

# **Review of health services for Children Looked After and Safeguarding in Lancashire**

## Children Looked After and Safeguarding The role of health services in Lancashire

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| <b>CCGs included:</b>  | NHS East Lancashire<br>NHS Greater Preston<br>NHS Chorley and South Ribble<br>NHS Lancashire North<br>NHS Fylde and Wyre<br>NHS West Lancashire   |
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## Summary of the review

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This report records the findings of the review of health services in safeguarding and looked after children services in Lancashire. 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 Lancashire's six Clinical Commissioning Groups (CCGs) and the NHS England North Area Team.

Where the findings relate to children and families in local authority areas other than Lancashire, 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.

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## About the review

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

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

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## How we carried out the review

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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 261 children and young people.

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## Context of the review

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Lancashire has a population of approximately 1,184,700 people, including 244,755 children and young people under the age of 18 years. Children and young people from minority ethnic groups comprise 13 per cent of all children living in the area, with most having an Asian or mixed heritage background. More than 170 different languages are spoken. Lancashire is a large and diverse area, comprising coastal, rural and urban communities, with areas of multiple deprivation and areas of affluence. The number of children eligible for and claiming free school meals is below the average for England.

The health and wellbeing of children in Lancashire overall is mixed, with some areas where levels of need and risk are significantly higher. Infant and child mortality rates are higher than the England average. The percentage of 3 year old children with dental decay is much higher, with high rates of admission to hospital for dental caries. Hospital admissions for children 0-14 years caused by unintentional and deliberate injuries are significantly higher. Rates of teenage conceptions (15-17 years of age) are also higher than the England average. Hospital admissions for alcohol, substance misuse and mental health conditions are high compared to England as a whole.

Six Clinical Commissioning Groups (CCGs) are responsible for planning and commissioning most local health services. These include NHS Chorley and South Ribble, NHS Greater Preston, NHS West Lancashire, NHS East Lancashire, NHS Fylde and Wyre and NHS Lancashire North. The Council and its CCGs have established strong commissioning and joint working arrangements with neighbouring councils and CCG's serving Blackpool and Blackburn with Darwen communities. Over 250 general practices operate in the area.

Four acute hospital trusts are located within Lancashire. These include:

- Lancashire Teaching Hospitals NHS Foundation Trust located within Central Lancashire, which also functions as a regional trauma centre;
- East Lancashire Hospitals NHS Trust serving the communities of East Lancashire and Blackburn with Darwen;
- University Hospitals of Morecambe Bay NHS Foundation Trust serving the communities of Lancashire North and the South Lakes area of Cumbria;
- Southport and Ormskirk Hospital NHS Trust serving West Lancashire from its hospital site in Ormskirk.

Local people, particularly those living within the Fylde and Wyre CCG locality also access services provided by Blackpool Teaching Hospitals NHS Foundation Trust. However, due to the scope of this inspection, only its community health services delivered within Lancashire were reviewed.

Health visiting, Family Nurse Partnership and school nursing services are commissioned by the Director of Public Health (Lancashire County Council) and provided by both Lancashire Care NHS Foundation Trust and Blackpool Teaching Hospitals NHS Foundation Trust.

Contraception and sexual health services (CASH) are commissioned by the Director of Public Health and provided by Lancashire Care NHS Foundation Trust (in partnership with a network of other small specialist providers) and by Blackpool Teaching Hospitals NHS Foundation Trust.

Young person's substance misuse services are commissioned by the Director of Public Health and provided by Young Addaction. Adult substance misuse services are also commissioned by the Director of Public Health and provided by CGL and partners- Inspire North Lancashire and Inspire East Lancashire, and by Discover (Greater Manchester West NHS Foundation Trust). In addition, CCGs commission alcohol liaison services which work closely with the acute hospitals in the area.

Child and Adolescent Mental Health Services (CAMHS) are jointly funded by the CCGs and Lancashire County Council. Services are provided by Lancashire Care NHS Foundation Trust and East Lancashire Hospitals NHS Trust. A Tier 2 service for Lancashire County Council's looked after children and post adoption support (SCAYT+) is commissioned by the Council. Local inpatient CAMHS (tier 4 provision) is commissioned by NHS England and provided by Lancashire Care NHS Foundation Trust. Adult mental health services are provided by Lancashire Care NHS Foundation Trust.

In June 2016, there were 1,564 children and young people were the subject of a child protection plan and 1,685 children were looked after by the local authority. In addition, 990 children were placed in Lancashire by other councils. Relatively small numbers of unaccompanied asylum-seeking children were in the care of the local authority. Strengths and difficulties questionnaire scores indicate young people in Lancashire who are looked after have better emotional and mental health compared to other areas. Fewer children who are looked after misuse substances.

The last CQC safeguarding and looked after children's inspection took place in 2012 as a joint inspection, with Ofsted. The overall effectiveness of the safeguarding services and capacity for improvement was judged as adequate. The outcomes for children looked after were judged as adequate. Progress against inspection recommendations have been considered in this review.

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## The report

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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.

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## What people told us

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We spoke to a father of a young boy attending Royal Lancaster Infirmary emergency department. He told us:

*“The service has been really good, much better than I expected. They spoke directly to my boy and have treated him like an individual. We’ve been told what is happening since we walked through the door and although the waiting area is not ideal, we have been able to wait in the little playroom”.*

A young person waiting to be seen at Royal Lancaster Infirmary emergency department told us:

*“It’s OK here. The nurse spoke to me and not my Mum. I like that because it makes you feel they are taking notice of you.”*

A young person we met during our visit to maternity services at Royal Lancaster Infirmary told us:

*“The teenage midwife taught me a lot about how to care properly for my baby. She’s been insistent at times, but it all makes sense to me now. She’s been really good. I’ve met my health visitor and I’m going to meet her again tomorrow. My midwife will be with me for a few weeks yet to make sure everything is okay”.*

A mother who had recently delivered her baby in Southport and Ormskirk Hospital told us:

*“They arranged for me to have an earlier scan as I had suffered two miscarriages before. I really appreciated this and it helped me to relax. My midwife told me about antenatal classes and breastfeeding support available at the local children’s centre. The midwives were fantastic and made everything right for me. I loved the support and they gave us ‘skin to skin’ contact straight away”.*

A young person we spoke to using the ELCAS service (CAMHS) provided by East Lancashire Hospitals Trust told us:

*"I wasn't in education before I started coming here. My anxiety was just too much. I have been attending education here four times a week (Burnley Hospital) and it is preparing me to go back full-time to school, hopefully in September. I also do cognitive behaviour therapy (CBT) which is really good. It teaches me coping and relaxation skills. My whole body used to ache with anxiety, but it's nowhere near as bad as it used to be. My keyworker is really nice and supportive and I reviewed my care plan with them yesterday. I know exactly what my plan is and have done so from the start. I'm feeling much more confident."*

A young person who had transitioned to adult mental health services at sixteen years of age told us:

*"I was admitted to a ward on two separate occasions. Both times to an adult ward which I didn't mind because I thought I was being listened to and my thoughts were important. Since I've been out of hospital I only see my consultant for a check of my medication. I don't feel like she is interested in me and what I'm thinking. It's like I'm just another patient she has to see, and not about the bad thoughts I might be having. It's just routine to her I guess. I came out of the last meeting feeling like I was just someone on her list and not a person or an individual."  
"I do feel better about myself now. I know my condition and what symptoms I need to look out for"*

A parent of a young person using Lancashire Care NHS Foundation Trust CAMHS provision told us of her experience of care and her recent involvement in work to improve local CAMHS services:

*"We have had involvement with CAMHS over several years at both tier three and tier four. Because of this we built up a pretty good working relationship with them although I still felt a little bit left out in the dark on occasion. However, overall they did keep me informed about what was going on. My child has made some good progress and the future is looking that bit more bright."*

*"We are definitely listened to. We meet every month and are currently spending time examining how the service might look in the future, such as the use of the different tier systems. We have also trained tier three staff in client participation, how better to involve parents and young people and how to think before they speak in a way that can be heard by us as inappropriate. It's a good group and we meet every month. I know it's worthwhile."*

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## The child's journey

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

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### 1. Early help

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- 1.1 We visited the emergency departments at Royal Preston, Royal Lancaster Infirmary and Ormskirk hospitals to review their systems for recognising the vulnerability of children. Two play practitioners worked in the emergency department and on the paediatric ward at Royal Lancaster Infirmary. They played a key role in observing children, young people and family interactions as well as providing distraction to children in distress.
- 1.2 We found the emergency care facilities at Royal Preston Hospital and Royal Lancashire Infirmary did not sufficiently support child safety. This was due to the layout of departments which prevented a clear view and monitoring by emergency department staff of people in the waiting room area. This risked impacting on their capacity to promptly identify a child with a rapidly deteriorating condition and did not provide sufficient oversight of adult- child interactions. (**Recommendation 13.1**)
- 1.3 The safeguarding activity of local NHS organisations was informed by a range of flowcharts, guidance and procedures to enable frontline health professionals promptly identify and report any concerns they had about the safety and wellbeing of children and young people. However local safeguarding practice seen in the emergency departments, the urgent care centre and minor injury unit did not consistently meet the required standards of practice in ensuring each child's presentation was underpinned by clear demographic information about the adult, their relationship to the child, and relevant other professionals involved in their care. Good information gathering at this early stage is important in helping understand what can sometimes be complex family relationships and situations where other professionals need to know about risks to the health or safety of children. (**Recommendation 11.1**)

- 1.4 The voice of the child was not sufficiently visible on some cases seen. Practice did not consistently demonstrate that safeguarding issues had been explored and that safeguarding tools had been effectively used to support analysis of risk. For example, Lancashire Teaching Hospitals had a safeguarding assessment that should be completed alongside the clinical record, but there was limited evidence that safeguarding issues had been considered or recorded using the required template. Adult admission documentation in use at Lancaster Royal Infirmary for children and young people did not include body mapping assessments to enable ongoing monitoring of injuries. In Ormskirk hospital, the care status of children had not been clearly identified. Gaps in safeguarding practice in areas such as these did not support effective recognition of the vulnerability of some children and young people. **(Recommendation 11.2)**
- 1.5 Good information sharing about pregnant women presenting at emergency departments was evident in the work of Lancashire Teaching Hospitals and University Hospitals of Morecambe Bay Trusts. However, midwives in East Lancashire Hospitals Trust did not routinely receive notifications from emergency departments of pregnant women. Although this Trust had guidance for admissions of pregnant women, this largely focused on medical risks and did not provide clear direction in response to the identification of safeguarding concerns. Routine notification of attendance would help strengthen the Trust's ongoing monitoring of vulnerable pregnant women. **(Recommendation 23.1)**
- 1.6 A new Urgent Care Centre recently opened in Chorley Hospital staffed by both Lancashire Teaching Hospitals and Lancashire Care NHS Foundation Trust staff. Current staffing arrangements do not include nurses trained in paediatric care, although it was estimated that 40 per cent of its users were children or young people. Most children and young people were promptly transferred to Royal Preston hospital if further assessment or treatment was required in line with previous protocols in use when the emergency department on the Chorley site was operational. The new service would benefit from an early review of its usage to determine the current need for on-site paediatric expertise. This includes the levels of paediatric immediate life support training that may be required by the existing workforce. **(Recommendation 9.1)**
- 1.7 The Urgent Care Centre had very good performance in seeing children and young people who attended in a timely manner. Weekly attendance by the independent domestic violence advisor (IDVA) provided positive support to people presenting with domestic abuse issues. However, its operational procedures required further development in a number of areas. These included a frequent attender policy, more in-depth checks of the circumstances and risks to children and young people up to 18 years of age who presented with injuries; and ensuring staff had child sexual exploitation (CSE) training given their role in the provision of emergency contraception. **(Recommendation 15.1)**

- 1.8 Not all case notes we reviewed at the Urgent Care Centre were signed, timed or dated, and the clinician's designation and grade was not clearly stated. Practice in this area did not comply with professional record-keeping standards or Trust guidance. (**Recommendation 15.2**)
- 1.9 Paediatric liaison in all the acute hospitals we visited in Lancashire was working well and provided good oversight of risks to young people 0-18 years. Health professionals undertaking this role provided an additional and important quality assurance check in ensuring concerns were appropriately addressed. Relevant community-based health professionals and GPs were informed in a timely manner about children's attendance and discharge. Emergency department attendances were appropriately followed up by health visitors and school nurses with children and their families on cases seen. This helped ensure children's needs continued to be met and that the opportunity to provide further support, where needed, was maximised.
- 1.10 All acute trusts visited had appropriate systems for tracking children and young people who left or were taken from the emergency department before they were seen.

