Care Quality Commission

Review of Health Services for Children Looked After and Safeguarding in Cheshire West and Chester

Children Looked After and Safeguarding The role of health services in Cheshire West and Chester	
Date of review:	20th to 24th January 2014
Date of publication:	27th February 2014
Name(s) of CQC inspector:	Sue Talbot Lynette Ranson Lee McWilliam Janet Lewitt
Provider services included:	Countess of Chester Hospital NHS Foundation Trust Cheshire and Wirral Partnership NHS Foundation Trust Mid Cheshire Hospitals NHS Foundation Trust East Cheshire NHS Trust
CCGs included:	NHS West Cheshire CCG NHS Vale Royal CCG
NHS England area:	Cheshire, Warrington and Wirral Area Team
CQC region:	North
CQC Regional Director:	Malcolm Bower-Brown

Contents

Summary of the review	**3**
About the review	3
How we carried out the review	4
Context of the review	4
The report	6
What people told us	6
The child's journey	**9**
Early Help	9
Children in Need	12
Child Protection	15
Looked After Children	19
Management	**22**
Leadership & Management	22
Governance	24
Training and Supervision	26
Recommendations	**29**
Next Steps	**32**

Summary of the review

This report records the findings of the review of health services in safeguarding and looked after children services in Cheshire West and Chester. 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 the NHS England Area Team.

Where the findings relate to children and families in local authority areas other than Cheshire West and Chester, 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* 2013.

How we carried out the review

We used a range of methods to gather information both before and during 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 75 children and young people.

Context of the review

Cheshire West and Chester local authority is located in the North West of England. It includes the city of Chester and the industrial and market towns of Ellesmere Port, Frodsham, Helsby, Malpas, Neston, Northwich and Winsford. The council has a population of 329,500 and covers 350 square miles. A third of the council's population lives in rural areas. Approximately 74,200 children and young people (0-19 years) live in the area. Young people currently comprise 22.5% of the resident population. Birth rates are below the regional and national average. The proportion of residents from black or minority ethnic groups is relatively low at 6.9% compared to a national average of 16.3%.

According to the government's '*Indices of Deprivation'*, the overall quality of life is good for many residents. However, there are some communities where people experience multiple disadvantages and where health inequalities are relatively high. The rates of children living in poverty in the area are lower than regional and national figures. Life expectancy compares well to the national average. The health and well-being of children, and infant mortality rates are similar to the England average. Teenage conception rates overall are below the England average.

The rate of emergency department attendances for children under four is low compared to other areas in England. Admissions for mental health conditions or as a result of self-harm are similar to other areas. However, hospital admissions of adults who misuse alcohol or drugs are relatively high.

Planning and commissioning of children and young people's health services is undertaken by two clinical commissioning groups (CCGs) coterminous with the local authority boundary. NHS West Cheshire CCG comprises 37 GP practices covering Chester City, Ellesmere Port and the surrounding rural areas. NHS Vale Royal CCG comprises 12 GP practices covering Winsford, Northwich and the surrounding rural areas.

NHS West Cheshire CCG contracts with Cheshire and Wirral Partnership NHS Foundation Trust (CWPFT) and NHS Vale Royal CCG contracts with East Cheshire NHS Trust for the delivery of children in care nurse specialist services. Cheshire and Wirral Partnership NHS Foundation Trust (CWPFT) is commissioned by both CCGs to provide adult mental health, learning disability and some child and adolescent mental health services (CAMHS) across the whole Cheshire West and Chester council area.

NHS England Cheshire, Warrington and Wirral Area Team commission primary care and a range of specialist services including CAMHs in-patient (tier 4) services from CWPFT, and health visitors and family nurses from CWPFT and East Cheshire NHS Trust.

NHS West Cheshire CCG commission the Countess of Chester Hospital NHS Foundation Trust (COCHFT) to provide maternity and emergency services. NHS Vale Royal CCG commissions Mid Cheshire NHS Foundation Trust (MCHFT) to provide maternity and emergency services to meet the health care needs of its local population. The Trust has a Minor Injury Unit (MIU) at Victoria Infirmary in Northwich. We visited this as part of our review. Leighton hospital was not included given its location in East Cheshire Council area, but we did include the work of community midwives operating in the NHS Vale Royal CCG area.

Cheshire West and Cheshire Council (Public Health) commissions school health advisers (school nursing) from CWPFT and East Cheshire NHS Trust[1]. It also commissions school nursing services from Wirral University Teaching Hospitals NHS Trust. The work of this Trust was not included in the review.

Cheshire West and Chester Council (Public Health) also commission COCHFT and MCHFT to provide contraceptive and sexual health services (CASH). Cheshire West and Chester Council (Public Health) is also responsible for commissioning adult substance misuse services.

A total of 477 children and young people were the subject of child protection plans during 2012-13. On 31st March 2013, 397 children and young people were looked after, 19.1% of whom were placed more than 20 miles from the council area. Numbers of children in care have steadily increased over the past year and at the time of this review there were 444 children in care living in the area, including those placed by other councils.

[1] School health adviser is used as a global term for health care professionals who support school aged children and young people throughout the report whilst recognising that in Vale Royal the role is described as school nurse.

The last inspection of health services for Cheshire West and Chester took place in November 2010 as a joint inspection, with Ofsted, of safeguarding and looked after children's services. Overall effectiveness of the safeguarding services was judged as inadequate. Whilst the overall effectiveness of services for looked after children and young people was assessed as adequate, health outcomes for looked after children and young people were judged to be inadequate. Recommendations from that inspection are covered in this review.

The improvement notice placed on the local authority by the Department for Education following the 2010 inspection was lifted in December 2012 following a re-inspection by Ofsted which rated safeguarding arrangements as adequate.

The report

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

What people told us

Parents and foster carers were very positive about the work and support they have received from a range of health professionals. This included midwives, health visitors, therapists and community nurses who provided regular support, information and advice to them.

A mother whose baby had complex health needs and who was at risk of being made subject to a child protection plan told us:

"They have given me 100% support. I have everything I need and feel well supported. The services are there, and we only have to pick up the phone if there is something we need".

She valued the regular visits and support from her child's community nurse and her community psychiatric nurse. She said that the Children's Hospital at Home Service and direct access arrangements to the Countess of Chester Hospital NHS Foundation Trust children's ward had all been well thought through and were effective in assisting the family to cope.

Another parent valued the support provided to their child by the school health adviser and CAMHS worker:

"My daughter can talk openly with them about anything at all".

They also rated the support provided by the paediatric staff at the Countess of Chester Hospital as excellent, and from their GP as very, very good.

A foster carer said they valued being given the direct number of the consultant responsible for detoxification in helping them to identify and act promptly to address the health concerns of a very vulnerable baby they are caring for. They also praised the work of the clinical assessment unit at the Countess of Chester Hospital:

"We were there for 5 hours and were really well looked after. The baby was examined thoroughly on 3 occasions during this period, and they even brought me tea and a sandwich."

