

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

Children Looked After and Safeguarding

The role of health services in Stockport

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

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

How we carried out the review

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

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

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

In total, we took into account the experiences of 54 children and young people.

Context of the review

Children and young people make up 23.5 % of Stockport's population with 14.3 % of school age children being from a minority ethnic group.

On the whole, the health and well-being of children in Stockport is generally better than the England average. The infant and child mortality rates are similar to the England rates.

The rate of looked after children under age 18 per 10,000 children as at March 2013, was significantly lower than the England average, and there were significantly better percentages of looked after children having up to date immunisations when compared to the England average. Despite the relatively lower numbers of looked after children in the area in comparison with England averages, it should be noted that the CAMHS review carried out in 2013/14, reports that the majority of these children are placed in the area from other local authorities.

Chi Mat data reports that in 2013, the overall percentage of all Stockport's children having MMR vaccinations and other immunisations such as diphtheria, tetanus and polio by aged two was significantly better when compared against the England average.

The indicator for the rate of A&E attendances for children under four years of age in 2011/12, was significantly better when compared to the England average rate. However, the rate of hospital admissions caused by injuries for children under 14 years of age and young people between the age of 15 and 24 years was significantly worse when compared to the England average.

Although the rates of hospital admissions for mental health conditions was not significantly different to the England average in 2012/13, the rates of hospital admissions as a result of self-harm in same time period was significantly worse than that the England average.

In 2011, the conception rate for under 18 year olds per 1000 females and the percentage of teenage mothers in 2012/13 were comparable to the English average. Breastfeeding indicators were mixed. The breastfeeding initiation indicator was significantly worse when compared to English averages and the breastfeeding prevalence at 6-8 weeks after birth indicator was recorded as being similar to the England average. A further indicator that was significantly higher than the England average was the rate of hospital admissions due to alcohol specific conditions.

A strengths and difficulties questionnaire (SDQ) was used to assess the emotional and behavioural health of looked after children within Stockport. The average score per child in 2013 was 14.5. This Department for Education (DfE) score is slightly greater than the England average and is considered to be borderline cause for concern. The average score has increased since 2011, although it has remained consistent between 2012 and 2013.

In 2013, the DfE reported that Stockport had 205 looked after children that had been continuously looked after for at least 12 months as at 31st March (excluding those children in respite care). The DfE reported that 87.8% (180) of these children received their annual health assessments. This percentage is similar to the England average of 87.3%. The percentage of looked after children that had their teeth checked by a dentist in Stockport was 80.5% (165) which is slightly lower than the England average of 82.0%. As at 31 March 2013, there were 40 looked after children who were aged five or younger, the DfE reported that all of these looked after children had up to date development assessments.

Commissioning and planning of most health services for children are carried out by Stockport CCG for acute care, maternity, continuing health care, allied health professional services and CAMHS. Stockport Metropolitan Borough Council commission school nursing and sexual health services and NHS England commission Health Visiting and Family Nurse Partnership.

Commissioning arrangements for looked-after children's health are the responsibility of the CCG and the looked-after children's health team and operational looked-after children's nurses, are provided by Stockport NHS Foundation Trust. The Designated Nurse for Looked After Children is employed by the CCG.

Acute hospital services are provided by Stockport NHS Foundation Trust.

School nurse services are provided by Stockport NHS Foundation Trust.

Contraception and sexual health services (CASH) are provided by Stockport NHS Foundation Trust.

Adult substance misuse services are commissioned by Stockport Metropolitan Borough Council and provided by Pennine Care NHS Foundation Trust.

Child and Adolescent Mental Health Services (CAMHS) are provided by Pennine Care NHS Foundation Trust.

Specialist facilities are provided by NHS England.

Adult mental health services are provided by Pennine Care NHS Foundation Trust.

The last inspection of health services for Stockport's children took place in 2012 as a joint inspection, with Ofsted, of safeguarding and looked after children's services. Recommendations from that inspection are covered in this review.

The report

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

What people told us

We heard from children in care and care leavers:

"I come to Café Zest every week and have been coming for ages. I come to see the looked-after children's nurse every week. She is really easy to talk to about looking after my baby. She gives good advice and she is really nice. It's so helpful to be able to meet her every week."

"Coming here to the café every week is great. I have two babies now and I get such helpful advice about being a mum. I get sexual health advice too as I don't want to get caught out again. The Central Youth service (is brilliant. The staff are really kind and easy to talk to."

“The youth centre is brilliant. They can answer really personal questions, give good information and no one judges you.”

“I like coming to the café every week, it gets me out of my foster home and I have friends here. I can socialise and talk about things if I want to”

“We can say anything here and get things off our chest. No one judges you here and I can get away from things for a couple of hours. I really look forward to it”

“When I left care I didn’t get any health history and anything. I had to find things out for myself.”

Foster carers told us:

“Whatever I ask for is put in place; I can’t speak highly enough of the LAC nurse”

“People always get back to you, no matter what the question is. They are really knowledgeable”

“Since the initial health assessment, it’s been really good, I can get hold of the consultant very easily.”

“My GP is brilliant, they know I’m a carer and will see the children at short notice if I’m worried”

“The LAC nurses are very good and patient at completing the review health assessments, especially with young people who are resistant”

Others told us:

“The staff in antenatal and on the maternity ward are lovely, everyone treats you so well here”

“Health at Treehouse were amazing, all I can do is praise them”

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 Vulnerable children and families in Stockport have access to a range of universal services which are effective in delivering positive outcomes; examples include the Early days parenting support programme and Talking Together initiative that takes account of particular local needs around speech and language development. Health visitors currently offer targeted ante natal visits which have resulted in those families who require additional support being identified at the earliest opportunity.