#### **Good Practice: Targeted Early Help Work**

Following delivery of new babies, parents accessing Lancashire Teaching Hospital's maternity services are given information about the NSPCC's "*I Promise*" programme. Parents are encouraged to watch a DVD and have further discussion about their coping strategies for delivering good care to their new born baby. This evidence-based programme aims to raise awareness and reduce incidence of head injuries in babies.

Lancashire Teaching Hospitals employ a patient experience adviser to lead its Families and Babies project who provides early help to vulnerable children and families on its neo-natal and paediatric wards. The post-holder helps build parental capacity and is well placed to hear about family concerns and encourages parents to access additional support with matters such as domestic abuse, parental mental health or substance misuse within the home. The role also involves working closely with local Children's Centres to promote follow up support for young babies with complex needs or vulnerabilities.

- 1.11 Pregnant women have access to a variety of ways to book the birth of their children, including through self-referral or via their GP or a Children's Centre. Midwives share completed copies of family social needs assessments with GPs and health visitors. Communication and handover of care was appropriately managed on most cases seen. Health visitors received further notification of the pregnancy following the 20 week scan to enable planning for ante-natal contact.

- 1.12 In most cases seen, midwives routinely asked about low parental mood and anxiety, and promptly referred women on to specialist services where concerns about their emotional and mental wellbeing were increasing. Appropriate arrangements were in place in all Trusts that ensured prompt follow up of pregnant women who failed to attend appointments. Midwifery teams were working to improve processes for the identification of concealed pregnancies which had been a key factor in two recent serious case reviews in the area. Southport and Ormskirk Hospital Trust provided a comprehensive range of information that helped pregnant women know what to expect at each trimester and post-natally.
- 1.13 Health visitor electronic records of work undertaken by Blackpool Teaching Hospitals Trust denoted gaps in recording of essential checks of maternal well-being in areas such as domestic abuse or mental health. The transition to a new electronic system, whilst at the same time, going paperless, meant that key information about family circumstances was not easily available to inform the need for and provision of early help. (**Recommendation 24.1**). *This was also brought to the attention of the Director of Public Health as the commissioner of health visiting services.*
- 1.14 Gaps in the capacity of specialist mental health services to meet current demand required further monitoring, particularly in East Lancashire, as one of the women we tracked in this locality had been waiting over 14 weeks to be seen by a mental health consultant. (**Recommendation 10.1**)
- 1.15 The focus on and voice of the child was strong in Lancashire Care NHS Foundation Trust's 0-19 team. Records evidenced that professionals knew their families well. Families had good access to packages of support including motivational interviewing and perinatal mental health support with good outcomes in enabling risk reduction. Health visitors were trained to provide brief interventions around domestic violence and smoking amongst others.
- 1.16 Transfer-in visits were well-managed by frontline community health professionals which evidenced learning from a recent serious case review. Families with children under 5 were routinely visited by the health visitor who carried out a full family needs assessment and a health check on the children. This helped connect families to local support services and ensured any existing or emerging health needs were identified and appropriately met. However, some teams and localities did not have sufficient capacity to deliver the full Healthy Child Programme (HCP) offer. Performance in meeting antenatal contact targets was the area where most improvement was needed. Performance reviews, including exception reporting, were in place to enable monitoring of areas that fell below delivery targets. *These issues were brought to the attention of the Director of Public Health as the commissioner of health visiting services.*

- 1.17 Following the Ofsted inspection in November 2015, the focus and capacity of Lancashire Care's Children and Family Health Service 0-19 team had been re-prioritised given the need for assurance that risks to children were being managed at the appropriate level across the wider partnership. In excess of 2,300 children in need cases were jointly reviewed in the period up to March 2016. This led to a significant increase in child protection and looked after children activity that has directly impacted on the capacity of 0-19 team to provide early intervention to prevent escalation of problems. Interim arrangements had been agreed with the Director of Public Health to help manage urgent priorities, with the intention to progress delivery of the full early help offer at the earliest possible opportunity.
- 1.18 Both Lancashire Care and Blackpool Teaching Hospital's health visiting service delivered a weaning visit at home at 3-4 months. This helped promote better outcomes in the high impact areas of healthy weight and diet. We found, however, that the care pathway underpinning the delivery of ante natal contacts in work undertaken by Blackpool Teaching Hospital's team required further review to help refine local priorities. In one example seen, a mother with a history of depression and domestic abuse who was expecting her sixth baby had not been offered an antenatal contact. This was a missed opportunity to provide early intervention. *This was brought to the attention of the Director of Public Health as the commissioner of health visiting services.*
- 1.19 The engagement of midwives, health visitors and school nurses in delivering the Common Assessment Framework (CAF) related work was well-embedded and audited, with generally good support provided to the whole family to help strengthen parenting capacity and improve outcomes for children. For example work undertaken by a case holding midwife in East Lancashire Hospitals Trust with teenage parents was holistic, and took good account of the future needs of the unborn baby and of their parenting capacity. The action plan was SMART, and the midwife had appropriately referred the family to children's social care given the likely future need for additional support. In contrast, in another case, we saw disagreement between health professionals about the management of the lead professional role which resulted in an unacceptable delay in progressing early help for an older child.
- 1.20 School nurses employed by Lancashire Care NHS Foundation Trust provided a good universal offer, including full implementation of the National Child Measurement Programme at reception and year 6. School health needs questionnaires provided a clear picture of risks and of children's progress at years 6 and year 9. The school nursing service knew its schools and communities well, and demonstrated a good awareness of local priorities and of work required to improve child health outcomes. Each school had an annual health profile that included relevant public health data to inform the development of a clear, shared and accountable school health action plan.

- 1.21 The school nursing service delivered by Lancashire Care NHS Foundation Trust was creative and flexible in its approach to making best use of its capacity. Managers and frontline staff continuously sought new ways of working to support better engagement and outcomes for children and young people. 'Chathealth' was established earlier this year and provided an accessible young person-centred approach to health promotion. Text message exchange with a duty school nurse offered responsive and confidential health advice, with signposting to relevant services.
- 1.22 In one area, where drop-ins within the school had been poorly attended, provision was re-located to a local youth centre. Following the move, levels of take up of the school nursing service markedly improved. Drop-in arrangements in another area positively also included a service offered by Young Addaction which was helping to strengthen earlier identification of young people misusing drugs and alcohol.
- 1.23 Young Addaction offered a range of early intervention programmes to ensure children of parents who misused substances were well-supported. Help was also available for parents and siblings of young people with addictions who would not engage with the service. In one case seen, this led to a family being effectively supported to manage threatening behaviour by a young person who wanted money to buy drugs. The young person was invited to group intervention for perpetrators of domestic abuse known as HEART (helping end abusive relationships in teens). As a consequence, the violence and substance misuse stopped.
- 1.24 School nurses provided emotional health support (at tier 2 CAMHS level) but this was not secured by a standard package of care, with some schools commissioning additional support. This had led to complexity in the management and governance of local care pathways, and risked promoting inequity in access to services. School nurses thought their practice would benefit from further training to help build their confidence and expertise in the use of relevant mental health assessment tools. They also welcomed plans in progress to improve access to consultation and supervision from CAMHS. *This was brought to the attention of the Director of Public Health as the commissioner of school nursing services*
- 1.25 School nurses had received online training for child sexual exploitation (CSE) and had good links with the specialist CSE nurses working in the multi-disciplinary locality teams. However, although the school nursing specification refers to expected use of relevant assessment tools, we found safeguarding practice and professional confidence in the recognition of and support for young people at risk of CSE was not fully embedded. This was an area to strengthen in enabling improved identification and support for young people whose needs fell below the levels of risk managed by the CSE specialist nurses. (**Recommendation 8.1**). *This was also brought to the attention of the Director of Public Health as the commissioner of school nursing services.*

- 1.26 Every GP practice in Lancashire had a named link health visitor. However, formal communication and liaison between GP practices and community health services in safeguarding children and vulnerable families was not well-developed in some localities. In one GP practice whilst there was an open invitation for midwives and health visitors to contribute to daily 'after surgery' meetings or the monthly clinician's meetings, their participation was limited. When such joint meetings took place, the practice did not keep records of the discussion of individual cases. The absence of such arrangements made it difficult for them to monitor any emerging concerns about vulnerable children. (**Recommendations 4.1, 4.3**)
- 1.27 The health visitor in another GP practice attended the surgery on a monthly basis and routinely discussed any children of concern on their caseload. The lead GP in this practice also reported good links with the adult mental health team who shared plans of care with them. This practice also hosted a joint weekly clinic run in partnership with the CGL Inspire substance misuse service enabling a strong shared approach to the management of recovery plans. All relevant professionals were kept well-informed about child safeguarding concerns and progress on a regular basis.