An experienced foster carer told us that Boughton Health Centre offered good support to children in care, and that this GP practice routinely saw children on the day an appointment was requested.

A foster carer caring for a young child with complex health needs and disabilities was full of praise for the help she has received from the Countess of Chester Hospital:

"*I have everything in place I need. The paediatric staff are fantastic. Nothing is too much trouble. I get clear explanations when I ask questions about her needs and future medical vulnerability. Everyone pulls together and works well together".*

A foster carer of an older child told us they had welcomed the guidance and support they had received from CAMHS in helping them to care for a young person with learning disabilities who had been emotionally abused and neglected. They also valued the additional support provided by the children in care nurse specialist in enabling them to access the health services she will continue to need as a young adult.

Parents and foster carers we spoke to also identified a few areas for improvement. These include:

- *"Making sure vulnerable babies are medically fit for discharge prior to their being discharged to foster care".*
- *"Delays whilst waiting for attention in the Emergency Department at the Countess of Chester".*
- *"Delays before CAMHS staff get back to them when they make contact".*

Young people we met who are active in the Children in Care Council told us they valued the regular opportunities they have for participation and seeing the proof that their views have been listened to and acted on. This is enabling them to have more ownership of services and encourages their ongoing participation.

They said they did not like school health advisers or specialist medical staff undertaking their health assessments in school time including having to explain about the nurse, or being asked to come out of lessons for appointments as it *"tells everyone in your class that you're different".* They also did not like having to talk to a different doctor- they would like to have access to the same GP in a practice that knows about their background.

Young people reported that sexual health services are *"clear enough to find",* although they said waiting times in Chester can be over 2 hours at the drop in clinic. One young person told us they have been turned away after waiting a long time as the clinic was too busy to see everyone that day. They were told to either attend at Ellesmere Port or come back following week. Young people would have rather have a specific appointment time rather than having to wait.

Young people said they were happy to be involved with *"Caring to Care*"[2] as they could get referred quickly and preferred the name of a service that they had chosen. This was seen by them to be a good example of their views being validated.

Whilst young people did not report any problems in relation to accessing CAMHS, they highlighted areas for further consideration in relation to its relevance to their needs and the quality of relationships. We were told:

"They make you open up. It's not easy for us to open up quickly, then when you do open up after a while they say your time is up. And then you're an emotional wreck and you don't know what to do with it all".

"I was messed about with so many different workers I can't be bothered with it now. But then I realised I need to offload so I go to my college counsellor instead".

Young people also raised concerns that they have to cope with too many changes at age 16 and then again at age 19. They told us:

"I don't understand why you have to go somewhere different when you turn 16".

"I turned 16 and they said you have to go somewhere else now. It takes about 3 months for me to build a relationship up then you have to start all over again. And then when you have to go to adult services at 19 it's another change when you're still trying to deal with things from years before".

"I want to keep the same person until I'm ready to change them, not be told I have to change."

One young person raised concerns around access to a dentist, saying it was not clear how to register and that it was too expensive. A care leaver told us they were unable to register at local dental practice as it was full so she has had to register at one some distance away. She feels the cost of transport makes it impossible to attend. Many young people reported they would like to see all health services in one place and for them to be "joined up."

---

[2] Service that provides emotional and mental health support for children in care

The child’s journey

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

1. Early help

1.1 Health and social care commissioners give a high priority to health promotion and are continuing to expand the range of information and guidance for children and their parents or carers. This includes stronger promotion of help with safeguarding children and recognition of common childhood illnesses. All NHS commissioners, Cheshire West and Cheshire Council (Public Health) and providers are working to ensure local services are young person friendly and have appropriate facilities for young people.

1.2 A number of CASH services have achieved the *‘You’re Welcome’* quality standards[3] and are actively encouraging young peoples’ awareness of and take up of services. Young people and their families have been positively engaged in developing the ‘*mymind*’ website hosted through CAMHS. However, whilst the emergency department at the Countess of Chester Hospital has a designated area where children can be medically examined and a quiet room where people who are distressed can be seen, its waiting area has limited facilities for children and young people.

1.3 COCHFT currently has two nurses trained in paediatric care working in its emergency department and can access additional expertise as required. In addition, advanced paediatric nurse practitioners are available to prioritise (triage) children and young people who self-present at A and E to determine their suitability for the Children’s Hospital at Home Service. NHS West Cheshire CCG has recently allocated additional non-recurrent funding to relocate the advanced paediatric nurse practitioners to the emergency department. This funding will enable refurbishment of the paediatric area to improve the environment and facilities for children.

1.4 The Minor Injury Unit (MCHFT), at Victoria Hospital, currently does not have any nursing staff trained in paediatric care. However, staff are trained in advanced paediatric resuscitation and have access to paediatric support from the main hospital site as required. The use of body maps within assessment documentation within the MIU is not routinely used. This means that the level of health concerns may not be sufficiently recorded.

[3] Department of Health’s quality criteria for young person friendly health services

1.5 Since the last inspection, stronger engagement and leadership by health professionals in '*Team Around the Family'* (TAF) work is evident. Health visitors and family nurses we spoke to felt they had sufficient capacity to undertake the lead professional role and that it fitted well with their primary roles and professional accountabilities. From a few of the cases we reviewed, practice in implementing TAF plans requires further development to ensure a record is routinely made of children and their families' views to strengthen their contribution to and ownership of their support plan. (Recommendation 4.1).

1.6 Adult mental health professionals are appropriately included in TAF cases where parental mental health has been previously identified as an area of concern. Records seen provide details of the wellbeing of children when they are seen in the presence of their parent/s. However, given the growth in demand for adult mental health services, more people are now being seen via clinic appointments. Whilst this has enabled increased capacity for direct work and has reduced travel time, home visits to adults with parental responsibility should continue to be given a high priority.

1.7 The impact of a relapse in parental mental health on parenting capacity was appropriately considered in most cases seen. Good arrangements are in place for responding to vulnerable families who move into the area. Early identification of risk and positive joint working between school, health and social care professionals is enabling vulnerable women and their children to be safely supported.

> Mum Z experienced domestic abuse and moved to a place of safety in the area taking her young children with her. Z has severe and enduring mental health needs and a history of non-compliance with medication.
>
> Z and her children have benefited from 'shared vigilance' combined with intensive support provided by school, the family support worker, adult mental health professional, school health adviser and health visitor. Her mental health assessment clearly highlights areas of historical and potential risk of harm to her children. Strategies to keep her and her children safe have been jointly developed and tailored to individual children and the wider family's needs. Mum's mental health has now stabilised and the children have settled well in the area. The case is being effectively managed at the *'Team Around the Family'* level.

