationship with K, and brought together relevant others including the GP and an adult social care social worker to support her to achieve their potential.

This young person told us:
My nurse is brilliant, so helpful and supportive. She helps me to attend appointments and to have a better understanding of my health needs. This means a lot to me- I was scared in hospital as I did not know what was wrong with me. She understands the challenges I face and is there for me if I am having a bad day.

My GP practice is fantastic. They have arranged for me to have all the tests I need. I am able to be seen straight away by the doctors in the surgery if I am unwell.

I have found people willing to help me, willing to give me the time of day.

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 CCG and the local area team of NHS England have maintained strong oversight of the improvement agenda put in place since the last inspection. NHS commissioners are well informed about progress against action plans and have set stretch targets in areas where the required standards of performance are not being achieved. Senior managers in the CCG have provided good leadership and support for NHS provider trusts together with Cumbria County Council in work to change organisational cultures and promote stronger partnership working.

5.1.2 Child safeguarding and looked after health activity remain as areas of high risk on organisational risk registers. All Trust Boards have performance dashboards that enable detailed analysis of key aspects of service delivery and trends. However, as the earlier sections of this report demonstrate, frontline health services continue to experience high demand; resources are being diverted into the management of high risk cases, with limited capacity to scope, deliver and sustain preventative work. Specialist mental health support out of hours requires rapid improvement to strengthen access to in patient care (tier 4 provision), to expand the range of community based options and the capacity of early help services. Health support for care leavers and transition arrangements is an area for significant improvement. Further work is required to improve early identification of families where mental health or substance misuse is a feature to reduce the risk of children being exposed to abuse and neglect.

5.1.3 The commissioning landscape has significantly changed since our last visit. The capacity and accountabilities of the designated professionals for safeguarding and children who are looked after requires further review to secure wider understanding of individual roles and to further strengthen organisational capacity to continuously improve outcomes for local children and their families. It is recognised that designated professionals would benefit from additional supervision and support. To date the designated nursing professionals have only undertaken limited supervision of the work of named nurses in provider trusts. (Recommendation 2.1).

5.1.4 Peer supervision and individual support provided by the designated doctor and county lead for safeguarding children is highly valued. It is having a positive impact in areas such as the training and development of GPs and work to improve the quality of analysis and actions arising from child deaths.

5.1.5 Commissioners and CPFT have further invested in frontline services such as children looked after nurses, CAMHs, health visiting and school nursing to strengthen local capacity. However, the pace of change has been too slow in some areas particularly in meeting intercollegiate requirements for training and supervision and the quality assurance of the work of frontline staff. The acute trusts have been slow to implement the levels of clinical and management oversight required. We identified good recent work by UHMBFT to strengthen its safeguarding arrangements, however further improvement is required in relation to its safeguarding practices within maternity services. Since the last inspection, NCUHT has appointed additional staff to improve coverage of safeguarding children training. However a number of improvement actions have yet to be completed to increase the competencies of its staff and embed clear, shared working practices for safeguarding children. (Recommendation 6.6).

5.1.6 Although we have seen stronger leadership at a number of levels within all local NHS organisations, further action is required to embed new ways of working that are sensitively tailored to individual circumstances, and promote continuous improvement in outcomes. These gaps in service provision are recognised by local managers who are seeking to find shared, creative and sustainable local solutions to the significant challenges that still remain.

5.1.7 Our previous inspection highlighted the need to improve participation of all looked after children and young people in service planning. We heard about work undertaken by CPFT with young people to design a new health passport providing key information for young people leaving care. Young people have also been involved in work to improve their experience of health assessments. Learning from children and young people's feedback is positively informing staff training programmes. Practice is changing to enable a choice of appointment times and locations to suit children and their carers' needs. Recent surveys of children's experiences of health assessments denote significantly improved satisfaction levels.