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## 2. Children in need

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- 2.1 A Family Nurse Partnership (FNP) had been recently established to support first time expectant young women under 20 years of age in two localities in Lancashire. Although there have not yet been any graduates, a recent review of the service found good outcomes including mothers stopping smoking, increased breastfeeding rates and uptake of contraception post-birth. This, alongside a very low attrition rate of young women disengaging was positive and formed a central strand of the area's strategy to reduce teenage pregnancy rates and to promote better life chances for young women and their babies.
- 2.2 All NHS Trusts in the area had recently reviewed and strengthened their domestic abuse policies and practice to support learning from serious case reviews. Notifications of domestic abuse incidents involving pregnant women via the MASH were promptly shared with relevant safeguarding staff in community and acute trusts. Health safeguarding professionals engaged well in the work of multi- agency risk assessment conferences (MARAC) and ensured frontline professionals were aware of decisions and agreed actions. We found positive promotion of the work of independent domestic violence advisors (IDVAs) in targeted work to help reduce risks of harm to women and their children.
- 2.3 University Hospitals of Morecambe Bay Trust's arrangements for the identification and monitoring of risks of domestic abuse were not sufficiently strong on midwifery case records seen in Royal Lancaster Infirmary. Most women were asked just once during pregnancy about domestic abuse despite prompts being in place for the question to be asked more often. Further work was required to embed practice in line with guidance so that women were routinely seen alone and were asked on more than one occasion about domestic abuse. (**Recommendation 19.1**)
- 2.4 Midwifery case records seen in Southport and Ormskirk Hospital Trust provided clear information about family and social circumstances including ethnicity and partners details. However, women were not being routinely asked about domestic abuse. The Trust carried out an audit approximately a year ago to establish the frequency of questioning, and found that this needed improvement. Changes were made to the process and expectant women were now being advised that for the first 15 minutes of the appointment they would be seen alone. However, these safeguards had not been consistently implemented on cases seen. (**Recommendation 19.1**)

- 2.5 Lancashire had relatively high numbers of children and young people who were missing from school (estimated at 1,000). When individual missing children were brought to the attention of school nurses; they ensured the young person was safe and well. However, school nurses were not being proactively informed about these children. Further work was required to ensure all schools recognised the importance of sharing this data. *We brought to the attention of the Director of Public Health as the commissioner of school nursing services.*
- 2.6 We saw exemplary practice by a Lancashire Care NHS Foundation Trust school nurse in the East of Lancashire working with a young person and their family where the root causes of their absence including significant deterioration in their mental health were not clear. This was one of many examples of holistic and effective work undertaken by school nurses across Lancashire in meeting a diverse range of needs. Cases we reviewed indicated purposeful and strong engagement by school nurses with most partner agencies, young people and their families.
- 2.7 Different service providers were responsible for the delivery of sexual health services in Lancashire, with some recent changes to contractual arrangements. Lancashire Care NHS Foundation Trust in partnership with Brook took the lead in young person's contraception and sexual health provision, with Blackpool Teaching Hospital's Trust leading the delivery of 'all age' provision. Children discussed at the multi-agency CSE meetings (MACSE) from Fylde and Wyre and Lancashire North were identified on Blackpool Teaching Hospital's sexual health database. However, this information sharing process was not yet embedded in the work of sexual health providers operating in Central and East Lancashire. **(Recommendation 16.1)**. *These issues were also brought to the attention of the Director of Public Health as the commissioner for integrated sexual health services.*
- 2.8 Case records seen of the work undertaken by the specialist young person's sexual health services demonstrated appropriate management of risk and tracking of outcomes for young people known to be at high risk of CSE. Children under the age of 13 years engaged in sexual activity were promptly referred to children's social care. Young people were recalled for further appointments when they did not attend for follow up care and treatment. All children and young people under the age of 16 were risk assessed.

- 2.9 However, we found recording of the voice of the child, analysis of emerging concerns and follow up of the outcomes of referrals to children's social care were not well-evidenced on some CASH and GUM records held by both lead providers. This included variable practice in the quality of checks made, recognition of the vulnerability of some young people, including those aged 16-18 years, and those with emotional and mental health needs. Whilst checks for Fraser competence were evidenced on genito-urinary medicine (GUM) records, further enquiry about risks of CSE was limited. **(Recommendation 16.2)**. *These issues were also brought to the attention of the Director of Public Health as the commissioner for integrated sexual health services.*
- 2.10 Three multi-agency CSE teams operated within Lancashire whose caseloads comprised young people at high risk of CSE. The specialist nurses worked effectively alongside team colleagues and with wider networks of community health professionals in shared work to protect young people and identify perpetrators. Assessments completed by CSE nurses were comprehensive and were regularly reviewed. Nurses were sensitive and persistent in their approach to engaging with and building the trust of young people. The voice of the young person actively shaped interventions and was captured well in case recording.
- 2.11 Young people in Lancashire with self-harming behaviour or mental health needs did not consistently benefit from a timely and holistic response to their needs, with young people transitioning to adult mental health services at 16 years of age. We heard that some young people refused to engage with adult services and, as such, there remains a risk that young people aged 16 to 18 may not receive the level of ongoing care and support they require. We were not assured that adult mental health practitioners could provide the full range of therapeutic interventions, including joint work with wider family members. **(Recommendation 3.1)**
- 2.12 Young people with mental health needs continue to be admitted onto paediatric wards in the absence of robust alternatives to support them at home. This reflected the legacy of disjointed commissioning with limited access to out-of-hours crisis teams in some localities. Environmental risk assessments were undertaken to promote their safety whilst on the ward. In some cases, they remained on paediatric wards for several weeks due to the lack of timely access to appropriate alternative step-down support or in-patient provision. Paediatric ward staff highlighted gaps in their training that contributed to a lack of confidence and expertise in delivering care to young people with complex or fluctuating mental health needs; with limited back up from specialist mental health professionals in some cases. In addition, some young people continued to be placed in specialist in-patient provision (tier 4) some distance away from home. **(Recommendation 2.1)**

- 2.13 Safeguarding leads in Lancashire Teaching Hospitals Trust were vigilant to concerns about young people aged 16-18 years presenting with deliberate self-harm or complex health needs and disabilities. The Trust was undertaking further work with partner agencies to promote person-centred care and improve recognition of equality and diversity. Access to CAMHS out-of-hours at Royal Preston hospital had recently been secured which aimed to help achieve safe and timely follow up of young people medically fit to be discharged.
- 2.14 In the last twelve months CQC was notified by Lancashire providers on nine occasions only that due to lack of available local provision, young people had been admitted onto adult psychiatric wards. This seemed to be a relatively low number given the current pressures on CAMHS in an area the size of Lancashire. (**Recommendation 3.2**)
- 2.15 Waiting times for access to CAMHS tier 3 services were variable with marked differences in the timeliness of initial response between the two main providers. Lancashire Care's waiting times for initial assessment following referral varied between teams, and averaged 15 weeks at the time of our visit. If accepted into the service, children and young people were then seen for a first appointment within a target time of two days in urgent cases, and within two weeks in other cases. In records seen, these targets were mostly adhered to with only minimal drift. Children and young people referred into ELCAS (ELFT provision), however, only had to wait for the target time of two weeks for an assessment to be undertaken. In records examined, we saw that young people were assessed within the target timescales. Those who required ongoing therapeutic support were offered this at the earliest possible opportunity. (**Recommendation 3.1**)
- 2.16 Screening and assessment activity undertaken by CAMHS practitioners was comprehensive and included appropriate information about young people's needs and requirements for therapeutic intervention. In one case seen, where a parent whose first language was not English and whose child's health needs were severe and complex, the school nurse sensitively worked with them to complete the strengths and difficulties questionnaire (SDQ) to help inform their therapeutic intervention. Good information sharing and communication between CAMHS and the school nursing service was embedded in this locality. However, inconsistencies in care pathways and clinical practice were evident not only between the two main providers, but between localities served by Lancashire Care NHS Foundation Trust's teams. Variable approaches to the use of risk assessments and care plans, paper and electronic records detracted from the delivery of equitable and young person-focused practice. (**Recommendation 18.1**)
- 2.17 In work undertaken by the ELCAS team, we saw examples of creative approaches with young people with mental health needs that led to positive outcomes for them.

**Good Practice: Holistic approach to meeting young people's mental health needs**

East Lancashire Hospitals Trust provided a range of services to children and young people at risk of admission to a tier 4 in-patient service. The modern, spacious and well equipped unit at Burnley Hospital provided a number of therapy, relaxation, mindfulness and education rooms where practitioners could meet young people either individually or in groups. Teachers also attended to provide education for those young people not attending school or who had poor attendance; enabling the development of a combined education and health package of support. This helped young people remain in education and prepared them to return to full-time education as their therapy progressed.

- 2.18 Group work was effectively used by Lancashire Care NHS Foundation Trust's CAMHS teams to help strengthen the resilience and coping capacity of young people and their parents. These included a dialectical behaviour therapy skills group, an anxiety group and a 'Cygnel' parenting support programme for parents and carers of children and young people with a diagnosis of an autistic spectrum condition. CAMHS practitioners also used Video Interactive Guidance (VIG) whereby interactions between children, young people and their parents helped to strengthen family relationships and coping strategies.
- 2.19 Young people supported by Young Addaction benefitted from regular access to a GP for holistic healthcare advice. Action had been taken to strengthen joint working in the light of learning from a recent serious case review. Cases sampled highlighted the important role Young Addaction played in supporting vulnerable young people who do not readily engage with health services including facilitating access to dentists and CASH services. Overall, with the exception of shared pathways with Royal Preston hospital; joint working arrangements with other acute Trusts and CAMHS services were relatively under-developed. (**Recommendation 5.1**) *This was also brought to the attention of the Director of Public Health as the commissioner of young person's substance misuse services.*
- 2.20 Lancashire Care NHS Foundation Trust's adult mental health systems clearly flagged children on child protection plans. Adults were routinely questioned about their parental responsibilities and care arrangements for any children they had. However, we found the level of questioning undertaken as part of the initial assessment process was relatively basic. It did not promote a sufficiently strong focus on the impact of parental mental ill-health or support wider exploration of the needs and experiences of children. Cases seen denoted significant variability by adult mental health professionals in their initial and ongoing review of risks to inform frequency of contact and the need for joint working. In one case seen, although the GP had highlighted a number of concerns about the safety and wellbeing of children, this had not been sufficiently explored in follow up work undertaken. (**Recommendation 22.1**)

- 2.21 CGL- Inspire, the adult substance misuse service, promoted a flexible approach to user engagement, appointment times and locations to help facilitate parental access and engagement with its service. Following feedback from service users, group work has been provided at two children's centres to strengthen the engagement of parents. Learning from feedback such as this was enabling Inspire to tailor its local offer and ensured its support programmes and interventions were easily accessible. Targeted work in conjunction with children's centres in East Lancashire was helping to strengthen 'Think Family' approaches.
- 2.22 One GP practice we visited had implemented a robust risk management system that enabled good oversight of children with complex health needs with clear protocols in place to address fluctuating needs. This approach positively strengthened parental knowledge and confidence in ensuring the specific and diverse needs of their children were appropriately managed. In another GP practice, however, we saw that risks to children were not clearly recorded on electronic patient records, although the staff we spoke to could explain what the concerns were. Greater care was needed in recording so that new or locum staff could easily recognise and promptly follow up concerns should the child or parent re-present. (**Recommendation 4.1**)