1.8 We saw positive examples of sensitive and skilled support by a range of health professionals working closely and thoughtfully together alongside parents and foster carers in effectively meeting the needs of young children with disabilities and complex health needs. Creative use is being made of the new '*All About Me'* single plan to provides a holistic picture of the special education, health and social care needs of young people 0-19 years.

1.9 Good progress is being made in strengthening transition arrangements for young people with complex health needs or disabilities who require a high level of ongoing support from adult health and social care services. NHS West Cheshire CCG has developed a CQUIN[4] with COCHFT and CWPFT that is focused on ensuring the successful and smooth transition of young people from children to adult health services. This includes a clear focus on the safety and dignity of young people in areas such as speech and language and continence services. Reviews of performance against best practice combined with audits are helping to strengthen awareness of young peoples' experiences and of their satisfaction with the transition arrangements.

1.10 CWPFT and East Cheshire NHS Trust pay good attention to equipping their staff to identify indicators of neglect. Most community health staff have received training in the use of the Graded Care Profile and Home Conditions Assessment Tools. From cases seen, these approaches are being effectively used to support improved understanding of parenting capacity and its impact on children.

1.11 Home conditions assessments undertaken by substance misuse workers are enabling improved awareness of hidden harm to children. However, the risk assessment tool could be strengthened through a more explicit assessment of the impact on children from parental alcohol or substance misuse.

1.12 Teenage pregnancy rates are relatively low and reducing and the rate of repeat terminations is low. Contraception and sexual health (CASH) services are well targeted. The C card scheme is widely promoted and enables young people to better protect themselves. In Vale Royal a drop in clinic has recently seen a significant fall in the numbers of young people attending following a change in location from a local "cyber-café" to the Primary Care Centre. Young people voiced concerns that they did not like the new location given its large public waiting area. They felt the new arrangements were not sufficiently private. Sexual health staff were unsure whether young people attending the previous location were now accessing the new service.

1.13 Case work seen indicates sexual health professionals sensitively explore young people's understanding, their capacity to consent and any risks or vulnerabilities they may be exposed to. Professional accountabilities for children under the age of 16 are clear, with tight oversight of risks to younger people aged 13 and under. Risks of pregnancy and sexually transmitted diseases are appropriately managed and followed up. The specialist outreach nurse tailors information and advice to promote greater awareness and protection of young people with learning disabilities. Action is being taken to encourage stronger engagement of boys and young men in sexual health clinics.

---

[4] A Commissioning for Quality and Innovation payment to promote improvement in the quality of local health services

1.14 School health advisers manage priority work well. This is evidenced in good attendance at child protection meetings, timely submission of review health assessments of children in care, and achievement of Healthy Child Programme targets. However, in Vale Royal caseloads are high and the capacity of the service is tightly stretched. School health advisers in Cheshire West and Chester raised concerns that they have limited time to proactively undertake work in areas such as sexual health and emotional wellbeing. The role of the school health adviser is ripe for further development to enable them to actively support early help and prevention work.

1.15 Health visitor workloads in Vale Royal are currently high as a result of recent sickness absences which have stretched capacity. Additional posts have been recruited to which now ensures antenatal visits are routinely undertaken.

2. Children in Need

2.1 Young parents are clearly recognised and sensitively supported in terms of their status as children. Care and support arrangements are tailored to helping them to take ownership of their own and their babies' health, to promoting their parenting capacity and future life chances. The teenage pregnancy midwives and family nurses across the area are having a positive impact in reaching and providing good support to vulnerable young parents. The Teenage Pregnancy midwife employed by COCHFT together with a youth worker and Cheshire College midwife facilitate a lunch time *Young Mum's* support group. Antenatal and post natal midwifery drop in support is available in children's centres in areas where teenage pregnancy rates are comparatively high. The use of text messages results in few incidents of failure to attend appointments or home visits.

2.2 However, the caseload of the Teenage Pregnancy midwife in COCHFT is high. The family nurse programme currently does not have capacity to take on new referrals. Whilst this denotes good performance in maintaining the engagement of the initial cohort of young people, with good outcomes from their work seen, it also has meant that some young people who would benefit from this intensive service are currently unable to be supported. Good joint working with the specialist outreach nurse is evident including making joint visits to follow up young women who need support with contraception. Given increased demand through improved recognition of young people at risk of sexual exploitation, her current capacity is insufficient to deliver the range and level of detailed casework now required. However, this service is currently not available in Vale Royal.

2.3 All women booking for midwifery care are now routinely asked about their own dependent children and dependent children of partners. In Vale Royal vulnerable women are well supported by four specialist midwives who provide continuity of care. However, COCHFT does not have a specialist perinatal mental health midwifery post. This means local women are not yet benefiting from the full range of mental health support in line with NICE guidance. Local commissioners are currently undertaking a review of specialist peri-natal services to further improve outcomes for mothers and their babies. (Recommendation 6.1).

2.4 The paediatric liaison arrangements are working well at the Countess of Chester Hospital and are secured by good teamwork and support between the lead safeguarding and named nurses. Appropriate follow up and support is available for young people attending the emergency department who live in Wales. Systems for routine tracking and follow up of young people under the age of 16 are effective, but across the county, further consideration is required to strengthen alerts in relation to vulnerable young people 16-19 years including care leavers. Paediatric liaison capacity in MCHFT is currently tightly stretched which is impacting on the timeliness of follow up in some cases. (Recommendation 2.3).

2.5 CAMHS were re-designed in March 2013 to provide a single point of access. We found almost all CAMHS teams had lengthy waiting lists, with significant delays in access for some young people. Waits for assessment and review of young people with attention deficit hyperactivity disorder (ADHD) are particularly long. Some frontline staff also told us that thresholds for access to the young person's substance misuse service are high. Action is urgently required to review the capacity of the service and to ensure a more timely response to need. Joint commissioners are currently undertaking a review of all emotional health and well-being services to improve understanding of service demand and the outcomes of work at different tiers of provision. (Recommendation 3.1).

2.6 GPs said they would welcome greater clarity about access routes to CAMHS and school health advisers and of the range of services that are available to promote young people's emotional and mental wellbeing. (Recommendation 4.2).

2.7 From cases seen, CAMHS have been able to successfully step up support to young people in crisis to prevent their admission to hospital. On call CAMHS consultant arrangements are managed on a sub-regional basis, and hospital staff reported a timely response in line with NICE guidance in most cases. We found only a few instances where young people had to wait on wards for a psychiatric assessment when they were otherwise medically fit for discharge. This largely related to young people who had self-harmed on a Friday and who had to wait until Monday before they could be safely discharged. Regular safety checks are undertaken whilst young people remain on the children's wards. We did not find any cases where young people were placed on adult mental health wards.