1.2 Midwifery booking in routinely takes place at a health location such as a GP surgery or health centre. There is limited opportunity to see expectant women alone or at home. Cases sampled illustrated the difficulties this presents in discussing sensitive issues such as domestic violence and in completing a thorough risk assessment including observation of their home environment. Whilst the use of the electronic patient database Euro King supports the confidential recording of important issues such as domestic violence via prompt questions, this was not routinely being completed or asked in cases we sampled. There is a risk that women who are experiencing domestic violence are not being identified or receiving appropriate support to ensure their own safety and that of their unborn child. **(Recommendation 1.16)**

1.3 Midwifery services have a do not attend (DNA) Policy to identify and respond to women who do not attend ante natal appointments. Although we saw compliance with the policy, some cases seen were not followed up within the timescales specified in the policy and there is an inherent risk that the autonomy of individual midwives may lead to a delay in follow up and further actions as necessary to ensure unborn babies' safety. **(Recommendation 1.10)**

1.4 We saw inconsistencies in timescales between midwifery practitioners in the completion of the vulnerable women referral form for the named midwife. This was the same for the subsequent common assessment framework (CAF) paperwork which is utilised across Stockport to access support for families when concerns are identified. There is a lack of management oversight of this process and more stringent management monitoring would ensure any safeguarding concerns are acted on more rapidly. **(Recommendation 1.12)**

1.5 Following feedback from parents, access to the local parent craft classes has been extended to include weekend and evening sessions. This is a positive development. A specialist offer is also in place for teenage parents-to-be, to ensure new parents are well supported in understanding how to meet the needs of their new-born infant.

1.6 There are close relationships between the teenage pregnancy midwife and the Family Nurse Partnership to identify and refer those expectant teenagers who would benefit from intensive support. The family nurse partnership makes good use of genograms to identify and evaluate family dynamics and relationships and uses these effectively to support their risk analysis. We heard how the family nurse partnership works effectively to support vulnerable young parents.

1.7 Individualised birth plans are not routinely available in a standard format to support midwifery staff, in identifying who needs to be informed about the delivery of the baby, and any specific action required. The lack of person centred plans is a missed opportunity to involve the woman and does not support midwives on the delivery suite and post natal wards to fully understand the mother's needs and ensure that new-borns are safeguarded effectively. (**Recommendation 1.9**)

1.8 Arrangements for access to specialist midwifery services for teenagers and women with mental health issues are good, with availability of either specialist practitioners or clinics to ensure women access the additional support they need. On a case by case basis we have seen some excellent joined up working between individual practitioners in midwifery and other services such as substance misuse. However this is not a formalised pathway and there are opportunities to further strengthen this work to ensure that expectant mothers and their unborns needs are being met. (**Recommendation 1.11**)

1.9 We saw some evidence of CAF being used to support vulnerable families where expectant mothers needed additional help, however these did not always clearly articulate goals to ensure families were accessing the most appropriate support on an ongoing basis. There is a lack of assurance that interventions are meeting families' needs and ensuring positive outcomes. (**Recommendation 1.17**)

1.10 Women who have been victims of female genital mutilation (FGM) are beginning to access hospital treatment at Stepping Hill Hospital with some cases recently accessing maternity services. However, there is currently no formal health FGM policy in place to guide staff across the foundation trust in how to respond and this is a gap. (**Recommendation 1.18**)

1.11 Opportunities are being missed for midwifery services to liaise with other disciplines and agencies to ensure succinct joined up working. There are currently no arrangements for midwives to attend GP practice safeguarding meetings in areas where they are happening, or to liaise with colleagues in social care as part of a safeguarding liaison forum. Likewise, liaison arrangements with health visiting are underdeveloped. There was a notable absence of face to face health visitor liaison with midwifery services, and communication is reliant on written maternity liaison forms. This leads to a risk that information is not always shared comprehensively and in a timely manner and there is also the potential of duplication of services in the early stages of infancy. (**Recommendations 1.13 and 1.20**)

Case K highlighted the important role of the “early days” group in supporting all mothers with the transition to parenthood and in early identification of concerns around maternal mood changes. Facilitated by a nursery nurse within the health visiting team, this open access group, which is delivered over a 6 week period when a baby is aged between 8-12 weeks, highlighted concerns around one new mum’s ability to cope without any family support locally and a subsequent slow deterioration in her mental health. The positive relationships built up in this group between health practitioners and “K”, along with the opportunity to see her on a regular basis at the group, meant further assessment and onward referral for specialist support was expedited, achieving positive outcomes for both mum and baby.

1.12 The reconfiguration of some health and social care services, including health visiting, into an integrated children’s service model in November 2014, aims to further enhance input and support available to families with a strong multi-agency focus. At the time of our review, it was too early to assess its impact but professionals were optimistic that families would have more rapid access to help in their local community.

1.13 Although health visitors and school nurses have recently been identified as link nurses for each GP practice, to date GPs across Stockport have been slow to build relationships with approximately 75% of GP practices not yet ensuring a school nurse is invited routinely to practice meetings. Where these links have been well secured and there is regular liaison between the health visitor, school nurse and the primary care practice, children are being safeguarded more effectively. We heard about several cases where, as a result of these strengthened links, there was prompt sharing and validation of information between the GP practice and the universal services involved, with risks quickly identified and actions taken to protect the children. (**Recommendation 1.15**)

1.14 School nurses undertake weekly sexual health and drop in clinics in the special schools as well as mainstream schools. This ensures equitable ease of access to sexual health advice and support tailored appropriately for specific cohorts as well as individual young people. The capacity of school nurses’ input into schools is being expanded as part of the developing Early Help offer.

1.15 Health visiting and school nursing files reviewed demonstrate that attendances of children at local emergency departments are routinely copied and recorded in patient records. This means that both teams have the most up to date information on health activity within a family. However, attendances both at Stepping Hill Hospital and at neighbouring hospitals for planned care are not communicated, meaning there is a significant gap in information exchange between acute and community services for families attending for specialist care. (**Recommendation 1.14**)

1.16 At Stepping Hill emergency department (ED) we saw case examples of good safeguarding risk assessment by ED clinicians. Appropriate referrals from ED staff to health visitors and notifications to GPs ensured prompt follow-up home visits in the community took place and support plans were developed for children and their families.