5.1.8 Young people using CAMHs services and DASH services and their families are being positively involved in plans to re-design these services. Their feedback is being used to strengthen new approaches to the delivery of lower level emotional health and wellbeing services.

5.1.9 We found frontline line staff had strengthened their focus on the experiences and wishes of young people who are looked after as an integral part of the health assessment process. However, young peoples' participation is not yet widespread and is an area for further review and challenge, particularly in relation to young people who are failing to attend their health appointments. Greater use still needs to be made of children and young people's feedback to inform their individual health plans and continuously improve contract monitoring and service delivery. (Recommendation 4.1).

5.1.10 NHS organisational leaders, managers and frontline staff have made a strong commitment to listening to and wanting to learn from the experiences and views of children and their families. The three local trusts are working to embed the young person friendly '*You're Welcome'* quality standards in order to deliver care that is more responsive to children and young peoples' needs. The intention to roll out the '*I want Great Care'* initiative early in 2014 is an important first step in ensuring NHS commissioners and providers receive regular feedback about peoples' experiences of using local health services. There are two versions for younger and older children.

5.2 Governance

5.2.1 Performance management of children looked after is now robust with regular reporting and review of activity against the required targets. The standards of practice overall are improving. Statutory timescales are being more consistently met and gaps in capacity in areas such as access to dental care and the delivery of immunisations are being addressed. There has been good initial work to benchmark the health of children looked after when they enter care so that their health needs can be better understood and improvement in tackling health inequalities systematically measured. However measures and outcomes in relation to the health care experience of care leavers require further development. Case records seen provided limited evidence of case review by line managers (Recommendation 6.6).

5.2.2 Information sharing in Cumbria remains a significant challenge given the diversity of paper and electronic records used by different local teams and organisations. Data management is a critical area for further improvement to ensure confidential personal information is secure, up to date, and enables timely transfer and follow up of concerns shared between local organisations. CPFT is working to radically transform its IT operations, but it will take some time before the new system is in place. In the meanwhile this has meant greater reliance on manual methods of communication between organisations with all the associated risks. This review also highlighted key areas where the transfer of information from the county council is not well managed which in turn is having a negative impact in areas such as the use and maintenance of alerts. The council is slow to provide minutes of strategy meetings, child protection conferences, child in need meetings, which if combined with health professionals not attending these meetings, risks lack of clarity and drift in the management of cases. (Recommendation 6.7).

5.2.3 Local governance and quality assurance systems have been strengthened with each trust being held to account in evaluating progress against the recommendations for improvement made at the last inspection, with improved scrutiny of the quality of services provided. The quality checks undertaken by designated professionals of providers are enabling tighter scrutiny of areas of activity that need to be strengthened, and mirror many of the findings of this review. However, some frontline staff are unaware of the findings of these visits and said they would welcome feedback.

5.2.4 Quality assurance and analysis of child deaths has been strengthened and the designated doctor has reported to Cumbria Safeguarding Children Board on the areas where systems require further development. However, there remains a backlog of child death cases for review. Action is required to ensure learning is widely promoted and that the required standards of practice are embedded. (Recommendation 2.2). Designated professionals are currently working to strengthen public health campaigns to improve awareness of risks in relation to co-sleeping, substance misuse and smoking.

5.2.5 Providers are working to build their capacity to audit the quality of clinical and safeguarding practice as evidenced in the audits of safeguarding arrangements in the Emergency Department of Furness hospital. CPFT has given priority to auditing the effectiveness of its risk management arrangements for adults with mental health needs. The trust has also reviewed the work of school nurses involved in CLA health reviews. As providers move forward in implementing follow up audits, they are building their understanding of improvement and of the areas where further work/new solutions are required to overcome barriers to the effective delivery of health care. Attention has been paid to training health visitor and school nursing staff to deliver the required standards of health care, and to using audits to test the quality of practice. However, given current management capacity challenges, these arrangements are not yet fully embedded. (Recommendation 6.6). A recent audit of GP work provides additional scrutiny of areas where improvements in safeguarding practice and levels of support are still required. Work undertaken in one of the Penrith GP practices for improving outcomes for vulnerable people is exemplary.