2.8 We saw an exemplary standard of practice in the work of a specialist learning disability CAMHS worker whose expertise has been highly effective in reducing the risk of harm to a young child. This is a family where care proceedings had previously been considered. Child protection concerns are no longer an issue.

A is a 4 year old boy with learning disabilities and health needs. His mother also has learning disabilities which were impacting on her capacity to effectively meet her children's needs. An easy read child protection plan was developed to build her understanding of what was expected of her.

Through developing a range of visual cues tailored to supporting parents in developing safe routines, their capacity to meet their children's development needs has been considerably enhanced. Parents have engaged well and have been able to implement the suggested strategies for meeting their children's emotional and behavioural needs. 'House rules' were designed that reflected what the parents wanted their children to learn and understand. Their young son is now making good progress at school.

2.9 However, some children in need cases seen, particularly those of adolescents, denote tighter multi- agency vigilance is required to strengthen joint approaches to harm reduction. This includes joint arrangements for identifying and supporting young people in need where substance misuse is an issue. We found gaps in information sharing systems between young person and adult substance misuse services that means information held on risk at a wider family level may be incomplete.

Parent Y is known to the adult substance misuse team due to his history of heroin and cocaine use. Y did not have any contact with his son B, now 15 years old, for many years. B was recently admitted to hospital in a state of hypothermia, under the influence of drugs and alcohol. B is known to the young person's substance misuse team.

B's social worker informed the adult substance misuse worker that he no longer wished to live with his mother. This resulted in Y being considered as a potential carer. The adult substance misuse worker raised concerns about Y's capacity to meet B's needs. A few days later B moved to live with parent Y. B's social worker developed a '*Contract of Expectation'* with Y that highlighted the need for him to comply with his drug rehabilitation treatment programme. The adult substance misuse worker did not consider that this approach was likely to deliver the required changes given his history of inconsistent engagement.

The adult substance misuse worker visited the home a few days later to complete a home conditions report and raised concerns about the suitability of the accommodation and lack of food in the house. Concerns were escalated to children's social care, and following a recent strategy meeting, a decision has been made to hold an initial child protection conference.

A child in need meeting had previously taken place in September 2013 which raised significant concerns about B's non-school attendance and risky behaviour.

2.10 Joint approaches to information sharing and risk management also require further development in relation to young people who self- harm or are at risk of child sexual exploitation. (Recommendation 2.4).

E is 15 year old girl who in earlier childhood witnessed domestic abuse and self-harming behaviour by her mother. Both parents are known to misuse alcohol.

- March 2013- E was 'stepped down' to a '*child in need'* plan.
- July 2013- E 'stepped down' to *'team around the family*' with school acting as the lead professional agency. At this time discussions were ongoing with the police in relation to possible sexual grooming of E.

During the period September to November 2013, E was admitted to hospital on 4 occasions for self-harming behaviour. She was assessed to be at risk of sexual exploitation. Whilst her increased vulnerability had been identified in a child in need meeting following the fourth hospital admission, follow up actions to reduce future risk were not sufficiently clear. Health professionals had repeatedly requested updates, but they had not escalated their concerns about lack of feedback to the named safeguarding professional.

3. Child Protection

3.1 Health staff are generally aware of how to make referrals to children's social care when they identify vulnerable children about whom they have safeguarding concerns. They benefit from good support from named safeguarding professionals and this is enabling more explicit analysis of risk and recognition of the urgency of response required. We saw some examples of sensitive work by mental health professionals with parents or young people about whom there were child protection concerns who were reluctant to engage with children's social care or midwifery staff. However, some health professionals, including GP's, are not yet clear about the work of the Early Support and Access (ESAT) team and when they need to refer to the Contact and Referral Team (CART) team. The ESAT team is still at an early stage of development, and the future role and contribution of health professionals has yet to be agreed. (Recommendation 2.5).

3.2 Frontline health staff are vigilant in identifying domestic abuse and its impact on children. From cases seen, midwives and health visitors generally pay good attention to identifying and supporting parents who are at risk of domestic abuse. However, midwives in MCHFT did not always ask or record feedback from pregnant women in relation to domestic abuse. (Recommendation 8.1).

3.3 COCHFT has appointed an independent domestic violence adviser (IDVA) who will work closely with its emergency and maternity services. This represents an important step forward in strengthening vigilance of domestic abuse and promoting wider awareness of support available. From cases seen, local health organisations are effectively engaged in local Multi-Agency Risk Assessment Conference (MARAC) arrangements.

3.4 Attendance at child protection conferences and core groups and ownership and support for the wider partnership's work is now well evidenced. Since the last inspection good progress has been made in most areas to ensure reports to child protection case conferences are of an acceptable standard. From cases seen, we did not have any concerns about the quality of reports undertaken by health professionals. This is an area of practice routinely checked in supervision. Frontline staff receive feedback and support to address areas for further improvement in their practice. Supervision records seen in these cases are of a good standard with clear direction provided by safeguarding leads. Health professions are expected to discuss their report with parents in advance of the conference and this approach is now embedded in practice.

3.5 Adult mental health professionals report they have good links with children's social care and that they are kept up to date about children who are the subject of child protection plans. However, data management and scrutiny of referrals from adult mental health to children's social care would benefit from further review. Data provided by CWPFT in relation to the attendance of CAMHS and adult health professionals indicates relatively low attendance at child protection case conferences. (Recommendation 9.1).

3.6 GP engagement in child protection work is much improved and is being continuously enhanced. This was an area highlighted for further development in previous inspection reports. The two GP practices we visited had a sound understanding of their safeguarding roles and responsibilities.

The Firdale Medical Practice in Vale Royal holds daily meetings that are attended by all GPs. Information is shared about new safeguarding referrals and cases of concern. This ensures all GPs are kept up to date and supports consistency of response. Good attention is paid to following up children and vulnerable parents who fail to show for appointments including post natal checks.

3.7 Overall communication between GPs, health visitors and midwives is adequate and improving. The programme of work to modernise and align health ICT systems should further strengthen information sharing. However further work is required to strengthen links and information sharing with school health advisers and CAMHS in both CCG areas. (Recommendation 2.8).

3.8 GP attendance and the provision of reports to child protection case conferences is now very good and is an area of practice the Local Safeguarding Children Board (LSCB) and CCG Governing Body routinely monitor. In Vale Royal GP involvement in initial child protection conferences has significantly improved with 40% attendance and 100% reports delivered on time in the last reporting period. This denotes a high standard of engagement. Strong partnership working between the designated doctor, CCG and senior GPs is evident.

GP practice receptionists have received training on things to look out for. We saw a case where a receptionist had noticed a mother's poor interaction with her baby while waiting for immunisations. The mother had presented in the waiting area as withdrawn and was unresponsive to her baby's needs. The receptionist proactively contacted the duty GP. The mother was seen right away and was sent to hospital for a medication review.