1.17 ED documentation for adult attendances does not include prompt questions to ensure practitioners are routinely considering children within the adult's household or with whom the adult has regular contact. The current risk assessment process governing adult ED attendances is over reliant on the knowledge, skill and awareness of the clinician to fully risk assess for any hidden harm risks to children and young people. The lack of prompt questions does not ensure a robust approach to ascertaining basic information about whether an adult is known to social care or what parental responsibility or contact with children they may have. Cases sampled in ED highlighted that practitioners treating adult attenders lack professional curiosity on occasions. There was no probing of the circumstances surrounding serious self-harm by the adult, and what impact this type of incident has had on children within the household. (**Recommendation 1.6**)

1.18 There is good acute hospital engagement with multi-agency risk assessment conference (MARAC) arrangements. ED practitioners make referrals to MARAC and the twice a month MARAC conferences are routinely attended by the specialist midwife and specialist safeguarding nurses. While input into the MARAC process by health practitioners is good, practitioners and managers told us that there is scope to strengthen the feeding back of information into the ED following MARAC to ensure staff are fully aware of families who may present at ED to support them most effectively.

1.19 GPs make excellent use of the electronic portal on the information system at Stepping Hill Hospital. The portal is checked daily giving the practice immediate information on adult and child patients attending ED, out-patients or hospital admissions. Where indicated, the GP practice administrator draws the attention of the duty doctor to individual cases which can be followed up promptly. This facilitates good health and wellbeing outcomes for children and families.

1.20 Young people have good access to sexual health services operated by the school nurses through school drop in and the “Central Youth” CASH service. These services are targeted at areas of highest need. “Central Youth” acts as a hub for a number of services including Mosaic substance misuse, specialist teenage pregnancy midwife and FNP. Young people we met told us that they found these services easy to access, with kind and sensitive practitioners which encouraged them to seek out future support from the service as they need it. There is a good gender mix within the staff team facilitating the engagement of all young people from all communities. The services share information where risks are identified and work co-operatively with other services, including the looked-after child health team, multi agency sexual exploitation group (MASE) and children's social care, to ensure young people's safety.

1.21 Effective arrangements are in place to support young people who are involved with the Mosaic young person's substance misuse team and the adult drug and alcohol team. However ongoing joint work with children affected by parental substance misuse team as part of the “Think families” parenting programme has been hampered recently by staffing availability. This joined up approach to supporting children and young people ensures children and young people who are vulnerable due to their parent's substance misuse are supported in the longer term. **(Recommendation 2.2)**

1.22 We saw evidence of the drug and alcohol team liaising with health visitors and schools to help children of service users access support services. Think family is well embedded and where adults are identified as using drug and/or alcohol , thorough risk assessments are carried out routinely about parental/carer responsibilities and contact with children. This ensures that appropriate referrals can be made where potentially vulnerable children and young people are identified. Home visits are a routine offer for service users with children under 5. In cases examined we saw that case workers are routinely identifying potentially vulnerable children and young people in the care of /in contact with adult clients.

2. Children in need

2.1 The co-location of health and social care partners within the Stockport Supporting Families pathway brokers relationships between professional groups and leads to a more cohesive package of support being made available to families. Cases seen indicated reduced duplication of services by different teams and rapid responses to early intervention, meaning that children and young people who need support can access it quickly before reaching crisis point.

2.2 Where vulnerable children are subject to a team around the child process (TAC) there are not always clear and well co-ordinated plans in place and held on individual children's case records. This reduces team around the child practitioners to effectively monitor and track progress in cases,; identify where there is lack of progress, or assess if the level of intervention needs to change. In one of our tracked cases, several siblings in the family were being supported through a single plan, even though their needs were very different and one sibling had also become pregnant. No additional plan was in place to address the needs of the unborn. The lack of individualised child centred planning increases the risk that children's needs are not being met effectively. (**Recommendation 4.2**)

2.3 The pathway into a range of CAMHS services is well established with access being closely monitored and we saw case examples demonstrating that young people are benefitting from the therapeutic interventions offered. All young people experiencing mental health difficulties who are referred to CAMHS can expect to have an initial assessment which takes place within 10 -12 weeks. Of these, 94-96% of young people will then be offered CAMHS intervention. Where cases are referred for urgent assessment, two urgent assessment clinics are available six days per week to ensure children and young people can be seen quickly.

2.4 CAMHS have an effective on-call system ensuring that there is availability of CAMHS expertise seven days per week for assessment. Access to CAMHS assessments for young people attending Stepping Hill ED with mental health needs has improved significantly.

2.5 There is daily contact between CAMHS and the paediatric ward staff to ensure ongoing access to guidance on self-harm. This contributes to the ward's ability to develop robust care plans and care effectively for any young person admitted with mental health needs.

2.6 Where young people do require in-patient mental health treatment, this can usually be sourced in local provision enabling the young person to have ongoing support from their CAMHS practitioner. Specialist pathways for most disorders including eating disorders, Attention Deficit Hyperactivity Disorder (ADHD) and Autistic Spectrum Disorder (ASD) are in place to ensure appropriate interventions for young people with additional needs.

2.7 Positive work is being undertaken by CAMHS with local schools, to raise awareness about services to facilitate young people's engagement with early help mental health support. This avoids the need for higher levels of intervention or hospital admission. We saw and heard case examples where intervention by the In Reach Out Reach service had successfully prevented the need for an admission or facilitated early discharge back into the community.

2.8 In CAMHs and adult mental health, there is generally good communication and liaison with other professionals, including health visitors and specialist midwives. Joint visits involving adult mental health, health visitors, family support workers and social workers are undertaken as routine practice in cases managed under TAC and where children are subject to child protection plans. School nurses told us they felt that direct liaison with adult mental health could be strengthened further, to ensure they are fully aware of families' needs so they can best support children and young people. (**Recommendation 2.4**)

2.9 Mental health practitioners and managers are clear that relapse indicators and mental health wellbeing and contingency plans can be shared with other disciplines, with the client's permission. We saw supporting evidence of this practice in adult mental health case records. It is not clear, however, that this is routine and common practice; rather it may be down to the individual practitioner. Relapse indicators can be of significant help to health visitors who often have the most contact with new mothers, aiding their early identification of signs and symptoms of deteriorating mental health which may result in increased risks to the child.

2.10 The referral pathway into the children's substance misuse service, Mosaic which is now part of Integrated Children's Services, is well established and is reported by ED staff to work effectively. All under 18s identified at ED as having a substance misuse issue are referred to Mosaic via a cause for concern form to ensure they are supported.