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### 3. Child protection

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- 3.1 Lancashire's multi-agency safeguarding hub (MASH) promoted a rigorous, co-ordinated approach to the gathering and sharing of information in relation to incidents that required a Police response. Health professionals within the MASH provided a timely and comprehensive response to requests for further information. We saw examples of effective multi-agency collaboration, including with another local authority where young people were missing from home. MASH work connected up with adult substance misuse and adult mental health services, however, joint arrangements could be further strengthened to promote clear shared strategies for managing shared responses. This included aspects of adult behaviours of concern in relation to domestic abuse, substance misuse and mental health. **(Recommendation 26.1)**
- 3.2 Referrals to children's social care were managed by the Council's Contact and Referral team (CART) which was co-located with the MASH. The MASH health team comprised staff from Lancashire Care and Blackpool Teaching Hospitals Trusts. Lancashire Care staff supported the work on a rotational basis. Strong teamwork between the two NHS Trusts ensured a prompt and flexible response to local need. Health-related information was used effectively to inform decision-making about the level of risk and actions required to protect children. Senior leaders from across the partnership were working to promote greater efficiencies and aimed to establish a single point of contact for all referrals. Plans had yet to be finalised to implement and resource the new model.
- 3.3 We found variable practice in the standard of referrals made by health professionals to children's social care overall; with exemplary practice seen in the quality of safeguarding information shared by the specialist midwives at Royal Preston hospital. Southport and Ormskirk Hospital emergency department staff, however, provided limited detail about concerns they had identified and the impact for children. Poor capture of relevant information and analysis of concerns at the point of referral risked unnecessary delay or protracted discussions to determine the most appropriate follow-up action. **(Recommendation 25.1)**
- 3.4 GP referrals to children's social care did not fully comply with Lancashire's multi-agency child protection procedures. In one GP practice, whilst we saw that the risks of sexual abuse had been appropriately recognised and entered on the electronic patient record; the GP had only made a verbal referral to children's social care, and had not followed it up in writing within 48 hours as required by local multi-agency procedures. **(Recommendation 4.2)**

- 3.5 Children's details and risks to their safety were well-recorded on the Discover adult substance misuse team's casework (Greater Manchester West Mental Health Trust). The Discover team used a web form to make referrals to children's social care. However, the ICT system used by the Trust did not retain a copy of the referral. This hindered organisational capacity to audit the level and quality of this work. (**Recommendation 27.1**). *This was also brought to the attention of the Director of Public Health as the commissioner of adult substance misuse services.*
- 3.6 The Ofsted single agency inspection of Lancashire's children's services in November 2015, highlighted the need for a more systematic multi-agency approach to managing strategy discussions and agreeing professional accountabilities. At the time of this inspection a number of actions were being taken to strengthen joint decision-making and ensure health professionals were consistently involved in planning and reviewing the outcomes of child protection investigations. New approaches were being piloted, which included the use of conference calling facilities to support strategy discussions in one locality. This response was both positive and pragmatic given the size and complexity of child protection arrangements in an area the size of Lancashire.
- 3.7 In the north of the county, the team leader for Universal Services (Blackpool Teaching Hospitals provision) and a social work manager held monthly case consultation drop-ins for children's social care and community health staff. The forum was established to help build a shared understanding of levels of concern and of the effectiveness of current joint interventions. Health practitioners could discuss cases they had referred to children's social care that had not led to a social work assessment. This helped strengthen multi-disciplinary discussion about referrals and encouraged shared learning. In addition, joint liaison meetings between social service team managers and University Hospitals of Morecambe Bay midwives provided a useful forum for sharing information about vulnerable expectant mothers and their unborn children. Midwifery safeguarding leads in Southport and Ormskirk Hospital Trust also held monthly multi-agency link meetings to discuss cases of concern and share learning.
- 3.8 Lancashire Care NHS Foundation Trust had a small number of specialist safeguarding health professionals (SHPs) working within Children's Social Care teams within East Lancashire locality (an area with high levels of multiple deprivation and child protection activity). These safeguarding health practitioners supported the ongoing child protection work of universal health professionals. These roles had been established for some time and targeted the most vulnerable hard to reach families within the designated localities. SHPs co-worked cases with children's social workers to address the health needs and safeguarding concerns. Their involvement influenced decision-making for children and families to bring about positive outcomes. The contribution of these posts to local safeguarding arrangements has been positively evaluated.

- 3.9 Lancashire Teaching Hospitals NHS Foundation Trust was the first in the country to adopt the child protection information system (CP-IS). Other acute trusts in Lancashire were ready to go live with CP-IS and were awaiting further development of the national server to support local requirements. Lancashire Teaching Hospitals had been working to expand its system's capabilities to provide alerts not only about children on child protection plans and those who were looked after, but also those exposed to domestic abuse or at risk of CSE. Ongoing development work in this area should help further strengthen preventative approaches.
- 3.10 Urgent Care staff were alert to child protection concerns and CP-IS was being effectively used to support 'professional curiosity' and proactively inform analysis of risk.

**Case example:** An 8 year old male attended Chorley UCC, with his mother due to sunburn. His school had advised his mother to take him for treatment. The mother told UCC staff she was upset with the school's management of the case. Nursing staff checked CP-IS and discovered the child was the subject of a child protection plan. Case notes clearly documented that the nurse immediately contacted children's social care. Relevant information was shared by the child's social worker to inform wider analysis of risk. This included learning that the family had recently been re-housed and that the mother and children had previously spent some time in a women's refuge.

The nurse noted that the mother had a large bruise around her left eye and questioned her about it. The mother said that her younger child had thrown a toy at her. The nurse clearly documented that she felt the bruise was inconsistent with the explanation. Full details were passed on in writing to the paediatric liaison nurse for sharing with the school nurse and with children's social care. The only area of practice that had not been completed as part of triage was the Trust's safeguarding template.

- 3.11 In Lancashire Teaching Hospitals, perinatal mental health arrangements were developing well and enabled good support for pregnant women with mental health needs prior to and following the birth of their babies. The twice daily 'Safety Huddle' provided an effective means of sharing information about changing circumstances and risks to mothers and their unborn or new born babies. Good joint working and information-sharing with Discover, the adult substance misuse team, helped reduce harm to pregnant women and their babies. Birth plans seen were of a good standard, provided clear analysis of risk, with specific actions to support the delivery of sensitive and safe discharge arrangements. Safety huddles were also in use in University Hospitals of Morecambe Bay Hospitals, where they too were used to good effect in ensuring tight vigilance to safeguarding concerns.

- 3.12 Mothers with mental health needs attending University Hospitals of Morecambe Bay needs received good support from the consultant and specialist midwife via the joint clinic. Birth plans were of a good standard, with safeguarding concerns clearly identified. Discharge plans provided a comprehensive review of risks and of the needs of mothers and their babies. Discharge summaries completed by medical staff however, even when there were safeguarding concerns, were of an inadequate standard. This meant GPs were not being adequately informed about risks to mothers and their new born babies. Commissioners were working with local managers to improve the quality of discharge summaries in the Trust. **(Recommendation 11.2)**
- 3.13 Risk management of unborn or new born babies about whom there were child protection concerns was well-managed on Southport and Ormskirk midwifery case records seen. Concerns and actions required to reduce the risk of harm were promptly shared and comprehensively recorded.
- 3.14 Lancashire Teaching Hospitals had effectively implemented FGM procedures with appropriate incident reporting within the Trust and information sharing with children's social care which enabled improved awareness and monitoring of incidence. However, we found routine enquiries were not made about FGM in either sexual health or GUM services. GUM staff recorded this only if there had been a physical examination. In East Lancashire Hospitals Trust, one of the cases we tracked denoted the need for greater vigilance when pregnant women attended. Action was required to promote a clear and consistent approach to identifying, recording and reporting FGM. **(Recommendation 16.3)** *These issues were also brought to the attention of the Director of Public Health as the commissioner of sexual health services.*

**Case example:** The initial midwifery assessment undertaken of a woman who was a refugee, who booked late in her pregnancy did not consider the risk of female genital mutilation. Midwifery records also did not evidence routine enquiry of domestic abuse at this visit or details of the male accompanying the woman to the appointment who translated for her.

The next appointment was arranged to ensure language line could be used and to facilitate the woman being seen alone. It was following this conversation that the woman disclosed she had been subjected to female genital mutilation as a child. Other risks not explored in the initial assessment were followed up, and no further concerns were identified.

- 3.15 Specialist midwives for vulnerable women employed by University Hospitals of Morecambe Bay Trust provided targeted support to protect women and their unborn babies. The work undertaken by the teenage pregnancy midwife was especially important given that this locality did not have a family nurse who could offer tailored and intensive support.

**Case Example:** An expectant teenage mother was known to be in a relationship with a man who was significantly older than her. Checks were made to ensure she was not at risk of child sexual exploitation. This was found not to be the case, but concerns were identified in relation to father's misuse of substances and learning difficulties. The young person's social worker and midwife made a joint visit to the family home to gain a clearer picture of the young person's views and circumstances.

The visit confirmed that the father led a chaotic lifestyle which could impact on the safety and wellbeing of the unborn child. The unborn child was made the subject of a child protection plan as was the expectant mother due to risks to her safety. The teenage pregnancy midwife provided a high level of support and challenge in enabling the young mother to prepare for the birth and build on her protective factors to keep herself and her baby safe.

The young mother gave birth to a healthy baby and is no longer in a relationship with the father. Both parents now recognise their parental responsibilities and are making good progress in caring for their baby. The father of the child has also now substantially reduced his use of illegal substances.

- 3.16 One GP practice we visited had a comprehensive system of alerts in place for all children at risk of abuse or who were on child protection plans. Codes used clearly highlighted children who had experienced domestic abuse, and whether they were looked after or a child in need. The practice safeguarding lead nurse received all child protection invitations and ensured a report was prepared for all child protection conferences. In cases where the GP had been working closely with the family, they, or the safeguarding nurse would attend. Safeguarding meetings within the practice included all staff which supported a strong shared approach to identifying risks. Awareness of joint accountabilities was recently evidenced when a member of the administration team raised concerns about a child with frequent attendance which led to further enquiries being made about her welfare.
- 3.17 The engagement of GPs and the quality of their reports to child protection conferences were recognised by Named GPs and CCG leaders as areas to further strengthen. The two GP practices we visited whilst strongly committed to safeguarding children were in very different places in relation to the maturity of their systems and tracking of high risk children, young people and vulnerable families. Named GPs had identified a number of priorities to strengthen GP leadership in joint work to promote improved outcomes for children. However current capacity gaps in these roles contributed to delays and uneven progress in some localities.  
**(Recommendations 1.1, 4.4)**

- 3.18 Midwives, health visitors and school nurses were actively engaged in child protection and core groups and discharged their safeguarding responsibilities well on most case records seen. Attendance by adult mental health and substance misuse practitioners at child protection meetings was variable. In one case seen, this led to further work and a delay in decision making in that key up-to-date information about parental compliance with the child protection plan was not available. On another case in contrast, we saw good multi-agency working with a young pregnant woman who had a history of self-harm, suicidal ideation, misused substances and who was detained under the Mental Health Act. Good joint work between the case holding specialist midwife, the adult mental health and substance misuse practitioners in conjunction with the child's social worker enabled the development of a robust birth and postnatal plan.
- 3.19 Overall, partnership working between child health and adult mental health and substance misuse professionals was variable. Community child health professionals reported they would welcome more frequent information sharing and strengthening of joint approaches to ensure shared direction and holistic support for families who were reluctant to engage. **(Recommendation 26.2)** *These issues were also brought to the attention of the Director of Public Health as the commissioner of adult substance misuse services.*
- 3.20 All children on a child protection plan received an individual comprehensive health assessment completed by a health visitor or school nurse. Frontline health professionals were vigilant to 'disguised compliance' and reported seeking further advice and guidance from named professionals and safeguarding champions in helping them to reflect on their concerns.
- 3.21 Health visiting plans to support delivery of child protection plans however were not sufficiently SMART; were often activity-based in focus and did not clearly demonstrate the impact of their interventions. Routine case recording of ongoing contact by community health professionals whilst detailed and descriptive, also did not clearly evidence the impact of their work for the child and the risks to them from lack of parental adherence to the protection plan. **(Recommendation 17.1)** *These issues were also brought to the attention of the Director of Public Health as the commissioner of health visiting and school nursing services.*
- 3.22 Reports to child protection conferences written by community health professionals and midwives were of good standard overall, and provided clear articulation of risk in most cases. Reports seen prepared by Southport and Ormskirk midwives however, provide limited information with insufficient analysis of risk. Good practice in this area is essential in ensuring a comprehensive picture of risks to help inform a clear shared direction across the partnership to promoting better outcomes. **(Recommendation 25.2)**
- 3.23 CAMHS practitioners were appropriately involved in the child protection processes and provided detailed reports and attended conferences when they were requested to do so.

