

Review of health services for Children Looked After and Safeguarding in Cheshire East

Children Looked After and Safeguarding The role of health services in Cheshire East

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Provider services included:	<ul style="list-style-type: none"> • East Cheshire NHS Trust (ECT) • Mid Cheshire Hospitals NHS Foundation Trust (MCFT) • Wirral Community NHS Foundation Trust (WCFT) • Cheshire and Wirral Partnership NHS Foundation Trust (CWPFT)
CCGs included:	NHS Eastern Cheshire CCG NHS South Cheshire CCG
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Summary of the review

This report records the findings of the review of health services in safeguarding and looked after children services in Cheshire East. It focuses on the experiences and outcomes for children within the geographical boundaries of the local authority area and reports on the performance of health providers serving the area including Clinical Commissioning Groups (CCGs) and NHS England Local Area Teams (LATs).

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

About the review

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

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

How we carried out the review

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

We tracked a number of individual cases where there had been safeguarding concerns about children. This included some cases where children were referred to social care. It also included some cases where children and families were not referred, but where they were assessed as needing early help that they received from health services. We also sampled a number 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 76 children and young people.

Context of the review

The latest published information from the Child and Mental Health Observatory (ChiMat) 2015 shows that children and young people under the age of 20 make up 22.1% of Cheshire East's population. There are 9.8% of school age children from a minority ethnic group. The proportion of children under 16 living in poverty is 11.5%, less than the England average of 18.6%, as is the rate of family homelessness with 0.2 per 1,000 as opposed to 1.8 for England. The number of children in care is fewer than the England average with 48, as opposed to 60 per 10,000. Infant and child mortality rates are not significantly different to the rest of England.

The ChiMat data shows that, on the whole, the general health of children and young people in Cheshire East is better than or not significantly different to the rest of England for most of the attributes measured. For example, Immunisation rates for children in care is better than the England average. Likewise, vaccinations for all children in the area are very good. However, hospital admissions in the area due to alcohol specific conditions; due to injuries in children and young people and as a result of self-harm in young people and young adults is significantly worse than the England average.

The Department for Education (DfE) provide annual statistics derived from outcomes for children continuously looked after. As at March 2015, Cheshire East had 245 children who had been continuously looked after for more than 12 months (excluding those children in respite care), 20 of whom were aged five or younger.

The DfE data indicates that a greater proportion of Cheshire East's looked after children (96%) had received an annual health assessment than the average for England (89.7%). All (100%) of looked after children aged five and under had an up-to-date development assessment, greater than the England average of 89.4%. The data also shows that 98% of looked after children were up-to-date with both their immunisations and with their dental checks, higher than the England average of 88% and 86% respectively.

The commissioning and provision of health care services for children and young people in Cheshire East is varied as follows.

Commissioning and planning of most health services for children are carried out by NHS Eastern Cheshire and NHS South Cheshire Commissioning Groups (CCG).

Health services for looked after children are jointly commissioned by both CCGs and the public health directorate of the local authority, Cheshire East Council. The term, 'cared for children' is used in Cheshire East instead of 'looked after children' and we have used this term from this point forward throughout this report.

Acute hospital services, including emergency care and maternity, are commissioned by the CCGs and provided by East Cheshire NHS Trust (ECT) in the North and East of the area and by Mid Cheshire Hospitals NHS Foundation Trust (MCFT) in the South and central of the area. A small number of non-complex maternity cases are managed by an independent midwifery provider known as 'One to One (North West) Ltd'.

ECT and MCFT share the paediatric provision of health services for cared for children with the specialist cared for children nurse team hosted by ECT and the designated doctor hosted by MCFT. Both the Eastern Cheshire and South Cheshire CCGs share the provision of the designated nurse for cared for children. We have commented on the provision of the cared for children statutory roles later in this report.

Community health services for children and families (health visiting and school nursing), are commissioned by the public health directorate of Cheshire East Council and provided by Wirral Community NHS Foundation Trust (WCFT).