A's mother is known to the substance misuse service and A regularly attends MOSAIC young people's support service as a child in need (TAC level 2). A's mother suffered a relapse and following an appointment with the drug and alcohol team whilst under the influence of alcohol was observed to get into the car with the intention to collect A from school. The substance misuse worker acted quickly to call the school and immediately made a referral to children's social care to ensure the case was stepped up to TAC 4 (child protection) and that A was safeguarded.

3. Child protection

3.1 Clear processes are in place to ensure midwives attend child protection conferences and we saw good compliance with this. There is more scope to develop and monitor the quality of reports and to ensure all relevant safeguarding paperwork is subsequently filed in the notes to ensure unborn babies needs are clearly identifiable by all staff. (**Recommendation 1.8**)

3.2 We have seen variable quality referrals to children's social care where health practitioners identify safeguarding concerns about children and young people. The use of CAF documentation is not aiding health practitioners in articulating the safeguarding risks to children clearly. To date, most health services aside from school nursing, are not routinely quality assuring referrals made to the multi agency safeguarding hub (MASH). Case examples reviewed in the ED did not set out clear reasons for the referral to MASH, what the actual risks of harm to the child were and what was the referrer's expectation of children's social care.

3.3 Most services routinely use CAF documentation to make referrals to children's social care where they have identified safeguarding concerns. Many practitioners told us that they do not find the documentation helpful in setting out clear, good quality referrals. In one case reviewed where the adult mental health practitioner had made the latest referral to the MASH via e-mail, this did state clearly that the practitioner had evidence of neglect of the children and supplied detailed supporting evidence. Although referrals had been made previously in this case using CAF documentation, they had been judged not to meet the threshold for intervention.

3.4 Practitioners within ED are being encouraged to use the ROPE (reason, observation, plan, evaluation) model as guidance for their completion of referrals to children's social care. This is beginning to be used and also forms the basis for discussion in the ED group supervision sessions. Managers in the ED acknowledge that they could make better use of this to help practitioners develop their skills in making good quality referrals.

3.5 Health visitors and school nurses are well engaged with formal child protection measures and prioritise attendance at case conferences. Practitioners we met felt confident in their ability to challenge conference decisions if they disagree. In one case example the school nurse had recorded her dissent from the conference decision in the case record and told us that if the formal minutes did not reflect this, then she would ask for their amendment.

One case sampled illustrated good collaborative working between health visiting teams and specialist provision for parents with mental health issues. Family C had experienced domestic violence and parental mental health issues. Child T was under a child protection plan and receiving high levels of support from the health visitor. The family were re- housed to a different area and the new health visitor completed joint visits with the previous health visitor to ensure seamless transition and that the family's complex needs would continue to be supported effectively. T's mother's mental health deteriorated after the move, and she was placed in a mother and baby unit outside the area. The health visitor continued to visit the family regularly whilst in the specialist unit and provided the enhanced healthy child programme in that setting. The aim of this was that when the family moved back to the local community, sustained relationships with the local health team would ensure that the mother felt supported by professionals with whom she was familiar. Child T is now no longer on a child protection plan but continues to be well supported by universal services.

3.6 Frontline mental health practitioners are routinely involved in strategy meetings where child protection concerns have been identified. CAMHS is well linked into local multi agency sexual exploitation work; routinely attend meetings and there is discussion of high risk cases in the weekly CAMHS team meeting. Although there is not currently a specialist service in place to support young people who have been victims of CSE, a pilot therapeutic service is to be launched imminently in a partnership with a third sector provider. This is a positive development to support a specific cohort of highly vulnerable young people.

3.7 There is a clear expectation among Pennine services including CAMHS, adult mental health and adult substance misuse managers and practitioners that they will be members of child protection core groups and attend child protection conferences routinely. Cover is arranged or reports submitted if the key practitioner cannot attend to ensure their contribution is included in the decision making process to best support vulnerable children and young people.

3.8 In both adult and child mental health services there was no evidence of child protection plans and conference minutes being routinely secured on the case record. There was not clear recorded evidence that practitioners had chased these up or escalated to managers if they had not been received. Without immediate access to child protection plans and documentation, the practitioner cannot be fully informed of their role in monitoring whether the parent is compliant with the child protection plan. The absence of this key documentation also undermines the effectiveness of the zoning model ¹ being applied to adult mental health service delivery.
(Recommendation 2.1)

3.9 GP surgeries we visited were not routinely attending child protection conferences and employed different methods in order to contribute. One practice routinely submitted a letter to child protection conferences setting out any contact the child and parent had had with the practice since the last conference and current treatment regimes. Another practice submitted letters to conference when they felt they had useful information. One case sampled highlighted the GPs observations of the interaction between parent and child during consultations. This is good safeguarding practice although the safeguarding lead GP acknowledged that this was not routine practice. There has been no exploration of alternative ways including the use of technology to develop GP participation in and contribution to child protection case conferences.**(Recommendation 3.2)**

3.10 Electronic records systems are in place in GP surgeries, including clear flags to alert staff to safeguarding concerns and children on child protection plans. One surgery included alerts for children whose parents had issues likely to impact on the wellbeing of their children such as mental health or substance misuse. This is good recording practice, enabling practitioners to be fully alerted to the potential vulnerabilities of the child and refer for additional support as necessary.

¹ zoning model in the adult mental health team ensures all team members and managers are aware of, and updated on high risk cases including those where there are child safeguarding or child protection issues

4. Looked after children

4.1 Initial health assessments (IHAs) are undertaken by appropriately qualified clinicians and when there are capacity pressures created by influxes of children coming into care, additional clinics can be scheduled to facilitate the timeliness of assessments.

4.2 Initial health assessments reviewed were basic in nature, setting out minimum information and demonstrating little evidence of the voice of the child or sense of the young person as an individual. Written information did not focus on the child's perspective or experience. (**Recommendation 1.2**)

4.3 In exceptional circumstances, for very hard to engage older children, the looked-after children's nurse has undertaken IHAs. The rationale of this has been well considered and documented and the nurse's assessment has been under the supervision and oversight of the designated doctor.