- 3.24 The Young Addaction Service had well-focused and responsive safeguarding arrangements that put safeguarding young people at the heart of its work. In cases seen, we found evidence of holistic initial and ongoing risk assessments in relation to domestic abuse and CSE. Plans were regularly updated and reviewed for their impact in securing improved outcomes. Addaction and CGL Inspire worked well together to ensure the most appropriate service was available for young people aged 18-25 years.
- 3.25 Think Family arrangements were well embedded in the work of CGL Inspire. Children were clearly visible and were at the centre of risk assessment and care planning processes. Children on child protection plans were appropriately flagged with key details clearly recorded on their electronic case management system. The provider was able to search within its national CGL database for a potential match for the whereabouts of parents and known risks. Whole family interventions were also offered in conjunction with children's social care staff for example the M-PACT group (Moving Parents and Children Together) which aims to develop parents' understanding of their substance misuse and its impact on children. However, the attendance of substance misuse professionals at child protection meetings and their use of the LSCB report template to support analysis of the impact of parental substance misuse on children was variable. *We brought this to the attention of the Director of Public Health as the commissioner of adult substance misuse services.*

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## 4. Looked after children

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- 4.1 Specialist LAC health teams within Lancashire Care NHS Foundation Trust and Blackpool Teaching Hospitals Trusts led and delivered statutory work to safeguard the health and wellbeing of children who were looked after. Good access to the Council's electronic case management system enabled timely and efficient sharing of information within and between organisations. In addition, in the localities served by Blackpool Teaching Hospitals, joint working benefited from IT connectivity with GP patient information systems.
- 4.2 The LAC health teams had appropriate operating procedures and systems to support their operational leadership and co-ordination of LAC health-related activity, including the management of consent which was obtained from the local authority prior to the request for a health assessment. There were a few areas where looked after children care pathways required strengthening to ensure the effective engagement of all relevant health professionals. For example, when the request for completion of a health assessment was sent out, the team specified who they wanted the assessment to be shared with. However, the completed document did not routinely evidence this. If the documentation is not shared with relevant other health professionals it will reduce opportunities for the identification and provision of holistic care. (**Recommendation 17.2**)
- 4.3 A programme of work was underway to promote wider recognition of the vulnerability of looked after children and care leavers including strengthening the engagement of GPs in contributing to their care. GPs were generally informed of children looked after on their case lists, and received a copy of the health assessment and care plan. However, they were not routinely approached to provide information to inform initial or review health assessments which would have supported stronger engagement and oversight of the child's health needs as they moved through different stages of childhood/young adulthood or into new care arrangements. The exception was in Central Lancashire where GPs were routinely engaged in supporting initial health assessment activity. (**Recommendation 4.4**)
- 4.4 Strengths and Difficulties Questionnaires (SDQs) were not routinely completed and shared by the local authority to help inform children's initial and review health assessments. The LAC Recovery Action Plan had identified the need to strengthen joint working and professional accountabilities to ensure equal weight was given to children emotional, mental health and physical wellbeing but this had yet to be fully implemented at the time of our visit. (**Recommendation 7.1**)

- 4.5 Children who were looked after with emotional health needs accessed help from *Supporting Carers and Young People Together (SCAYT+)* which was commissioned by the Council we understand partly as a consequence of challenges of access to specialist CAMHS provision for Lancashire's looked after children discussed in an earlier section of this report. The picture of local demand and care pathways in Lancashire is complex- given that approximately 1,000 young people are placed by other local authorities in the area at any point in time. Some of these young people as well as Lancashire's own looked after children were seen by CAMHS specialist teams. Case examples of CAMHS work with children and young people looked after indicated good recognition of their vulnerability and provision of appropriate support at points of crisis. However, responding to the needs of these high risk children significantly challenged CAMHS teams' capacity to meet performance targets.

**Case example.** A 15 year old girl had been looked after from an early age due to physical and sexual abuse. Her previous foster care placement had broken down, and the children's home she had moved to had also recently closed; requiring her to move again at short notice to another residential home. She was not attending school. A number of concerns were raised about her safety and emotional well-being when she attended a local emergency department following an episode of self-harming behaviour. She was admitted onto a paediatric ward, and at the time of our inspection was awaiting further clinical review and the identification of an appropriate care placement.

A CAMHS practitioner had been working with the young person for approximately 12 months; but was concerned that on reaching her 16<sup>th</sup> birthday the young person would have to be transferred to adult mental health services. Additional information gathered indicated that she may be at risk of child sexual exploitation, and had learning difficulties that had not been formally assessed. It was agreed that the CAMHS practitioner would remain involved until all relevant risk assessments had been undertaken and a comprehensive care plan was in place to keep her safe.

- 4.6 We found variability in the standard, timeliness and impact of initial health assessments undertaken by paediatricians and a GP who were commissioned to undertake this work. Performance was being closely monitored by CCGs with evidence of recent improvements in timeliness; but further work was required to secure a consistently high standard of record-keeping practice and achieve sustainability of work in this area.  
**(Recommendation 6.1)**

- 4.7 Practice weaknesses in initial health assessment included limited capture of essential demographic details. Inconsistencies in the recording of children's health needs did not support holistic analysis or the development of child-centred plans. The identity and wishes of the child or young person at the centre of the process was not sufficiently strong on some records seen. Some health action plans underpinning the initial health assessment process were not SMART which risked delay and drift in referral and access to relevant services. All initial health assessments were quality assured by the LAC nurses who returned documentation for amendment and liaised closely with the designated nurse within the CCG to flag areas of weak practice. For those children/young people placed out of area whose assessment documentation did not meet the required standards, this risked leading to a delay in fees being authorised by the designated nurses until the required standards were met. (**Recommendations 6.1**)

**Case examples of the variable quality of initial health assessments**

- The case record of a 15 year old young unaccompanied asylum seeker did not provide details of their ethnicity or religion, or who they were living with. They had been placed in care in February this year. Their initial health assessment was completed well outside statutory timescales. Their record did not include a copy of this assessment or of communication with partner agencies which meant there was limited evidence of how well his needs were being met.
- A comprehensive initial health assessment and care plan of a young child enabled the health visitor to promptly follow up areas of concern in her follow up six month review. A referral for further assessment was made given the known family history of sensory loss. The outcome was well-documented in the child's record and would help inform further monitoring and review as the child developed.

- 4.8 Local commissioners working with the Lancashire Care NHS Foundation Trust specialist LAC team had recently addressed an historical gap in local arrangements for young people over the age of 16 years who required an initial health assessment. A suitably experienced GP had been engaged to respond to such requests in East and Central Lancashire. This was helping to strengthen the focus on the diverse needs of young people who were older when they were admitted/re-admitted to care.

- 4.9 Good practice was generally seen in the quality of review health assessment work undertaken by health visitors and school nurses. Children and young people had good access to dental services, an area for improvement highlighted in our previous inspection report. School nurses offered young people a choice of venue and sought to actively involve them in building their awareness and understanding of their health needs. However, previous assessments and health care plans were missing or were not easy to locate on some Lancashire Care NHS Foundation Trust case records we sampled. *This was also brought to the attention of the Director of Public Health as the commissioner of health visiting and school nursing services. (Recommendation 22.2)*
- 4.10 Specialist LAC nurses were case holders for young people with complex needs including children being cared for in children's homes or foster care. Their approach supported positive engagement with young people and enabled continuous monitoring of their health and wellbeing. Review health assessments undertaken by them were of a good standard. The voice of the child was strong, and included a clear focus on health promotion and management of risk.
- 4.11 Blackpool Teaching Hospitals specialist LAC nurses had developed a risk assessment tool to determine the frequency and nature of visits and levels of specialist intervention that may be required. Health action plans developed within the review health assessment process were generally comprehensive and SMART. Case records demonstrated positive therapeutic relationships resulted in improved health outcomes for young people who were dealing with significant changes or challenges in their daily lives.

**Good Practice: Recognising the health care needs of children in residential care**

Blackpool Teaching Hospitals specialist LAC team has forged strong relationships with 26 residential homes within the Lancashire footprint it serves. The team are promptly informed about any young people newly placed which promoted timely introduction and follow up of any health risks.

One of the cases we reviewed was a young pregnant woman where there were increasing concerns about her emotional wellbeing. The LAC team worked to establish a trusting relationship with her and ensured she had access to maternity services and other sources of advice and support at the earliest possible opportunity.