3.9 GP practices have appropriate alert systems in place. Local practices pay good attention to ensuring electronic recording systems are kept up to date, with additional alerts used to identify other risk factors such as domestic abuse. The named GP in conjunction with the designated nurse and doctor has positively promoted safeguarding children training with very good coverage in line with expected levels of knowledge and competencies. However, we found a few cases where children's social care staff had not informed GPs of the outcomes of follow up visits made in response to concerns raised by them about the safety of wellbeing of children who were on child protection plans.

3.10 Both acute trusts have clear flagging arrangements for children on child protection plans. The views of children and young people are clearly recorded on cases seen. Electronic child health records indicate when a child is on a child protection plan. An additional alert is used for a twelve month period following a child protection plan being discontinued. This provides improved scrutiny of the vulnerability of young people and of parental coping capacity. However, hospital systems require further development to improve identification of children who are at risk of child sexual exploitation. (Recommendation 2.6)

3.11 Emergency department staff at the Countess of Chester Hospital reported good communication with children's social care in enabling a shared approach to managing risk and discharge arrangements. The hospital has appropriate security arrangements for managing young people or parents who attend under the influence of drugs and alcohol. Emergency staff reported a timely response from adult mental health professionals in identifying the best outcomes for people presenting with mental health difficulties. The Minor Injuries Unit at Victoria Hospital is effective in identifying children and adults at risk of domestic abuse and has good information sharing systems to inform midwives of risks to unborn babies of parents who present for treatment.

3.12 Named midwives hold a database of vulnerable unborn babies including those who are likely to be the subject of care proceedings. Alerts are also in place in relation to adults and children who are at risk of domestic abuse that have been discussed within MARAC arrangements. In one case seen, MCHFT had secured additional health care assistant capacity to enable close monitoring of a mother on the labour ward about whom there were serious concerns in relation to her safety and that of her unborn baby. Domestic abuse screening tools are increasingly used by frontline health staff to improve awareness of levels of risk.

3.13 From cases tracked the discharge of newly born babies is well managed with additional support provided to young parents and those caring for children with additional health needs or disabilities prior to discharge. We were informed about one case where a baby whose parent misused drugs may have been discharged too early. The foster carer was provided with the contact details of the consultant and was well supported by the midwife and health visitor until the baby's condition became stable.

3.14 The electronic management system in use in sexual health services does not automatically flag young people under the age of 13 or those who are looked after. In these cases it requires professionals to use special notes to ensure their vulnerability is captured, and that these are checked to inform any re-presentation. Professionals recognise this is not providing the levels of assurance required and it is flagged as an organisational risk. Plans to strengthen the IT system should assist in improving awareness of risk and analysis of trends including if young people are using different points of access. (Recommendation 2.4).

3.15 From checks made of young peoples' attendance at CASH services, we found the 'Special Notes' section provided a clear overview of young peoples' vulnerability. Community pharmacists are alert to safeguarding children issues with appropriate systems for the management of emergency contraception in relation to young people.

3.16 A significant programme of work is in progress to equip staff with the knowledge and tools to support improved identification of and multi-agency responses to young people at risk of sexual exploitation. Arrangements for managing child sexual exploitation (CSE) in Vale Royal are not yet sufficiently aligned to child protection processes. In West Cheshire risks are proactively explored as child protection issues. This enables clearer flagging of concerns as young people enter different parts of the health system. However, in one case seen, multi-agency responses to indicators of serious concern were slow and risks to younger siblings were not sufficiently assessed. (Recommendations 2.6).

3.17 The LSCB's focus on children missing from home and school has been strengthened. Tighter case tracking of these children on a multi- agency basis is enabling improved scrutiny of the quality of parenting and identification of risks to their safety and wellbeing. Better outcomes in one case have resulted in a young boy being able to make new friends. He was previously very socially isolated. A long standing eye sight problem has now been addressed. However, good outcomes have yet to be seen in another case of a 14 young girl with a long history of risky behaviour, where serious concerns and absences have been known about for some time. In Vale Royal there is a need to ensure substance misuse staff are fully engaged in tracking such children and ensuring they are safe via closer collaboration and information sharing with health visitors and school health adviser staff.

3.18 The impact of delays in young people being seen by CAMHS is an area that requires closer scrutiny by senior managers. Unallocated cases seen included a 15 year old referred by both his GP and by school for self- harming, poor sleep and diet and who was seen to be mixing with young people who were known to be using drugs. In another unallocated case, school and her GP had made referrals due to incidents of self- harm, alcohol misuse and depression. This young person was on a child protection plan and said she would welcome support from CAMHS. (Recommendation 3.1).

4. Looked after Children

4.1 The appointment of additional Child in Care specialist nurses in Cheshire West and Chester since the last inspection has been an important lever in raising the quality and enabling greater consistency in the delivery of statutory health assessments. The Independent Reviewing Officer's (IRO) annual report in August 2013 recognises and values their expertise, accessibility and enthusiasm, and has enabled tighter tracking of health concerns raised through statutory reviews. The report also highlighted a few areas for further improvement including ensuring health reports are up to date and submitted in good time for consideration by the IRO prior to the child's statutory review meeting.

4.2 Improvement planning currently in progress includes actions to strengthen adoption medical adviser arrangements and put in place an agreed assessment pathway to respond to the increased numbers of children looked after awaiting adoption.

4.3 Health assessments and care plans are now routinely audited, and areas where the required standards are not met are clearly identified and underpinned by improvement activity. Re-audits demonstrate sustained and continuous improvement in practice. This denotes a significant improvement since the last inspection. East Cheshire NHS Trust has recently appointed additional specialist nurse capacity and this is helping to raise the quality of health care planning, and reduce delays formerly experienced in initial or review health assessments taking place.

4.4 We saw good practice in capturing the views of children and in recording their presentation, with some good analysis of the attachment of younger children to their carers. Interpreters were appropriately provided in one case to enable family members to understand and contribute to their child's initial health assessment. Health staff reported easy access to Language Line support in all areas visited.

4.5 Good attention is paid to ensuring children in care benefit from regular health checks. Performance in meeting key performance indicators is strong compared to other areas. High performance in these areas has been sustained over the past couple of years. The LSCB monitors trends in this area and appropriately challenges designated professionals and representatives of provider NHS trusts when the required performance targets are not being met. It is positive to note that there is equally high performance in key areas such as immunisations, dental checks, registration with GPs and coverage of health assessments in line with the required timescales irrespective of whether children are cared for locally or out of area.