Both the community child and adolescent mental health services (CAMHS) and adult mental health services are commissioned by the CCGs and provided by the Cheshire and Wirral Partnership NHS Foundation Trust (CWPFT).

Contraception and Sexual Health services (CASH), which incorporate the genitourinary medicine service, are commissioned by Cheshire East Council and provided by ECT, under the branding 'gosexualhealth' from a number of clinics across the area.

Substance misuse services are commissioned by Cheshire East Council and are provided by CWPFT although the children's substance misuse service is further contracted out to 'Catch 22'. We did not visit the children's substance misuse service as part of this review.

The last inspection of safeguarding and looked after children's services for Cheshire East took place in June and July 2011. This was a joint inspection with Ofsted. At that time, the effectiveness of the arrangements for both safeguarding children and looked after children were judged to be 'adequate'. Recommendations for the providers arising from our recommendations of that review were considered during this review.

All four of the provider NHS trusts identified above have been inspected by the CQC under the regulatory inspection framework since September 2014. The findings of those inspections in relation to children and young people have been considered as part of this review.

The report

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

What people told us

A parent speaking about the emergency department in Macclesfield General Hospital said:

“We are really happy overall, always made to feel welcome. Only thing I would like to see is more resources for my 9 year old.”

Another said:

“We have had fabulous care throughout; they know what they are doing”.

The manager at a children’s home told us:

“(Cared for children nurse, name) is very supporting and we have good communication. She will visit and complete all health checks and also do the review health assessment’s for our children.”

“We can phone (nurse) at any time and she will provide us with advice and signpost us to where we can get it.”

“We have not had any problems getting children’s health needs met from routine registration and treatment through to Child and Adolescent Mental Health Services support.”

“Support from Child and Adolescent Mental Health Services has been good and you can always phone them for advice.”

A young adviser told us of their experience:

“I didn’t trust anyone before but my work with the young advisers built up my trust with CAMHS– my new CAMHS worker has really helped a lot and has been really great.”

“If I have a problem I can go to my CAMHS worker and they are easy to contact – by phone or by text.”

“When they changed my CAMHS worker they helped me to adjust by letting me see my old CAMHS worker for a while too.”

“I can ask the looked after children nurse anything.”

“For the young advisers I do talks in schools, interview staff, do service appraisals.”

“They do listen to the young advisers and act on their advice. I sit on the steering group for the new residential building.”

The child's journey

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

1. Early help

1.1 Before examining the child's journey from the perspective of the health services, it is important to understand the pathway for referral to other services at each level of intervention in Cheshire East. This is important as it affects the liaison arrangements between health and with other agencies for each level of intervention. The agencies in Cheshire East use the Cheshire East Local Safeguarding Children Board's (LSCB) document known as the 'Guidance to Support the Levels of Need' to determine the level and nature of support offered to children, young people and their families. This guidance describes four levels of intervention with the purpose of ensuring that children and their families have access to services that meet their needs. The four levels are described according to the degree of need.

- Universal – where there are no identified additional needs, no identified risks and children and young people routinely gain access to support from GPs and community health teams
- Targeted – where targeted additional help may be required, provided by a single agency
- Complex – where additional and more complex needs affecting different areas of life are identified and requiring co-ordinated support from more than one agency working together
- Specialist – where the level of needs for children and young people reach the statutory level of intervention as a child in need or where they may require protection.

1.2 'Early help' is referred to as the intervention at either the targeted or complex levels. This is where the Common Assessment Framework (CAF) may be used as an early help assessment tool to assist in assessing and planning to meet children's needs. Health services in Cheshire East feature at each of these four levels to a varying degree, whether as single agency providers of universal or targeted support, or support as part of a multi-agency team around the family (TAF).