- 4.12 Health professionals were effectively engaged in joint work to reduce harm to young people missing from care or who were at risk of sexual exploitation. The CSE specialist nurses worked directly with young people in partnership with the LAC specialist teams and frontline community health professionals to help promote their wellbeing and safety. Risk assessment tools were sensitively used to engage young people and to jointly review protective factors. All specialist LAC nurses had received additional training in sexual health awareness and helped young people understand risks and take responsibility for their sexual health. Arrangements to support vulnerable young people in care through their pregnancy were variable as not all acute trusts had teenage pregnancy midwives, and family nurses were only available in two localities. The adequacy of such arrangements in supporting looked after children who were pregnant warranted further review to ensure levels of need were being effectively met. **(Recommendation 1.2)** *This was also brought to the attention of the Director of Public Health given his leadership role in commissioning Family Nurses and work to tackle local health inequalities.*
- 4.13 Care leavers in Lancashire now benefit from the provision of health passports. The passports contained a full health history of the young person, including the health of their birth parents and siblings (if known) in order to support them be aware of any potential risks to their future health. Young people were offered them as they approached the age of 16. Specialist nurses worked closely with them to help them fully understand the contents of their health passports and supported them to take personal responsibility for their health when they moved out of care. The design and approach taken to implementing health passports for care leavers has been positively informed by members of the Children in Care Council. Specialist LAC nurses in Lancashire Care NHS Foundation Trust however, needed to ensure they routinely scanned such documents onto the child's electronic health record once the young person had seen and agreed the contents. The use made and impact of health passports in promoting young people's health and wellbeing would benefit from further review. **(Recommendation 22.2)**

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# Management

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

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## 5.1 Leadership and management

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- 5.1.1 NHS England together with Lancashire's CCGs provided good leadership and worked closely with each other and with provider organisations to ensure local safeguarding arrangements fully complied with '*Safeguarding Vulnerable People in the NHS- Accountability and Assurance Framework*' (2015). Key gaps remained in the capacity of named GPs, with some CCG localities not yet benefiting from or having less than the recommended levels of coverage of safeguarding leadership within primary care. The capacity of designated and named doctors and nurses for safeguarding and LAC also remained below recommended levels in some localities. These issues were highlighted in our last inspection report. (**Recommendation 1.1**)
- 5.1.2 Named GPs and designated safeguarding professionals were working to provide stronger leadership and support for frontline general practice staff. A recent audit against the *Safeguarding Children Toolkit for General Practice* was helping to identify priorities and strengthen leadership and engagement in shared work to protect children, young people and vulnerable families.
- 5.1.3 NHS provider Trusts had reviewed, and in some cases, further strengthened their safeguarding capacity with new or additional posts established to support expansion of activity, strengthen Board oversight and enable the delivery of improvement work. These include the development of dedicated named midwife capacity in Southport and Ormskirk and East Lancashire Hospital Trusts and the appointment of an operational safeguarding lead nurse to oversee the work of named professionals within Lancashire Care NHS Foundation Trust. Blackpool Teaching Hospital had also strengthened its safeguarding capacity with the appointment of a Head of Safeguarding directly accountable to the Director of Nursing. This additional post recognised the need to strengthen delivery of the commissioned activity within Fylde and Wyre and Lancashire North CCG localities. Networks of safeguarding champions had been established in Lancashire Care NHS Foundation Trust, East Lancashire Hospitals and Greater Manchester West Trusts to complement the leadership of named professionals and enable easy access to advice and support for frontline staff.

- 5.1.4 Lancashire's 'Making Safeguarding Personal' programme denoted a new vision and approach to protecting vulnerable children and their families. Designated and named safeguarding professionals were actively supporting new ways of working that moved beyond compliance with processes to ensuring a stronger focus on the needs and experiences of children at risk of abuse. New shared approaches focused on promoting stronger engagement with children, young people and those with parental responsibility. New models of service delivery were being designed to promote more efficient and effective joint working, and secure the best outcomes using evidence based practice. A high priority was the implementation of the next phase of MASH which had been delayed given the number of other high priority improvement actions required to provide local leaders with assurance of the quality and safety of local arrangements.
- 5.1.5 The engagement of health leaders in the work of the Local Children's Safeguarding Board (LSCB) and its sub-groups was good. Joint working between health and social care services was open and mutually supportive in shared work to drive forward improvements and promote new models of working to better manage organisational demand and risks. An escalation policy was in place to address professional disagreements in the management of child safeguarding work. In practice, this rarely needed to be used.
- 5.1.6 Current commissioning and service delivery for young people aged 16 to 18 years required radical and urgent transformation to ensure their vulnerability and ongoing support needs were appropriately recognised and addressed. Operational practices in emergency departments, CAMHS, and sexual health services did not sufficiently support a robust young person-centred approach. (**Recommendation 3.1, 16.2**)
- 5.1.7 Positive practice was seen in the commissioning of Addaction with flexibility to provide transitional care and support up to the age of 25. The model provided useful learning about the creation of seamless pathways for other vulnerable young people who continued to require support into adulthood. The recent joint work with Lancashire Teaching Hospitals Trust which enabled a stronger focus on young people with substance misuse issues attending emergency departments in crisis had the potential to be expanded to other NHS Trusts in the area.

- 5.1.8 Significant gaps remained in some localities in the availability, responsiveness and range of services available for young people with emotional, mental health and behavioural needs spanning early help through to in-patient care. Gaps remained in access to specialist provision for young people with learning disabilities and eating disorders; and the availability of crisis response teams to young people presenting at Lancashire's hospitals out of hours. Lancashire was still at a relatively early phase in implementing its '*Children and Young People's Resilience, Emotional Wellbeing and Mental Health Transformation Plan 2015-2020*'. Risks had been flagged by local commissioners regarding current capacity and the pace of transformation. Frontline CAMHS practitioners we spoke to did not feel sufficiently informed about the future management of change. **(Recommendation 3.1)**
- 5.1.9 Joint commissioning between the CCGs and the Director of Public Health (Lancashire County Council) was good overall with a shared commitment to improving child health outcomes and value for money through promoting new models of service delivery. However, there was a need to ensure local CCGs and NHS providers were consistently involved and at a sufficiently early stage in decisions alongside Council colleagues that had a significant impact on the operational delivery of local health services, in particular in relation to decision-making about the future of local Children's Centres. Whilst CCGs had been involved in decisions about joint funding of specialist nurses within the multi-agency CSE teams from an early stage; given the short term funding/pilot status of some of this work, there were concerns as to its sustainability. For example, the fixed term CSE nurse role in Central Lancashire was due to expire in August; and at the time of our visit, a decision about the future joint funding commitment by the Director of Public Health had yet to be agreed. *This was brought to the attention of the Director of Public Health to ensure urgent attention was given to agreeing the way forward alongside CCGs and the local provider.*
- 5.1.10 The comprehensive joint recovery plan in place aimed to promote stronger joint working with children's social care in tracking children newly placed in care; with actions to strengthen the engagement of health professionals in LAC statutory reviews as appropriate. The plan was also helping to address historical gaps in the capacity, availability and quality of services for children who were looked after. Regular quarterly meetings of LAC specialist teams and commissioners promoted consistency of practice and sharing of innovative work. We found a good sustained level of performance in the delivery of review health assessments, with examples of effective engagement with young people and those caring for them. Improvements were still required in the levels of expertise, quality and coverage of initial health assessments and the development of smart health action plans in particular. These issues had also been identified in our previous inspection in 2012. **(Recommendation 6.1)**

- 5.1.11 Whilst community health providers had strengthened their health visiting capacity and the Lancashire Care Children and Family Health Service 0-19 team provided flexibility in recognising and responding to the needs of the whole family; there remained gaps in the levels of school nursing capacity in particular. Despite having high caseloads and increased pressures in the day to day management of complex work, many health visitors and school nurses in Lancashire Care NHS Foundation Trust and Blackpool Teaching Hospital Trusts impressed us with their commitment and availability to young people and their families. Given the significant increase in safeguarding work; management oversight, quality assurance and supervision of their work had been tightly stretched.
- 5.1.12 The emergency department at Royal Preston Hospital did not have sufficient nurses trained in paediatric care to ensure there was at least one paediatric nurse working each shift. This was mitigated through back up from the paediatric wards and increasing the numbers of staff competent in paediatric immediate life support work. However, the availability of paediatric staff and paediatric immediate life support training still needed to be effectively addressed. (**Recommendation 21.1**)
- 5.1.13 ELCAS practitioners spoke of excellent relationships with their supervisors and managers. The service had a stable workforce with staff continuity and low turnover. This in turn promoted good relationships with young people who benefited from consistent care and had to 'tell their story only once'. The management culture in the Trust was described as 'looking after the staff that look after the kids'.
- 5.1.14 Positive recognition and promotion of learning from the voice and experience of children and young people was evident in the work of some local providers, with examples of their feedback directly influencing work to improve the quality and range of local services. 'The Crew' – Lancashire Care NHS Foundation Trust's service participation group met regularly to discuss and plan improvements to its CAMHS services.
- 5.1.15 Adult mental health services had recently undergone a significant restructuring of its local services. All specialist roles were redeployed into new integrated locality teams with a lead champion for safeguarding in each team. It was too soon to measure the impact of the service redesign on promoting continuous improvement in safeguarding practice. Practitioners told us the presence of experienced social workers in each team increased their confidence in recognising risks to children as an integral part of their work.
- 5.1.16 Perinatal mental health arrangements were being strengthened with evidence of appropriate actions being taken to implement recent Department of Health guidance; including the appointment of lead consultants and other specialist mental health professionals.

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## 5.2 Governance

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- 5.2.1 Two senior health leaders representing all commissioning and provider organisations were actively engaged in supporting the delivery of the Council's Service Improvement Plan to address areas of weak performance identified in the Ofsted single agency inspection in November 2015. This inspection highlighted some areas where the contribution of health professionals to partnership working required strengthening. This included issues with health professionals not being invited to the multi-agency strategy discussions/meetings, and in some cases, lengthy waiting times for access to CAMHS services. The report also noted that some review health assessments for looked after children were not being completed within statutory timescales. At the time of this inspection visit, good engagement of relevant health professionals/lead safeguarding professionals was evident in strategy discussions. Priority actions within the area's emotional and wellbeing transformation plan aimed to provide a timely range of support to address historical capacity challenges in local area provision. The joint looked after children recovery plan was helping to strengthen partnership working and to address issues of timeliness and quality; with active monitoring of progress by senior leaders.
- 5.2.2 A significant programme of improvement work had been mapped and was in progress across the LSCB partnership to ensure all professionals were clear about safeguarding thresholds and their responsibilities for helping to achieve better outcomes for children, young people and their families. In cases seen, health professionals were aware of the safeguarding thresholds and their personal accountabilities for keeping children and young people safe. Lancashire Care Children and Family Health Service 0-19 team had received training in the new 'Risk Sensible Approach' (initially developed within Blackburn with Darwen Council); with plans for this model to be adopted across Lancashire to help embed consistent approaches across the partnership to the management of risk. The role and contribution of named safeguarding professionals in quality assuring referrals to children's social care was helping to reinforce the standard of information and analysis required. We saw examples of frontline health professionals being appropriately challenged and supported to secure the required level of performance.