4.6 However, the quality and coverage of health assessments and care plans was limited in some of the cases seen. The focus of initial health assessments (IHAs) and subsequent reviews could be strengthened through clearer analysis of the impact of previous trauma and neglect on children. For example, the health care assessment of a 3 year old child did not provide a clear enough picture of the impact of domestic abuse on his emotional and mental wellbeing. His health plan did not provide a clear overview of strategies for managing and preventing future distress. The use made of SDQ scores and review of progress requires strengthening to clearly evidence improvements in children's mental health and wellbeing. Practice requires further development to embed smarter care planning, with a stronger focus on risks to children across the age range, with clearer follow up actions for managing and monitoring risky behaviour. (Recommendation 4.3).

4.7 The role of GPs in supporting children in care and care leavers is adequate overall, but would benefit from further development. Whilst GPs are provided with copies of children's health assessments and plans, they are not being asked to give their opinion of the child's health in advance of the review. It was not sufficiently clear to them what areas within the child health care plan they needed to follow up. Given that many of the records continue to be handwritten and some are poorly presented, this does not give these health records the status and profile they need. (Recommendation 2.7).

4.8 Systems in use in emergency departments In COCHFT and MCHFT and the Minor Injury Unit, MCHFT in Northwich are unable to proactively identify children and young people in care. This means that the vulnerability of some young people, particularly those presenting with self-harming behaviour, may not be clearly identified. For example in one case seen a 14 year old girl had 8 previous emergency department attendances, 3 in the last 12 months, for self- harming behaviour. We would encourage further review of self-harming pathways to ensure a comprehensive response to children and young people with repeat attendances. Particular attention needs to be paid to assessing any additional risks posed to children in care and care leavers within triage assessments and prior to their discharge. (Recommendation 2.3 and 2.4).

4.9 Cheshire West and Chester Council has recently commissioned Barnardo's to provide the *'Caring to Care Service' (*CAMHS tier 2). The new service aims to provide a range of therapeutic support to children in care including areas such as attachment and childhood trauma. The new service is also working to enhance the coping strategies of their foster or adoptive carers. This work was previously carried out by CWPFT. It is too early to assess the impact of this new service. Frontline health staff we spoke to are not yet clear about the pathways for access to or the scope of the service.

4.10 Young people 14 years and older are provided with a *'Me and My Health Guide'* that provides useful information about where to access help. We saw good outcomes from the support provided by family nurses to young people in care and care leavers who become pregnant.

4.11 The children in care nurse specialists undertake the health assessments of young people 16–18 years of age. We saw examples of positive joint working with young people and their foster carers to help plan for when they leave care. The nurse specialists also provide health input to the care leavers' drop-in service. However, levels of attendance are relatively low and other approaches require development to provide a more responsive service to young people post 18. Feedback from young people highlights the importance of continuity and having a smooth handover of their care.

4.12 Drug and alcohol screening tools are used at the discretion of practitioners rather than routinely undertaken. A stronger focus is needed on the emotional and mental wellbeing of young people about to or who have recently left care. One case seen denotes the need for a robust approach in undertaking the young person's final health assessment, with more explicit analysis of his individual needs and how to address future concerns. (Recommendation 4.3).

Young person C is a 17 year old living in supported housing. It was not clear from his final health assessment whether previous health concerns had been fully addressed. His GP had not been contacted in advance of the review to determine his current state of health. His final review health plan highlights the following actions:

- *Needs to be registered with a dentist*
- *Ongoing support*
- *His SDQ is 14 – no help required*
- *Review glasses as required*

4.13 In contrast we saw good work in supporting a care leaver aged 17 placed out of area reluctant to engage with and receive help in meeting her health needs. The children in care specialist nurse was persistent in making contact and encouraged her to accept help to address some concerns in relation to her health and wellbeing.

4.14 Health passports for care leavers are not yet in place. Local managers recognise that health support for care leavers is an area that requires further development to improve identification of future needs and ensure targeted support for those with ongoing risks to their health, personal safety and wellbeing. (Recommendation 4.3).

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 area benefits from strong and effective leadership underpinned by improvement-driven senior health managers, designated and named professionals. The two CCGs are innovative and collaborative in their approach, and have strong and clear contract management and performance monitoring arrangements in place. NHS England Area Team and the CCGs are working closely and effectively together and with the Council's Public Health team to continue to implement NHS reforms in relation to the transition of community health professionals and to embed the new '*Safeguarding Assurance Framework'.* The Safeguarding Forum is meeting regularly and has made a good start in addressing its development agenda.

5.1.2 NHS England Area Team provides good strategic direction and peer support for the work of designated professionals. Their job descriptions have been reviewed and updated. Action is being taken to continuously strengthen the capacity of designated professionals. However, designated nurse capacity for looked after children across the area and the named GP and designated doctor capacity in Vale Royal is not yet sufficient to consistently meet operational demands and achieve timely delivery of the strategic changes required to further transform local services for children. The lack of a clear shared strategy for addressing the diverse health and wellbeing needs of care leavers is a key gap in local arrangements. (Recommendations 1.1 and 1.2).

5.1.3 Strong commitment to involving and learning from the views of children and young people is evident in a growing number of areas of commissioning and service delivery. This denotes good progress since the last inspection. We saw positive examples of young person engagement in the work of CAMHS and sexual health services. The '*Rate Your Health Assessment*' work is providing a clearer picture of the experiences of children and young people attending their health reviews. Findings are being used to promote better engagement of children and young people and a stronger focus on their wishes and feelings. Recent re-commissioning of the continence service has been informed by the experiences and wishes of young people and their families. Young people are now increasingly being involved in the recruitment of key child health staff.

5.1.4 A high priority is given to partnership working and we found open and mature, supportive and challenging working relationships between health organisations and with the local council and police service at a number of levels. Health engagement in and support for the work of the LSCB and its working groups is good. For example, health professionals highlighted the need to review procedures in relation to Fabricated and Induced Illness and have actively contributed to work to strengthen safeguarding arrangements. Recent peer review work with LSCB members, including health representatives, 'walking the floor' and seeing at first hand the safeguarding practices of other agencies denotes a positive learning culture. Local health commissioners report being effectively held to account by the LSCB for the delivery of quality improvements. For example, the Chair of the LSCB wrote to NHS England Area Team raising concerns about the gap in named GP capacity in Vale Royal.

5.1.5 In a few cases seen, 'step down' arrangements from child protection or child in need would benefit from further analysis of the history or sustainability of arrangements, ensuring effective engagement of all relevant agencies and of the accountabilities of lead professionals. This requires ensuring threshold levels are appropriate, are working effectively to keep children safe and are likely to be sustained. (Recommendation 2.1).

5.1.6 The *'Starting Well'* programme provides a clear framework for supporting early intervention and integrated working between local health and social care services in the commissioning and delivery of 0-19 services. This is enabling better use to be made of local resources. Action is being taken to ensure a consistent standard and equitable access to local health services across the Cheshire West and Chester communities. NHS England is working closely with CCGs and local providers to review access to and the suitability of current Tier 4 CAMHS provision. A new access protocol has been developed that aims to promote care closer to home and facilitate smoother discharges. It also seeks to strengthen accountabilities through the development of individual management plans for young people who do not meet the criteria for admission to CAMHS tier 4 services.