4.4 For the most part, the reason for a child coming into care and the legal status of the child was included by children's social care, but there was often minimal, if any, parental health history or child's birth history included in the IHA. The lack of this information being gathered and conveyed to health at the point of the initial health assessment can result in the child never having that information; this can have a long-reaching, negative impact on the looked-after child as they leave care and enter adult hood. (**Recommendation 1.19**)

4.5 Recent changes to the IHA clinics has resulted in additional capacity for the looked-after children's nurse who is now able to spend time gathering additional information; part populating the documentation and developing the health plans based on the consultant's assessment. We also heard about cases where the looked-after children's nurse had worked closely and constructively with other health and social care professionals, including residential staff, to support vulnerable placements and find creative solutions to ensure young people's high priority health needs were addressed.

An 18 year old female care leaver was frequently experiencing mental health crises and accessing the mental health crisis team on many occasions. Although the young person was living outside Stockport in a nearby local authority area, the looked-after children's nurse visited her on several occasions, being a stable source of support for the young woman whose life was often chaotic, including a volatile relationship with her birth mother.

The looked-after children's nurse liaised well with the named and specialist nurses for safeguarding and the young person's social worker. This case demonstrates the commitment and willingness of the looked-after children's nurse to work creatively and effectively with other services to the benefit of hard to engage young people.

4.6 We saw an example of an IHA undertaken for an unaccompanied asylum seeker. An interpreter had been arranged and there was good attention paid to the cultural, language and religious needs of the young person and how these might impact of the young person's health needs and how they are. A prompt follow-up by the nurse ensured the young person had a hearing check. However, the information set out in the IHA was basic and showed little consideration of the impact of the young person's experiences as an asylum seeker on their wellbeing and emotional health.

4.7 Overall the quality of review health assessments (RHA) was good, with evidence that practitioners had taken time to build a rapport with the child and encourage the child to enter into a discussion about their health and wellbeing. In some cases however, it was clear that the response of the child had been interpreted rather than the assessment documentation reflecting the actual voice and personality of the young person. In case examples where the health professional quoted the child, the sense of the child as an individual was evidenced more strongly.

4.8 Most health plans reviewed were SMART although there were some where it was difficult to track progress and timescales and accountabilities were not always clear. There is a lack of cohesion and carry over in planning, particularly between health assessments. Cases sampled highlighted the episodic nature of assessments, ongoing targets that had not been actioned and limited follow up to monitor children's progress. There is a lack of assurance that looked after children and young people's needs are being met in a timely manner (**Recommendation 1.4**)

4.9 Young people have some choices about where they have their RHA and the looked-after child nurses are able to offer some flexibility about location and time of day to suit the needs and wishes of the young person; for example one young person had their RHA at the factory where they worked, with the permission of their employer so that they did not have to take time off work. However, children and young people of school age continue to be seen for their assessment in school, despite having given feedback that they would prefer not to be seen in this way. (**Recommendation 1.5**)

4.10 There is an expectation that the lead health professional involved with a looked-after child will attend the statutory looked-after child review or send a brief report. While CAMHS practitioners do send progress reports in the form of letters to inform the statutory review, the review health assessment is not informed in the same way. CAMHS do not routinely submit progress reports to the looked-after child health team. As a result, the RHA is not a fully informed assessment and the opportunity to review the emotional needs of the child as part of their overall health assessment is lost. (**Recommendation 2.5**)

4.11 Strengths and difficulties questionnaires (SDQs) are not generally informing RHAs. SDQs are often being given to the foster care at the time of the RHA rather than in advance in order that the SDQ can inform the review. As a result of this, the opportunity for the young person to engage with the SDQ is missing within the health review and the opportunity to track their own emotional growth is lost.. School nurses routinely facilitate young people undertaking a wellbeing self-assessment and there is scope to utilise this to a greater degree as part of the health review. Most health practitioners told us that although they routinely receive the SDQ score for the young person, it is unclear how the overall score is made up and its use in informing the RHA is very limited. Although work has been undertaken to develop the provision and analysis of SDQs, the current SDQ arrangements are not fully contributing to the provision of healthcare of looked-after children.

(Recommendation 1.21)

4.12 Looked-after children, along with families on low income, benefit from the “leisure key” which entitles them to discounts at local authority sport and leisure facilities. This encourages young people to engage in healthy leisure activities and promotes good health and wellbeing.

4.13 There is no commissioned health support to care leavers beyond 18 years. In some exceptional circumstances and dependant on service capacity, the looked-after child health team do offer some extended support to individual young people who they feel are at risk or who have specific needs that would benefit from longer term support.

4.14 The health offer to care leavers is being developed positively. Young people are issued with a “My health” booklet which contains generic health service information and local service details as well as personalised health information and their immunisation record.

4.15 Older looked-after children and care leavers are very well supported by the weekly “Café Zest” run by Pure Insight. Young people we met with attended this regularly and told us that they valued the opportunity to come to a “safe” environment where they could immediately access health and daily living advice in a non-judgemental setting. Care leavers who are young mums told us how they value being able to meet the designated looked-after child nurse every week at the café to get parenting advice and reassurance from a trusted health professional. It is clear that this service provides effective early help support for vulnerable young people as they are entering adulthood which they regard as essential. We heard about one care leaver with frequent attendances at ED for serious self-harm who, since accessing the mentoring service operated by Pure Insight, had not attended ED and had not required intervention from the crisis mental health team.

4.16 A specialist CAMHS service for looked-after children (KITE) is available for local children in care up to the age of 18 although the service is not available to looked-after children who are living in Stockport but under the care of another local authority. KITE provides support to foster carers, residential care staff and looked-after children where placements are at risk of breaking down. Although KITE do report into statutory looked-after child reviews, there is no routine submission of progress briefings or reports to inform the young people' review health assessments and this is a gap. (**Recommendation 2.8**)

4.17 A new group for young people called "Living life to the Full" is operated by KITE. Sessions run for 6-8 weeks offering a good opportunity for looked-after children to meet with peers, develop social interaction skills and build their emotional resilience.