- 5.2.3 Health leaders and partner organisations have taken seriously the lessons learned from serious case reviews (SCRs) with evidence of improving outcomes from work to strengthen practice at a partnership and individual organisational level. They included a stronger focus on domestic abuse, co-sleeping and strengthening information sharing between GPs and services supporting adults who misused substances. East Lancashire Hospital's midwifery team had strengthened their practice in completing family and social need assessments with a stronger focus on risks to women who presented late in booking their maternity care. Lancashire Teaching Hospitals had strengthened links between its emergency department, Young Addaction and CAMHS to promote shared approaches and clear accountabilities in supporting young people with a complex range of needs.
- 5.2.4 A number of new serious case reviews were in progress at the time of this inspection. The partnership was working to better understand the root causes of these and analyse for trends that contributed to these recent failures to protect local children. Senior managers and safeguarding leads were open to learning and vigilant to areas where practice did not meet the required professional standards.
- 5.2.5 LSCB Section 11 audits, combined with the review of NHS contract safeguarding requirements helped to provide a clearer picture of commissioner and provider performance against key standards. The process was underpinned by action plans and review of progress in addressing gaps in capacity or the quality of provision. Executive and designated safeguarding roles had been reviewed and strengthened to provide stronger governance and oversight of safeguarding and looked after children arrangements.
- 5.2.6 Commissioners and providers submitted safeguarding children and adults reports to their individual Trust Boards at least annually. The inclusion of patient stories in a number of Trust reports helped build a shared understanding of the complexity of safeguarding work and of the Trust's performance in addressing challenges and delivering the required quality standards and outcomes. However, the local joint strategic needs assessment was not adequately informed by the health care needs and inequalities experienced by looked after children and young people. This meant that commissioners were not sufficiently informed about progress in delivering improvements in child health outcomes and local trends. **(Recommendation 1.2)**. *This was also brought to the attention of the Director of Public Health given their lead role in this area.*

- 5.2.7 A number of actions had been delivered, with others in progress, to strengthen quality assurance of local statutory health arrangements for children looked after and care leavers. This included the provision of training to frontline staff undertaking assessments and developing health care plans. Front line health professionals were required to self-audit their work prior to submission with a further review by the LAC health team prior to sign-off. However, further work was needed to strengthen quality assurance of the work by frontline practitioners and their managers. For example, in one case, we found the frontline practitioner had not effectively challenged the quality of her work. Gaps in practice against the quality standards had not been effectively picked up in the sign-off process by the LAC health team. Our review of LAC health records indicated the need for tighter management oversight, reflection on risks to children and on the outcomes achieved. (**Recommendation 17.3**). *This was also brought to the attention of the Director of Public Health as the commissioner of health visiting and school nursing services.*
- 5.2.8 Monthly multi-agency audits of MASH activity were helping to embed shared learning and improve the focus on outcomes for children and on the impact of help provided at different stages of the child's journey.
- 5.2.9 Lancashire Teaching Hospitals had equipped its staff to undertake a range of risk assessments including the DASH checklist (Domestic Abuse, Stalking, Harassment and Honour Based Violence). This Trust had also recently updated its 'Do Not Attend/Was not Brought' procedure to enable better tracking of children and young people where further assurance of their health and wellbeing was required.
- 5.2.10 Within CGL Inspire, high levels of audit activity were positively impacting on shared work to strengthen safeguarding practice. We saw evidence that audits were proactively helping to shape a positive learning culture.
- 5.2.11 University Hospitals of Morecambe Bay Trust had implemented a robust system for tracking risks to vulnerable women through monthly auditing of its database. This helped ensure concerns about women and their unborn babies were accurate and up to date.
- 5.2.12 In one GP practice, the safeguarding lead nurse conducted a monthly audit of child protection records. Learning from this was recorded on the electronic case management system with details of actions required to provide further assurance of the safety of children.
- 5.2.13 We found improvements in the standard of safeguarding practice in Royal Lancaster Infirmary in response to recommendations we made in our previous inspection report in 2012. These included implementing a safeguarding alert system; improvements in safeguarding training and paediatric nurse coverage, with work in progress to strengthen supervision of paediatric ward staff and midwives.

- 5.2.14 Record-keeping including case co-ordination across multiple partnerships was a significant challenge in an area as large and diverse as Lancashire with multiple commissioners and service providers. In East Lancashire and Southport and Ormskirk Hospital Trusts midwifery record keeping did not support timely information sharing between hospital and community records. This negatively impacted on their capacity to maintain contemporaneous records in line with professional standards. We saw in the case on one record in East Lancashire Hospitals Trust that the case holding midwife working with a teenage parent updated the hospital record 21 days after her home visit. (**Recommendation 20.1**)
- 5.2.15 The electronic case management system in use within Lancashire Care NHS Foundation Trust CAMHS teams also created difficulties for frontline staff in maintaining a high standard of record keeping. We were informed and indeed witnessed the system ‘crashing’ with practitioners reporting ongoing challenges in keeping client records up- to- date or delays before they were able to access information. (**Recommendation 20.1**)
- 5.2.16 Lancashire Care NHS Foundation Trust had addressed concerns about the capacity of its health visiting workforce highlighted in a previous CQC regulatory inspection report. A full review of anticipated workload and associated resource requirements was undertaken that took account of caseload numbers and levels of deprivation to inform its organisational change programme across Child and Family Health Services. Changes have been implemented with effect from Sept 2015.

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## 5.3 Training and supervision

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- 5.3.1 Designated nurses provided good support, regular supervision and contact with named professionals in provider trusts. Training figures were closely monitored by commissioners including progress in coverage of the newer safeguarding agendas such as FGM agendas, PREVENT and honour-based violence.
- 5.3.2 We found a number of other frontline health professionals- ranging from emergency department and urgent care staff, GPs, health visitors, school nurses, sexual health services, midwives and CAMHS required further development so that they were confident and knowledgeable in the use of CSE screening tools and risk assessments appropriate to their role and level of engagement with young people. (**Recommendation 8.1**)
- 5.3.3 All LAC specialist nurse teams were trained to an appropriate level against the intercollegiate safeguarding competencies. They reported good access to single and multi- agency safeguarding training. The named nurse in Lancashire Care NHS Foundation Trust offered one to one supervision to all LAC specialist nurses on a monthly basis. However, records of actions discussed in supervision were not available on the children's cases we tracked. This meant that the Trust lacked assurance about the effectiveness and impact of supervision in helping address risk and support improved outcomes for young people looked after. (**Recommendation 22.3**)
- 5.3.4 The two GP practices visited had appropriate arrangements in place for safeguarding children training, with lead GPs accessing level 3 training. Named GPs send out regular information bulletins to all GP practices with updates to support learning in areas such as FGM and CSE. They recognised a stronger programme of learning and development was required to ensure a consistently high standard of practice in all localities, but their ability to deliver this was constrained by current capacity gaps. (**Recommendation 1.1**)
- 5.3.5 GP practices benefited from case studies developed by named and designated professionals and were encouraged to use these to guide discussion as part of the monthly protected learning sessions for all practice staff. In one GP practice visited we saw that the lead GPs took a positive leadership role for training and outcomes from supervision discussions were recorded on children's records. One of the named GPs was working to develop a network of safeguarding champions within each practice within East Lancashire and aimed to ensure all lead GPs received additional training in safeguarding supervision. A similar approach needed to be rolled out in all areas. (**Recommendation 4.5**)

- 5.3.6 Lancashire Teaching Hospitals paid good attention to sharing learning across its frontline emergency department, maternity and paediatric services. The Trust enabled a strong team approach to safeguarding through its monthly case review meetings which routinely included practice development issues, with tight scrutiny of domestic abuse cases. Safeguarding children training at level 2 against intercollegiate standards and paediatric immediate life support training remained areas where Trust performance did not meet intercollegiate and professional body standards. Training had been flagged as a risk on the Trust risk register with the expectation that e-learning at level 2 will be available from October 2016 with compliance by March 2017. Figures provided by Southport and Ormskirk Hospital Trust whilst achieving expected standards against levels 1 and 3, coverage of level 2 safeguarding training was well below expected levels of provision. (**Recommendation 14.1**)
- 5.3.7 Safeguarding children training figures in Blackpool Teaching Hospitals Trust were good against all intercollegiate levels. Supervision for its community health staff included quarterly 1:1 meetings which were generally well-attended with positive feedback from most frontline staff.
- 5.3.8 One to one safeguarding supervision was not well developed in midwifery in most NHS Trusts, the exceptions were specialist midwives (Lancashire Teaching Hospitals) and midwives working for East Lancashire Hospitals Trust who received monthly face to face supervision. All midwifery professionals would benefit from regular face to face safeguarding supervision. Given the significant expansion of safeguarding children and adult activity; levels of support and opportunities for reflection required further review. (**Recommendation 12.1**)
- 5.3.9 Safeguarding training delivered within University Hospitals of Morecambe Bay Trust ensured a good range of training and coverage for its workforce against level 3 intercollegiate standards.
- 5.3.10 Supervision arrangements in adult mental health services included regular individual monthly face to face supervision that included a safeguarding component. Each adult with parental responsibilities was discussed. Records were continuously updated until such time as the patient was discharged from their care. A record was made of the outcome of the discussion on the staff supervision record and practitioners were required to include relevant safeguarding actions on the client's record.
- 5.3.11 Lancashire Care NHS Foundation Trust's safeguarding children training offer was good. As a consequence of learning from a domestic homicide review an external company was commissioned to provide bespoke domestic abuse and mental capacity training. Its network of safeguarding champions in each team helped promote peer support and improvements in practice and complemented quarterly supervision provided to the Lancashire Care Children and Family Health Service 0-19 team. The preceptorship model for newly qualified health visitors and school nurses was competency-based and ensured regular access to 1:1 supervision.

- 5.3.12 The CSE nurses employed by Lancashire Care and Blackpool Teaching Hospitals NHS Foundation Trusts were compliant with Level 3 safeguarding children training and completed in excess of the learning hours required. As well as providing CSE training to a wide range of health agencies and schools, the three CSE teams also worked with partners to facilitate an annual CSE learning week to actively raise awareness of CSE with professionals, young people and the general public. The CSE nurses have also contributed to national reports and national CSE events. They received one to one supervision on a monthly basis. They reported good access to peer support, advice and guidance in managing what is often intensive and complex work.
- 5.3.13 CAMHS practitioners employed by Lancashire Care NHS Foundation Trust and East Lancashire Hospital Trusts had good access to safeguarding training and supervision.
- 5.3.14 CGL Inspire made a positive contribution to safeguarding training across the partnership and effectively helped to raise awareness about hidden harm. Other professionals including the police, fire and the ambulance service have benefited from learning more about brief interventions in the management of people who are intoxicated/under the influence of drugs. Supervision arrangements within Inspire were regular and well-managed. Supervision was well embedded both formally and informally, however there was not a formal record of this on case records. Good management oversight ensured all safeguarding issues had been considered, including a monthly check on any outstanding actions following supervision to prevent drift.

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## Recommendations

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- 1. NHS England together with NHS East Lancashire, NHS Greater Preston, NHS Chorley and South Ribble, NHS Lancashire North, NHS Fylde and Wyre and NHS West Lancashire CCGs should:**
  - 1.1. Address remaining gaps in the capacity of named GPs and designated and named doctors and nurses for safeguarding and for looked after children to ensure appropriate levels of coverage and safeguarding leadership within primary care and for children looked after.
  - 1.2. Enable the joint strategic needs assessment to be fully informed by analysis of the health needs and inequalities experienced by children looked after and care leavers.
  
- 2. NHS England and NHS East Lancashire, NHS Greater Preston, NHS Chorley and South Ribble, NHS Lancashire North, NHS Fylde and Wyre and NHS West Lancashire CCGs together with Lancashire Teaching Hospitals NHS Foundation Trust, Southport and Ormskirk Hospital NHS Trust, East Lancashire Hospitals NHS Trust and University Hospitals of Morecambe Bay NHS Foundation Trust and Lancashire Care NHS Foundation Trust should:**
  - 2.1. Ensure timely and responsive admission and discharge arrangements for young people presenting at local hospitals; and ensure hospital staff are confident, knowledgeable and well-supported to provide holistic care.
  