5.1.7 The LSCB recently initiated a multi-agency safeguarding audit of the effectiveness of information sharing where concerns about the safety or wellbeing of children were perceived to be increasing. The audit highlighted deficits in the capability, efficiency and coverage of child health electronic case management systems. Particular risks are evidenced in stand- alone systems such as those as used by CASH services. In Vale Royal, frontline community health staff do not have sufficient access to computers. Gaps in ICT systems risk delays in information being shared, which in turn may detract from effective analysis and co-ordination of multi-agency responses. (Recommendation 2.8).

5.2 Governance

5.2.1 The CCGs have good performance management systems to assess the quality of service delivery and the robustness of Provider Trust's governance arrangements. The designated nurse for safeguarding children provides rigorous challenge of the effectiveness of local arrangements and of progress made in areas identified for improvement. Monthly quality and safeguarding reports ensure tight oversight of safeguarding arrangements and organisational risk. For example, NHS West Cheshire CCG identified in September 2013 that COCHFT and CWPFT were not meeting the required safeguarding children training target. The CCG have now introduced financial penalties for non- compliance and at the time of this review, both providers have responded positively to the challenge and are meeting the required standards. Performance reporting however, requires a stronger focus on the impact and outcomes of the work delivered, with higher priority given to the needs of vulnerable groups including young people in care and care leavers. (Recommendation 2.2).

5.2.2 The two CCGs are vigilant in identifying patient safety risks and carefully review activity levels that may denote a decline in performance. For example it explored the reasons for an increase in the number of unexpected admissions to neonatal intensive care from deliveries at COCHFT. In response the Trust's Director of Nursing completed an internal review. The appointment of a Patient Safety Lead (with an emphasis on midwifery) and a Practice Development Midwife have supported the recommendations of the review. The Practice Development Midwife is currently undertaking a review of the education and training of all midwives. Midwifery staff we spoke to welcomed these developments.

5.2.3 MCHFT has also recently commenced a maternity review given that its midwives have relatively high caseloads compared to other areas. MCHFT has yet not undertaken audits of its safeguarding children work specific to maternity services due to the current maternity workload capacity in the Trust. A new tool has recently been developed to address practice gaps in this area. (Recommendation 8.2).

5.2.4 Health professionals are appropriately engaged in work to learn lessons from child deaths. All child deaths have been reviewed over the past year with clear analysis of the causes of such deaths and of trends. The Child Death Overview Panel is now managed on a pan Cheshire basis with effective use of thematic meetings for example to explore issues in relation to the vulnerability of new born babies.

5.2.5 Cheshire West and Chester has not had a serious case review since 2009. Senior health managers and the LSCB are mindful of the need to proactively identify areas where the required standards of practice are not being met. Such '*Practice Learning Reviews*' have been effective in promoting greater awareness of risk in areas such as bruising in children who are not mobile and the assessment of risks to unborn babies.

5.2.6 The peer challenge for LSCB members and specific developmental session for senior health managers and designated professionals indicates a further important milestone has been achieved in the maturation of inter-agency working. The individual multi- agency case audits are providing an additional source of learning about the effectiveness of the whole system in keeping children safe and of actions to improve the way individual needs are met. The inclusion of people using services and young people in this process is a positive development.

5.2.7 A recent practice review flagged concerns in relation to the management of thresholds in relation to decisions to 'step down' from child in need plans to team around the family arrangements. Cases seen as part of this review also indicate this is an area where tighter vigilance and follow up is still required particularly in relation to adolescents presenting with risky behaviour. This is recognised by the LSCB and is flagged as a priority area for further review in its multi-agency audit programme. New approaches including multi systemic therapy are being implemented to help strengthen joint approaches to managing risk when young people are presenting with complex emotional, mental health and behavioural needs.

5.2.8 Strong and effective communication and partnership working is evident between the LSCB and local Healthwatch. This ensures learning from the experiences of children and families using local health and social care services is effectively shared and acted on. *'Enter and View'* visits have identified good practice in signposting and the provision of information in relation to safeguarding children in the children's wards at both Leighton and the Countess of Chester Hospitals.

5.2.9 Professional challenge is encouraged and is enabling a stronger focus on young people's lived experiences and risk to their safety and wellbeing. The LSCB has promoted stronger awareness of and promotion of the escalation procedure. From cases seen most health professionals are raising concerns in a timely way with named safeguarding professionals. The designated nurse has recently implemented a new system to support improved data capture of such incidents and analysis of trends.

5.2.10 The council and its health partners have built local capacity and strengthened their information sharing arrangements to provide tighter scrutiny of the health needs of children in care. The joint strategic needs assessment for the area does not provide a clear picture of the health needs and health inequalities experienced by children in care and care leavers. Given the increase in the number of children who are looked after including increasing use made of out of area placements this is a key area for further analysis to strengthen awareness of priority improvement areas. Work has recently commenced to improve data capture of the specific health needs, disabilities and long term conditions of young people who are looked after. Success in this area is dependent on further improvement in the quality and specificity of child health plans. (Recommendations 1.2 and 2.2).

5.2.11 Actions taken since the last inspection denote strengthened governance arrangements. The LSCB recognises the vulnerability of children in care and is working to establish a new sub-group to raise the profile of children who are looked after and of the risks they may continue to be exposed to following their placement in care. Annual health reports have been prepared and presented to the CCGs and provide a clear outline of planned actions to continuously improve the quality of local arrangements. Quality assurance of children's health assessments and individual health plans has been strengthened, but our review indicates there are a few areas for further challenge including ensuring health plans are holistic and promote rigorous follow up of young people with high needs. The work of the specialist child in care nurses is not yet formally quality assured. (Recommendation 5.1).

5.2.12 Work to improve analysis of hidden and unmet need in relation to the sexual health of the local population has recently commenced. Whilst there is growing awareness of the needs of the local traveller communities, work is needed to provide assurance of how well local health services are effectively supporting other minority groups. (Recommendation 2.2)

5.3 Training and Supervision

5.3.1 Most local Trusts are meeting requirements in relation to safeguarding children training. Named and designated professionals pay good attention to ensuring the appropriate level of training is accessed by all relevant staff, including porters and receptionists. Front line staff we met had a good understanding of their safeguarding responsibilities and knew how to raise concerns. However, East Cheshire NHS Trust at present is not yet achieving the required levels of training and this has been highlighted as an area for improvement in its annual safeguarding report. (Recommendation 10.1)

5.3.2 CWPFT's corporate safeguarding team comprises a range of safeguarding professionals. This approach has enabled a flexible and joined up response to providing advice and support to frontline health professionals involved in complex safeguarding work. The team comprises named and lead safeguarding professionals, children in care and safeguarding children nurse specialists, the paediatric liaison nurse specialist, adult safeguarding professionals and administrative support staff. The team is well used and valued by frontline staff.