5.2.6 The impact of stronger management capacity within CPFT combined with additional targeted support to teams such as adult mental health, CAMHs, sexual health, school nurses and health visitors is contributing to improved risk assessment, with positive examples of actions taken in challenging circumstances to reduce risk. Further action is required by all provider trusts to review standards of practice against NICE guidance and to promote learning from research including embedding lessons from serious case reviews. (Recommendation 6.6).

5.3 Training and Supervision

5.3.1 CPFT has taken action to ensure its workforce is trained to the appropriate level compliant with the requirements of the intercollegiate standards and local stretch targets. Current safeguarding training across CPFT however, does not include awareness of the health needs of looked after children. This means that practitioners may not be always aware of the additional support and poor health outcomes of this vulnerable group of children.

5.3.2 UHMBFT has paid good attention to training its emergency department staff and other staff who work primarily with children. The trust acknowledges it has more work to do to engage adult health professionals so that they have a better awareness of and easy access to safeguarding children training. NCUHT has pockets of poor performance where it is not meeting its safeguarding training requirements. (Recommendation 6.6). GPs have significantly strengthened their awareness of child safeguarding issues since our last inspection and the named GPs are working very well with lead GPs and other surgery staff in an increasing number of GP practices to build their awareness and confidence in safeguarding practice.

5.3.3 Safeguarding children supervision requires further development to secure the required standards within the work of NCUHT. UHMBFT now has a clear framework in place and it is building its capacity to deliver dedicated safeguarding children supervision in line with inter collegiate guidelines through identifying and training safeguarding champions. Although arrangements across this trust are still at a relatively early stage of implementation, the quality of supervision on a few cases selected for review was good and supported clear reflection and direction in managing complex cases.

5.3.4 Safeguarding arrangements in CPFT have significantly improved since our last visit with increasing numbers of health visitors and school nurses benefiting from supervision. However not all practitioners are yet accessing regular individual supervision. It is recognised that further work is required to fully embed supervision arrangements, and the establishment of additional posts is helping to strengthen management oversight of the quality of work undertaken and to offer case consultation to professionals in partner agencies. There continue to be capacity issues in the CLA specialist health team. Supervision and auditing of the quality of CLA records is under developed. (Recommendation 6.6).

5.3.5 Positively CPFT has achieved its *'Call to Action'* [2]targets in relation to the employment of health visitors. CPFT has implemented a robust training and development programme for health visiting and school nursing staff that has been effective in driving improvements in the quality of health assessments for children who are looked after. There is currently insufficient cover for school nurses during school holidays to provide an adequate response to new referrals or oversight of cases during this period. Managers recognise the importance of developing a more flexible service and recent appointments have included the provision of all year contracts.

[2] Implementation plan 2011-15 to expand and strengthen health visitor services

Recommendations

1. NHS England to:-

1.1 Ensure the capacity of in-patient mental health provision (tier 4) is sufficient to enable young people to have timely access to specialist care when they need it, with evidence of improved outcomes for them.

2. NHS England and Cumbria CCG to:-

2.1 Review the roles, capacity and accountabilities of the designated and named professionals for safeguarding and children who are looked after to further strengthen organisational capacity in shared work to continuously improve outcomes for local children and their families.

2.2 Address the backlog of child death cases for review and ensure learning from these cases is widely promoted.

2.3 Ensure Responsible Commissioner requirements are effectively met so that children placed by Cumbria in other areas benefit from effective support, and local health professionals have timely access to relevant information about children with complex needs placed in the area.

3. NHS England, Cumbria CCG and Cumbria Partnership NHS Foundation Trust, to:-

3.1 Ensure timely access to an appropriate range of specialist mental health, sexual health and substance misuse services for young people who require a high level of skilled support to keep them safe.