- 3. NHS England and NHS East Lancashire, NHS Greater Preston, NHS Chorley and South Ribble, NHS Lancashire North, NHS Fylde and Wyre and NHS West Lancashire CCGs together with Lancashire Care NHS Foundation Trust and East Lancashire Hospitals trust should:**
  - 3.1. Ensure timely and easy access to a range of local child and adolescent mental health services that promote holistic joined-up care and support a smooth transition to adult mental health services for young people who require ongoing care.
  - 3.2. Ensure providers routinely report and learn from breaches of the expected standard of practice whereby young people who require in-patient care are placed on adult psychiatric wards.

**4. NHS England together with NHS East Lancashire, NHS Greater Preston, NHS Chorley and South Ribble, NHS Lancashire North, NHS Fylde and Wyre and NHS West Lancashire CCGs together and all local GP practices should:**

- 4.1. Ensure child health records provide a clear and up to date picture of child safeguarding concerns and of actions being taken to help reduce risk.
- 4.2. Ensure all referrals to children's social care are also backed up in writing in line with local multi-agency procedures and provide a clear audit trail of actions taken.
- 4.3. Ensure all local GPs have a clear network of local health professionals working closely with them to support a strong shared focus on safeguarding vulnerable children and families.
- 4.4. Ensure all GPs are effectively involved in and contribute to child protection and looked after children statutory work to help safeguard vulnerable children and their families.
- 4.5. Ensure appropriate supervision arrangements are in place within all GP practices delivered by appropriately trained staff.

**5. NHS East Lancashire, NHS Greater Preston, NHS Chorley and South Ribble, NHS Lancashire North, NHS Fylde and Wyre and NHS West Lancashire CCGs together with Southport and Ormskirk Hospital NHS Trust, East Lancashire Hospitals NHS Trust and University Hospitals of Morecambe Bay NHS Foundation Trust and Lancashire Care NHS Foundation Trust should:**

- 5.1. Ensure strong partnership working with young person's substance misuse services to secure effective joined-up approaches to addressing the needs of young people to enable reduction in their presentation at emergency departments and continuously improve outcomes.

**6. NHS East Lancashire, NHS Greater Preston, NHS Chorley and South Ribble, NHS Lancashire North, NHS Fylde and Wyre and NHS West Lancashire CCGs together with Southport and Ormskirk Hospital NHS Trust, East Lancashire Hospitals NHS Trust, University Hospitals of Morecambe Bay NHS Foundation Trust, Lancashire Care NHS Foundation Trust and Blackpool Teaching Hospitals NHS Foundation Trust together should:**

- 6.1. Ensure all initial health assessments undertaken are within the required timescales and provide clear and comprehensive analysis of children's needs to support SMART individual health care plans. This will enable effective tracking of the child's development and of improved outcomes.

- 7. NHS East Lancashire, NHS Greater Preston, NHS Chorley and South Ribble, NHS Lancashire North, NHS Fylde and Wyre and NHS West Lancashire CCGs together with Lancashire Care NHS Foundation Trust, Blackpool Teaching Hospitals NHS Foundation trust and East Lancashire Hospitals Trust should:**
  - 7.1. Promote shared awareness of risks to the emotional health and wellbeing of children and young people who are looked after and ensure appropriate and timely support to meet their needs with effective tracking of outcomes.
  
- 8. NHS East Lancashire, NHS Greater Preston, NHS Chorley and South Ribble, NHS Lancashire North, NHS Fylde and Wyre and NHS West Lancashire CCGs together all local NHS providers should:**
  - 8.1. Ensure additional training for frontline staff to help them achieve high levels of confidence and expertise in the use of CSE risk assessment tools, tailored to their specific roles and levels of contact.
  
- 9. NHS Chorley and South Ribble and NHS Greater Preston CCGs together with Lancashire Teaching Hospitals NHS Foundation Trust should:**
  - 9.1. Further review and address shortfalls in the levels of paediatric expertise required to meet the current levels of demand from children and young people using its Emergency Department and Urgent Care Centre.
  
- 10. East Lancashire CCG together with East Lancashire Hospitals NHS Trust and Lancashire Care NHS Foundation Trust should:**
  - 10.1. Ensure prompt access to specialist mental health services for women who require additional support prior to and following the birth of their baby.
  
- 11. Lancashire Teaching Hospitals NHS Foundation Trust, Southport and Ormskirk Hospital NHS Trust, East Lancashire Hospitals NHS Trust and University Hospitals of Morecambe Bay NHS Foundation Trust should:**
  - 11.1. Ensure receptionist and clinical staff clearly record the names of adults, those with parental responsibilities and of health, social care professionals and schools involved in the child's life to promote good information- sharing about risks to the health or safety of children.
  - 11.2. Strengthen the focus of clinical staff on the voice of the child and ensure safeguarding tools are used effectively to support clear recognition of the vulnerability of children and young people and analysis of child safety risks.

- 12. Lancashire Teaching Hospitals NHS Foundation Trust, Southport and Ormskirk Hospital NHS Trust, and University Hospitals of Morecambe Bay NHS Foundation Trust should:**
- 12.1. Ensure all midwifery staff can access safeguarding supervision to promote a consistently high standard of casework and professional impact in working with others to reduce harm to women and their unborn or new-born babies.
- 13. Lancashire Teaching Hospitals NHS Foundation Trust and University Hospitals of Morecambe Bay NHS Foundation Trust should:**
- 13.1. Ensure emergency department facilities provide a clear view and good oversight of children waiting to be seen to promote effective early identification of children with deteriorating medical conditions and parent-child interactions.
- 14. Lancashire Teaching Hospitals NHS Foundation Trust and Southport and Ormskirk Hospital Trust should:**
- 14.1. Ensure their workforce fully complies with the intercollegiate training requirements for safeguarding children.
- 15. Lancashire Teaching Hospitals NHS Foundation Trust together with Lancashire Care NHS Foundation Trust should:**
- 15.1. Ensure the Urgent Care workforce is well supported by operational procedures and relevant training that promote clear identification and pathways of care for vulnerable children and their families.
- 15.2. Ensure record keeping within the Urgent Care Centre fully complies with the standards of professional recording practice.
- 16. Lancashire Care NHS Foundation Trust together with Blackpool Teaching Hospitals NHS Foundation Trusts and their sexual health partner organisations should:**
- 16.1. Develop clear systems and care pathways for sharing information, flagging and tracking of risks to young people using their integrated sexual health services.
- 16.2. Strengthen the child's voice, analysis and recording of emerging concerns for young people, including those aged over the age 16 years.
- 16.3. Promote clear and consistent approaches to identifying, recording and reporting incidences of female genital mutilation (FGM).

- 17. Lancashire Care NHS Foundation Trust together with Blackpool Teaching Hospitals NHS Foundation Trust should:**
- 17.1. Ensure their health visiting and school nursing teams provide SMART outcome-focussed protection plans and analysis within routine recording to clearly evidence the impact of their work to strengthen parental capacity and keep children and young people safe.
  - 17.2. Ensure all relevant health professionals are aware of, and have the opportunity to identify and contribute to the health assessments and care plans for children who are looked after.
  - 17.3. Strengthen quality assurance by frontline health professionals involved in undertaking LAC health assessments and care plans to ensure the health care needs of children and young people are appropriately identified and met.
- 18. Lancashire Care NHS Foundation Trust together with East Lancashire Hospitals NHS Trust should:**
- 18.1. Ensure a clear, consistent, shared approach to care management and clinical practice that promotes high standards of recording, equitable provision and sharing of innovative practice in CAMHS services.
- 19. University Hospitals of Morecambe Bay NHS Foundation Trust and Southport and Ormskirk Hospitals Trust should:**
- 19.1. Ensure midwives appropriately and consistently discharge their professional responsibilities for routine enquiry of domestic abuse in line with Trust and professional guidelines.
- 20. East Lancashire Hospitals NHS Trust and Southport, Ormskirk NHS Hospital Trust and Lancashire Care NHS Foundation Trust should:**
- 20.1. Ensure frontline teams are appropriately equipped to effectively manage their caseloads and ensure timely recording and ease of access to relevant information and review of risks.
- 21. Lancashire Teaching Hospitals NHS Foundation Trust should:**
- 21.1. Ensure staffing arrangements in its emergency department provide sufficient coverage of paediatric nursing and suitably qualified other staff to effectively meet the needs of children with complex and deteriorating conditions as befits its role as a regional trauma centre.

**22. Lancashire Care NHS Foundation Trust should:**

- 22.1. Strengthen its approach to identifying risks to children of parents with mental ill-health to ensure effective initial and ongoing review of risks and sharing of expertise to inform partnership working.
- 22.2. Ensure children looked after care records provide a complete picture of previous assessments and care plans in line with the required standards of record-keeping to support the development of a comprehensive health history for young people leaving care.
- 22.3. Ensure records of actions discussed in supervision are routinely recorded on the case records of children and young people to provide assurance about the effectiveness and impact of work to address risks and support improved outcomes.

**23. East Lancashire Hospitals NHS Trust should:**

- 23.1. Ensure maternity staff are routinely informed about the care needs and circumstances of pregnant women attending its emergency department or minor injury unit to help strengthen monitoring of their health and early warning of risks to them and their babies.

**24. Blackpool teaching Hospitals NHS Foundation Trust should:**

- 24.1. Ensure health visitor electronic case records clearly evidence domestic abuse and maternal mental health checks to inform the need for and provision of early help.

**25. Southport and Ormskirk Hospitals NHS Trust should:**

- 25.1. Ensure referrals to children's social care provide a clear picture of safeguarding concerns and the impact for children to support timely decision-making about the management of risk
- 25.2. Ensure midwifery reports to child protection conferences are of a consistently high quality and provide clear articulation of risks to help inform a clear shared direction across the partnership to promoting better outcomes.

**26. Lancashire Care NHS Foundation Trust together with Greater Manchester West NHS Foundation Trust and CGL Inspire should:**

- 26.1. Strengthen their links with the local MASH (multi-agency safeguarding hub) to support shared work in reducing the number of repeat referrals with aspects of concerning adult behaviours in relation to domestic abuse, mental health and substance misuse.
- 26.2. Ensure adult mental health professionals actively engage in all aspects of child protection work to ensure good and regular sharing of information about concerns and changes in parental capacity to effectively support and protect children.

**27. Greater Manchester West NHS Foundation Trust should:**

- 27.1. Ensure referrals made to children's social care are effectively managed to provide a clear audit trail of actions taken and strengthening of management oversight of levels of activity

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## Next steps

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A joint action plan addressing the recommendations above is required from NHS East Lancashire, NHS Greater Preston, NHS Chorley and South Ribble, NHS Lancashire North, NHS Fylde and Wyre and NHS West Lancashire CCGs within 20 working days of receipt of this report.

Please submit your action plan to CQC through [childrens-services-inspection@cqc.org.uk](mailto: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.