5.3.3 Named safeguarding professionals oversee each written referral to children's social care to ensure it is appropriate and timely. The quality of reports to child protection conferences is routinely monitored. School health advisors and health visitors value the opportunities they have for consultation and joint supervision with CAMHS workers. However, they felt they would benefit from closer joint working arrangements and training with adult mental health staff to fully embed *'Think Family'* approaches. Staff in the emergency department at the Countess of Chester Hospital have identified they would benefit from further training in adolescent mental health. (Recommendation 7.1).

5.3.4 Safeguarding supervision is generally provided in accordance with inter-collegiate requirements. Supervision and peer review arrangements for child health staff and adult substance misuse staff are developing well. The named doctor at the Countess of Chester Hospital has implemented a tight system of peer review of the work of the paediatric team including scrutiny of the quality of child protection medicals and outcomes of safeguarding alerts. Supervision of health professionals involved in supporting children in care has been strengthened in the light of learning from a previous serious case review. NHS Vale Royal CCG has enhanced the capacity of children in care nurse specialist which is enabling better oversight of the work of frontline teams.

5.3.5 Although clinical supervision and weekly discussions of cases in adult mental health includes a focus on safeguarding children, practitioners are not yet routinely accessing safeguarding supervision in line with inter collegiate guidance. Adult mental health training and supervision arrangements require further development to fully embed child safeguarding issues in their practice. Adult mental health practitioners currently access level 2 training. The extent to which the current training strategy fully equips adult mental health professionals in safeguarding children needs to be reviewed. (Recommendation 9.2).

5.3.6 Increasing attention is being paid to strengthening knowledge and practice tools for working with young people who are at risk of or are being sexually exploited. The LSCB has developed a new course and is strengthening local procedures for responding to sexual abuse. The Brook *'Traffic Light Tool'* for sexualised behaviour is now being used to help practitioners identify and respond appropriately to sexualised behaviour in children. Further work is in progress to embed awareness and joint systems to improve early help and the availability of therapeutic support for vulnerable young people at risk of sexual exploitation.

Recommendations

1. NHS England Cheshire, Warrington and Wirral Area Team, NHS West Cheshire CCG and NHS Vale Royal CCG should:-

1.1 Further expand the capacity of designated professionals to ensure they fully meet inter collegiate requirements and enable timely and comprehensive assessments of children coming into care or being placed for adoption.

1.2 Actively support the development of a clear shared strategy for addressing the diverse health and wellbeing needs of local children, including children about whom there are safeguarding concerns, children in care and care leavers.

2. NHS England Cheshire, Warrington and Wirral Area Team, NHS West Cheshire CCG and NHS Vale Royal CCG together with the Countess of Chester Hospital NHS Foundation Trust, Mid Cheshire Hospitals NHS Foundation Trust, Cheshire and Wirral Partnership NHS Foundation Trust and East Cheshire NHS Trust should:-

2.1 Further review 'step down' arrangements from child protection or child in need to ensure effective engagement of all relevant health agencies and shared understanding of the accountabilities of lead professionals.

2.2 Strengthen performance management and reporting arrangements to enable a clear focus on the impact and outcomes of work in meeting the needs of vulnerable groups including young people in care, care leavers and others in communities where health inequalities is of concern.

2.3 Ensure a stronger shared focus on the needs of young people attending hospital or Minor Injury Units, including young people in care and care leavers.

2.4 Strengthen safeguarding alerts, risk management and information sharing arrangements for young people who misuse substances, are self-harming or at risk of sexual exploitation.

2.5 Clarify the role and contribution of health professionals to the Early Support and Access Team and ensure all frontline professionals, including GP's, understand the referral process and their accountabilities for tracking outcomes.

2.6 Strengthen safeguarding arrangements for young people at risk of child sexual exploitation and ensure all frontline health staff receive additional training in relation to their specific roles and responsibilities.

2.7 Strengthen the focus and engagement of GPs in addressing the health care needs of children who are in care and care leavers.

2.8 Ensure the work of local providers, including GPs promotes strong links and information sharing, with continuous improvement in the capabilities, efficiency and coverage of child health electronic case management systems.

3. NHS England Cheshire, Warrington and Wirral Area Team, NHS West Cheshire CCG and NHS Vale Royal CCG together with Cheshire and Wirral Partnership NHS Foundation Trust should:-

3.1 Reduce delays in access to local CAMHS services and ensure young people with emotional, mental health and behavioural needs are promptly followed up.

4. NHS England Cheshire, Warrington and Wirral Area Team, NHS West Cheshire CCG and NHS Vale Royal CCG together with Cheshire and Wirral Partnership NHS Foundation Trust and East Cheshire NHS Trust should:-

4.1 Ensure *'Team Around the Family'* plans routinely include the views of children and their families.

4.2 Strengthen links and information sharing between GPs, school health advisers and CAMHS to promote regular feedback on areas where outcomes are improving and where risks to their wellbeing remain.

4.3 Further develop initial health assessments and health care plans for children in care to ensure they provide a holistic overview of children and young people's needs across the age range and provide a tighter system monitoring outcomes and ongoing risk.

5. NHS West Cheshire CCG and NHS Vale Royal CCG together with Cheshire and Wirral Partnership NHS Foundation Trust and East Cheshire NHS Trust should:-

5.1 Ensure the work of the specialist children in care nurses is quality assured.

6. NHS West Cheshire CCG together with the Countess of Chester Hospital NHS Foundation Trust should:-

6.1 Address gaps in perinatal mental health services to deliver improved outcomes for women and their babies.

7. The Countess of Chester Hospital NHS Foundation Trust should:-

7.1 Provide additional training in adolescent mental health for emergency department staff.

8. Mid Cheshire Hospitals NHS Foundation Trust should:-

8.1 Strengthen its focus on domestic abuse and ensure midwifery records clearly evidence screening for domestic abuse is routinely undertaken.

8.2 Implement a programme of audit of its safeguarding children work in maternity services.

9. Cheshire and Wirral Partnership NHS Foundation Trust should:-

9.1 Strengthen scrutiny of referrals from adult mental health to children's social care and ensure sufficient levels of engagement by CAMHS and adult mental health professionals in child protection case conferences.

9.2 Strengthen access to training and safeguarding supervision for adult mental health professionals and promote stronger links and sharing of expertise with child health professionals.

10. East Cheshire NHS Trust should:-

10.1 Ensure all its staff are appropriately trained in line with inter collegiate requirements for safeguarding children.

Next Steps

An action plan addressing the recommendations above is required from NHS West Cheshire CCG and NHS Vale Royal CCGs 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.