4.18 GPs are not actively contributing to the IHA or RHA process, meaning that not all health professionals involved with a young person are fully versed with their most up to date health issues, leading to a risk that there may be ongoing unmet areas of need. (**Recommendation 1.22**)

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 Other than the strong leadership, advice, support and guidance given by the designated nurse, the cohort of Stockport GPs lack leadership on child safeguarding. The absence of a named GP role for the area is contributing to this lack of focused drive and expectation setting in primary care. One GP we met with was unable to name the designated doctor and we did not see evidence of the impact of this role. The lack of a local agreement between NHS England area team and the CCG about how GP safeguarding will be taken forward and supported contributes to the slow progress in ensuring effective primary care safeguarding arrangements. (**Recommendation 3.3**)

5.1.2 All under 16 year old presentations to the ED) and those 16-18 year olds where safeguarding concerns have been highlighted are reviewed daily (Monday-Friday) by the paediatric liaison health visitor role to ensure that all vulnerabilities and safeguarding risks to children have been identified and acted upon appropriately. This is good practice.

5.1.3 Written feedback notes on the quality of safeguarding practice or completion of cause for concern forms are routinely given back to ED practitioners. This helps to promptly address any sub-optimal practice and facilitates an ethos of continuous improvement across the ED staff team.

5.1.4 The social care manager for the out of hours emergency duty team (EDT) is expected to attend the monthly ED liaison meeting to discuss common issues and ensure effective ongoing communication and information sharing between ED and the EDT team and this is a positive development. However, recently this attendance has become less consistent. As a result, there is a risk that the positive and co-operative communication developed across this interface between key out of hours services may not be sustained.

5.1.5 It is hospital policy at Stepping Hill to ensure that there is a paediatric trained nurse on every shift in the ED in line with best practice. Currently, while there are two paediatric trained ED nurses on maternity leave, interim cover arrangements have been put in place to ensure paediatric nurse cover at certain periods when children are most likely to attend the ED. This is not in accordance with intercollegiate standards. (**Recommendation 1.26**)

5.1.6 Monthly meetings between the ED and CAMHS have facilitated more cohesive working since the 2012 SLAC inspection. A CAMHS representative periodically attends ED group supervision enabling mutual understanding between the services to continue to be developed in a positive way. These are established forums through which inter-service difficulties can be promptly addressed and resolved. In response to ED staff requests, CAMHS are developing prompt questions and guidance for ED staff to further strengthen practitioners' assessment of young people's mental health.

5.1.7 The Stepping Hill Hospital IT system includes a portal into GP record systems allowing hospital clinicians to promptly clarify current prescriptions and any recent contact with primary care. This system covers about 80% of Stockport GPs currently and is a positive development in ensuring health professionals are informed and can comprehensively risk assess when children and their families present for hospital care.

5.1.8 Developing improved access to KITE support for young people has been identified as an area for improvement with scope to address this being increased since KITE was moved into Pennine services a year ago. Plans are in place for CAMHS to be part of the integrated children's services model from Spring 2015 which should facilitate increasingly seamless working to the benefit of young people. The five year CAMHS strategy is in the process of being updated and the service development priority is to integrate service tiers two and three. This aims to deliver a more robust service continuum for young people and ensure young people's mental health needs are met quickly and appropriately.

5.1.9 There is no formal jointly agreed professional disagreement or escalation policy in place for CAMHS and adult mental health practitioners. Any professional differences or potential escalation issues are resolved generally according to custom and practice. The lack of an agreed framework to support practitioners across service interfaces may make it difficult for health practitioners to dissent in formal child protection processes. Whereas most practitioners we met told us they felt confident in raising disagreement at case conferences, they and managers were aware of practitioners who may lack confidence in doing this. **(Recommendation 2.6)**

5.1.10 The zoning model operating in the adult mental health team ensures that all team members and managers are aware of high risk cases including those where there are child safeguarding or child protection issues. This increases the strength of support to the family and enables other professionals to be able to access knowledge and expertise from the adult mental health team about the case at all times. The introduction of an electronic recording system across adult mental health should facilitate effective information sharing to the benefit of vulnerable adults and children.

5.1.11 There are limited arrangements in place either at an organisational or systems level for joint working between the substance misuse team and midwifery services to ensure unborn babies are effectively safeguarded. Whilst we saw some good work on individual cases, there is an opportunity to develop more sustained multi-disciplinary working. In general across Stockport, we saw some strong collaborative working however this was not necessarily underpinned organisationally, but tended to be built on long standing interpersonal relationships at an individual practitioner level.

5.1.12 Health visiting and school nursing case records reviewed were of a variable quality with some detailed information about intervention and liaison with other agencies. We did review some records where the chronology of significant events paperwork was being utilised as a running record and often entries in the main body of the notes were therefore missing or incomplete. Although the use of ROPE for note writing is embedded as a service expectation, there is more work to do to develop the evaluation and analysis sections rather than records of contacts consisting of lists of descriptive tasks. This would ensure drift in cases is more easily recognised and would allow practitioners to be more outcome focused, helping them to see when they have achieved success in cases. **(Recommendation 1.3)**

5.1.13 Practitioners across all Pennine care teams prioritise the safeguarding needs of children in their day to day work. Although adult mental health has not formally adopted or trained on a Think Family model, these principles are underpinning the development of child safeguarding practice. Practitioners understand the need to prioritise the safeguarding of children while working with the adult and risk assessment documentation includes identifying children with whom the client has contact as well as those for whom they have parental responsibility.

5.1.14 In order to ensure services learn from serious incidents and that practice is subject to continuous improvement, a multi-agency learning review panel has been established chaired by the Local Authority Head of Children's services. Health managers we met with viewed this as an important learning forum.

5.2 Governance

5.2.1 Quality assurance processes for both IHAs and RHAs are underdeveloped. There is no robust quality assurance process in place for initial health assessments. Whereas the looked-after child nurses undertake some quality assurance of RHAs, signing off those they have audited, the quality assurance tool the service has developed is based on the BAAF documentation rather than the latest NICE Guidance on the Health & Wellbeing of looked-after children. (**Recommendation 1.1**)

5.2.2 The looked-after children's health team operates a database which contains basic performance data and key points from individual child's health plans. It is not clear that the database has been developed to best support effective governance of the timeliness of IHAs and RHAs as it does not identify when children's RHAs are due; rather, there is a reliance on this being triggered by the social worker. Performance on timeliness of IHAs and RHAs is reported quarterly to the CCG.