4. Cumbria CCG and Cumbria Partnership NHS Foundation Trust to:-

4.1 Ensure children and young people's participation in their health assessments and care planning is widespread and that good use is made of their feedback to continuously improve practice.

4.2 Address waiting times for access to primary mental health services and ensure priority is given to those with parenting responsibilities or those expecting a baby.

4.3 Ensure CAMHs staffing is sufficient to enable effective coverage of routine work to strengthen preventative approaches and achieve a reduction in the numbers of young people in crisis.

4.4 Ensure administration capacity is sufficient to maintain accurate and up to date information about children who are looked after and care leavers so that changes to their placements or their health needs are promptly identified and addressed.

4.5 Further strengthen the quality and timeliness of review health assessments and health plans to maximise their impact in work to improve health outcomes.

4.6 Clarify the input GP's in initial health and review assessments and strengthen their support arrangements for children looked after and care leavers.

4.7 Ensure Strengths and Difficulties Questionnaires are creatively used to inform analysis of young peoples' emotional and mental wellbeing at key points in their development or journey through care.

4.8 Strengthen transition arrangements for care leavers to ensure a comprehensive review of their health needs and of areas where they require additional support to improve outcomes.

5. Cumbria CCG, Cumbria Partnership NHS Foundation Trust, University Hospitals of Morecambe Bay NHS Foundation Trust, North Cumbria University Hospital Trust and Greater Manchester West Mental Health NHS Foundation Trust to:-

5.1 Strengthen joint systems for identifying and following up young people and those with parental responsibilities who present at Emergency Departments or MIUs under the influence of alcohol or drugs.

6. Cumbria CCG, Cumbria Partnership NHS Foundation Trust, University Hospitals of Morecambe Bay NHS Foundation Trust, North Cumbria University Hospital Trust to:-

6.1 Strengthen the capacity of the paediatric liaison nurses in recognition of the increase in number and complexity of cases that are being referred on to primary care, community health and children's social care.

6.2 Continue to strengthen joint approaches to risk management with children's social care to ensure cases are managed at the appropriate level.

6.3 Ensure all alert systems are informed by timely and accurate information about risks to children, including children on child protection plans and those who are looked after; and that they are consistently used by frontline health staff to identify and report concerns.

6.4 Implement clear pathways for managing the care of children and young people who self-harm.

6.5 Implement clear strategies for the identification and reporting of sexually harmful behaviour and child sexual exploitation and ensure a robust shared response in meeting individual need.

6.6 Ensure intercollegiate standards and NICE guidance for safeguarding and looked after children including training, supervision and quality assurance requirements are consistently met.

6.7 Strengthen systems for data management and information sharing to ensure it is secure, up to date, and enables timely transfer and follow up of concerns between local organisations.

7. Cumbria Partnership NHS Foundation Trust, University Hospitals of Morecambe Bay NHS Foundation Trust and North Cumbria University Hospital Trust to:-

7.1 Routinely record key information about children’s identity, faith and ethnicity and ensure practice is sensitive to and reflective of all aspects of a child’s life.

7.2 Ensure full coverage of appropriately trained nursing and medical staff working with children and young people in Emergency Departments and Minor Injury Units.

7.3 Ensure community health and midwifery teams are effectively involved in the delivery of improved outcomes for children and their parents through stronger engagement in and review of the Common Assessment Framework arrangements.

8. University Hospitals of Morecambe Bay NHS Foundation Trust and North Cumbria University Hospital Trust to:-

8.1 Strengthen the capacity of named and supervisory midwives and ensure the safeguarding practices of midwives fully comply with trust and multi-agency safeguarding arrangements.

9. North Cumbria University Hospital Trust to:-

9.1 Fully implement its teenage pregnancy pathway to support its work with young parents.

Next Steps

An action plan addressing the recommendations above is required from NHS Cumbria 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.