5.2.3 The foundation trust reported that regular audits by operational managers and members of the trust's safeguarding team are in place to quality assure case recording. We did not see evidence of case record auditing or a robust approach to ensuring good, consistent case record management across services and practitioners we met with described activity and actions which were not recorded in the case record.

5.2.4 While there are multi-agency learning days arranged to disseminate lessons learnt from serious incidents, there is evidence from recent audits undertaken by the foundation trust named nurse that improvements to practice as a result of lessons learnt are not yet embedded. An example of this being that in cases where the TAC is led by health, minutes of TAC meetings should be sent to GPs. The recent audit demonstrated that there is currently only 50% compliance with this expectation. (**Recommendation 1.23**)

5.2.5 Practitioners new to the community health teams such as health visitors and school nurses have not all had training on the ROPE recording model and our reviews of case records show that the application of the model is not yet embedded. While chronologies are routinely used by school nurses, practitioners are not always clear on what should be included in these and events recorded in the chronology are not always recorded along with more detail in the main running record. It is not clear that there is sufficiently robust case record management and governance arrangements in place. (**Recommendation 1.24**)

5.2.6 The Stockport wide use of the CAF format has had a positive impact on ensuring comprehensive assessments are undertaken and in some areas we saw some excellent planning with clear goals and outcomes in some cases. However, despite recent audits, many files we sampled highlighted the ongoing inconsistency with reference to details and articulation of risk and impact to children and young people. Managerial oversight and monitoring of CAFs and case recording is not fully embedded to ensure consistent risk analysis and that multi-agency practice to support vulnerable children and families is effective. **(Recommendation 4.3)**

5.2.7 The recent revision to risk assessment documentation at Central Youth CASH service has significantly strengthened safeguarding assessment, resulting in almost double the weekly rate of safeguarding referrals being made by the team.

5.2.8 While there is expertise in the CASH service about FGM, this is not included in the list of vulnerabilities the service encompasses in its risk assessments. The new risk assessment proforma does not include consideration of FGM or prompt questions when young people who may be from a higher risk cohort accesses the Central Youth service. Given that there may be young people at risk of FGM accessing sexual health services, this is a gap. **(Recommendation 1.27)**

5.2.9 Multi agency safeguarding arrangements as part of the Stockport supporting families' pathway are effective in ensuring joined up working between agencies and health disciplines to achieve best outcomes for children, young people and their families. The use of the team around the child system (TAC) at levels one (early help), two and three (child in need) and four (child protection) ensures focus on who is the best professional to take the lead in supporting the family's needs. Rigorous follow up of professional's actions within 20 working days of referrals, alongside accountability and evaluation is built into the system. Regular update points are scheduled to ensure families are benefitting from the types of support being offered with changes made if necessary. This ensures health and social care activity is clearly targeted and outcome driven.

5.2.10 Information regarding children and young people who are vulnerable as a result of their parent's substance misuse is clearly recorded in a separate part of the drug and alcohol team notes and is easily identifiable on blue paper. Children's details and pertinent information is updated regularly and robust management oversight is in place to ensure ongoing risk assessment. Updates are discussed with a team leader on a regular basis as part of the "TOPS monitoring" and flow and continuation meetings process. This ensures practitioners working with adults who have contact with children are fully focused on the child's needs.

5.2.11 There is an area for development across most health services in the quality of safeguarding referrals made to children's social care. Quality assurance processes in relation to safeguarding referrals to children's social care are underdeveloped. Referrals seen do not set out the risks of harm to the child with sufficient clarity, consisting mainly of a chronology of events or digest of contact records. **(Recommendation 4.1)**

5.3 Training and supervision

5.3.1 Pennine managers are clear that CAMHS and adult mental health practitioners are expected to undertake regular level 3 child safeguarding training, although the adult mental health practitioners we met were uncertain when they had last undertaken safeguarding training and one had not undertaken training at level 3. **(Recommendation 2.7)**

5.3.2 Whereas there is an expectation that non-clinical staff in the foundation trust such as receptionists will undertake level 2 safeguarding training within two months of them taking up post, some staff we spoke to had only undertaken level 1 e-learning. Given the receptionist's position and role in overseeing the waiting areas, particularly in ED, this may not be sufficient in equipping staff to discharge their safeguarding responsibilities. **(Recommendation 1.7)**

5.3.3 Action has been taken to strengthen supervision arrangements across health services. Safeguarding supervision champions have been identified in midwifery services and group supervision arrangements for midwives are being established, with plans to introduce safeguarding supervision as a key performance indicator as is in the case in other foundation trust services. Innovative group supervision arrangements are in place for ED staff at Stepping Hill. Twice monthly group supervision sessions are run in the ED seminar room with ED practitioners being expected to attend a minimum of 3 per year. This attendance is monitored closely by the safeguarding team and non-compliance with the minimum attendance is followed-up with individual practitioners. However, within some foundation trust services, we saw limited evidence of safeguarding supervision or action plans being recorded in notes, therefore the trust cannot assure itself of optimal outcomes currently as actions may not be followed up.

5.3.4 Appropriate arrangements are in place to ensure effective safeguarding and clinical supervision support to health practitioners in the newly created Integrated Children's Services teams for the first 12 months of this new model's operation at which time we understand, arrangements will be reviewed.

5.3.5 In CAMHS, where cases are discussed in supervision, a record of this and any decisions made is routinely noted in the client's case record. This is not routinely done in adult mental health however, although records of the daily zoning meeting discussions are kept on the client's electronic record and updated each time the case is discussed at the zoning meeting.

5.3.6 In the health visiting and school nurse service, each practitioner has one CAF document reviewed and quality assured at each individual supervision session. CAFs we saw in these services were good quality and highlighted enhanced practice by the team.

5.3.7 Following the 2012 SLAC inspection, a programme of training for health professionals undertaking review health assessments was delivered and as a result the quality of review health assessments has been improved. However, new staff coming into community services, including the continuing care nurses, who are undertaking review health assessments for looked-after children have not had access to specific training to understand the looked-after child process and their role within it. As a result, staff taking on these responsibilities since 2012 may not be fully equipped and supported to discharge these responsibilities. (**Recommendation 1.25**)

5.3.8 Where cases known to the substance misuse team (DAT) are discussed in professional supervision, even when the case identifies vulnerable children subject to child protection measures, the safeguarding discussion and actions/outcomes are not always recorded on the client records. Aside from adhoc on request supervision from the Pennine team, formal safeguarding supervision outside of professional clinical supervision is not currently available to staff in the DAT and would act as a forum for learning and case discussion around safeguarding to further improve practice. (**Recommendation 2.3**)

5.3.9 Training for GPs remains a significant challenge. Safeguarding GP leads we met attend the designated nurse's primary care update forum regularly and value the opportunity for information and discussions about cases which GP sometimes bring to the group. However, It was not clear that GPs are fully versed in child protection arrangements and processes such as section 47 enquiries. GPs in the surgeries we visited had undertaken level 2 safeguarding training only and this is not in line with statutory and intercollegiate guidance. In one practice the safeguarding lead doctor was undertaking level 3 training but this consists of online training only, again this is not in line with guidance or best practice with no face to face or multi-agency component. (**Recommendation 3.1**)

Recommendations

- 1. Stockport CCG and Stockport NHS Foundation Trust should ensure:**
 - 1.1 That a robust quality assurance process is established for initial and review health assessments
 - 1.2 That the observation, engagement and use of voice of the child is developed in initial health assessments
 - 1.3 That record keeping policies are clarified within health visitor and school nursing teams to ensure appropriate use of case notes, chronologies and ROPE methodology
 - 1.4 That actions from initial health assessments are reviewed routinely as part of next health assessment, with a process for monitoring follow up actions from health plans to ensure children and young people's needs are being met
 - 1.5 That service user involvement for children who are looked after is further developed established and monitored
 - 1.6 That paperwork used for adult attendances at emergency departments is modified to include prompt questions regarding any children at home
 - 1.7 That receptionist staff in ED are trained in safeguarding in line with trust policy
 - 1.8 That staff training and development is undertaken to drive up the quality of child protection reports in midwifery services
 - 1.9 That individual birth plans are established using a consistent format in midwifery notes
 - 1.10 That adherence to the DNA policy is monitored across midwifery practitioners to ensure there is not drift in cases due to lack of follow up
 - 1.11 That robust processes for liaison between maternity services and the adult substance misuse team is formally established
 - 1.12 That a definitive policy to include timescales is implemented for notification of vulnerabilities and completion of appropriate paperwork to named midwife
 - 1.13 That formal face to face liaison mechanisms are established between health visiting and maternity services

- 1.14 That information and outcomes of specialist planned care appointments is communicated to health visiting and school nursing services
- 1.15 That health visitors and school nurses attendance at GP safeguarding liaison meetings is prioritised
- 1.16 That domestic violence enquiries are made routinely by midwives throughout pregnancy and recording of this is monitored
- 1.17 That CAF forms completed in midwifery clearly articulate goals, outcomes and expected timescales
- 1.18 That a health policy on FGM is developed
- 1.19 That parental health history and child birth history is routinely collected by health professionals undertaking initial health assessments
- 1.20 That a formal process for midwifery liaison with GP's is established
- 1.21 That the use of SDQ's is developed to fully contribute to the provision of healthcare for children and young people who are looked after
- 1.22 That the LAC health team routinely request contributions from GPs for IHAs and RHAs
- 1.23 That learning and action points from serious incidents is audited to ensure improvements in practice are embedded
- 1.24 That case record management audits are established in community health teams to ensure the ROPE model of record keeping is further developed and monitored to ensure continual evaluation and thorough analysis in case notes
- 1.25 That a rolling programme of training for health professionals undertaking RHAs is established
- 1.26 That arrangements are established to ensure sufficient numbers of paediatric trained nurses are available to cover periods of absence within the emergency department in line with intercollegiate standards.
- 1.27 That the CASH team risk assessment proforma is modified to include FGM vulnerability.

2. Stockport CCG and Pennine Care NHS Foundation Trust should ensure

- 2.1 That practitioners in the CAMHs and AMH teams are proactive in their approach to ensuring attendance at child protection meetings and subsequent receipt of written plans, which are secured on client records
- 2.2 That staff availability is monitored to facilitate ongoing joint working between the Adult substance misuse team and MOSAIC team as part of the hidden harm Think family parenting programme
- 2.3 That formal safeguarding supervision arrangements are put in place for the adult substance misuse team
- 2.4 That liaison processes between the Adult mental health team and school nursing is developed
- 2.5 That the CAMHs team routinely contribute to RHAs
- 2.6 That a formal professional disagreement and escalation policy is established for CAMHs and Adult mental health teams
- 2.7 That level 3 safeguarding children training in Adult mental health and CAMHs teams is robustly monitored for compliance.
- 2.8 That the KITE team provide progress reports for review health assessments.

3. Stockport CCG and NHS England should ensure:

- 3.1 That level 3 safeguarding children training for GPs is developed in line with national guidance
- 3.2 That ways to develop GP participation and consistency in style of contribution to child protection conferences is explored and trialled across Stockport
- 3.3 that named GP arrangements for Stockport as part of the Greater Manchester strategy are finalised imminently

4. Stockport CCG, Stockport NHS Foundation Trust and Pennine Care NHS Foundation Trust should ensure :

- 4.1 That referrals to the MASH and CAF documentation clearly sets out the safeguarding risk to children and is quality assured with management oversight.
- 4.2 That all teams ensure team around the child plans are developed for each child within a family rather than one plan for a family, to ensure individual needs are effectively addressed

- 4.3 that audit arrangements are established for CAF assessment, impact of intervention and case recording across all teams and that audit findings and actions are regularly monitored to continually improve practice.
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Next steps

An action plan addressing the recommendations above is required from Stockport CCG within **20 working days** of receipt of this report.

Please submit your action plan to CQC through childrens-services-inspection@cqc.org.uk. The plan will be considered by the inspection team and progress will be followed up through CQC's regional compliance team.