1.3 All referrals for additional co-ordinated services are made through the Cheshire East Consultation Service (ChECS) who are described as the 'front door' for access to support and advice. This includes all referrals made about children who need protection, those who may be children in need and those who may require additional support as coordinated through the Early Help Brokerage Service. All referrals to ChECS are submitted on a multi-agency referral form (MARF).

1.4 Maternity staff working in Leighton hospital (Mid Cheshire Hospitals NHS Foundation Trust – MCFT) and Macclesfield District General hospital (East Cheshire NHS Trust – ECT) have received additional training in domestic abuse, including a risk assessment process which supports them being able to act promptly when concerns are identified. The maternity records used in both trusts prompt staff to make a routine enquiry about potential domestic abuse when safe to do so; for instance, in Macclesfield, this is done on the first ante-natal appointment when women are routinely seen alone. Making this routine enquiry is a positive approach to identifying women at risk of domestic abuse as research recognises an increased risk of domestic violence beginning or escalating during pregnancy. However, the assessment of risk could be further enhanced by ensuring this routine enquiry is undertaken on more than one occasion as the records we looked at in both hospitals did not evidence this was happening. This will ensure that risk is identified for women where the risk may be evolving or escalating later in pregnancy. [Recommendation 1.1](#)

1.5 Both the Leighton hospital and Macclesfield District General hospital maternity staff have access to an independent domestic violence advisor (IDVA) through their respective safeguarding teams. The IDVA is able to assess risk and manage onward support and referrals, strengthening the additional support to pregnant women that both maternity units can offer in such cases.

During admission to Leighton maternity unit a pregnant woman disclosed she was a victim of domestic abuse. The information was briefly shared during a moment when the client was not with her partner. The midwife promptly contacted the safeguarding team and the IDVA.

A planned but creative approach was taken to assist the woman to be seen on her own as her partner had an active presence and this offered the woman the opportunity to discuss the issue. A safe diversion was put in place and she was able to share details with the practitioners.

The IDVA was able to complete a risk assessment which supported the woman in keeping safe. The information was shared with the midwife and formed an alert on the record. Further liaison with the Health Visitor ensured that the risks to the woman and her baby continued to be monitored.

1.6 Mid Cheshire Hospitals NHS Foundation Trust have a well-developed team of specialist midwives within Leighton hospital who support pregnant women with increased vulnerability. The six midwives have a corporate case-load approach, each having mixed cases of clients with different vulnerabilities such as mental health, domestic abuse and child protection. The team takes referrals from community and hospital midwives, social workers, police and a range of other agencies ensuring that vulnerable women are well supported and receive co-ordinated services throughout their period of care. The team is well-resourced and the processes in place to support safeguarding practice are robust.

1.7 East Cheshire NHS Trust uses a different model to support women with particular needs. A 'vulnerable families' midwife works directly with some vulnerable women but also works collaboratively with other case-holding midwives, supporting them with expertise and guidance. The processes for making a referral to the vulnerable families midwife (a special circumstances form) and for evidencing involvement and case progress are robust. For example, the community midwives have access to the records of care and current activity being undertaken by the vulnerable families midwife. An update of each case is shared with the midwifery team leader the health visitor, GP and Neonatal Intensive Care Unit at 28 weeks pregnancy. This helps practitioners to understand each expectant woman's needs and supports in ongoing care planning.

1.8 The vulnerable families midwife at Macclesfield hospital also collaborates with other practitioners who are involved with families. The midwife routinely undertakes at least one joint home visit with social workers in active cases, and also the family nurse or health visitor during the antenatal period. This helps the early and joint identification of additional means of support for the mother-to-be and her baby.

1.9 The universal 0-to-19 service across Cheshire East is provided by a single provider (Wirral Community NHS Foundation Trust) from four 'footprint hubs', clustered around the two main population centres of Macclesfield and Crewe. This enables closer links with children's centres, schools and GP localities on a smaller scale. This promotes effective day-to-day communication with those services about vulnerable families and allows health visitors and school nurses to act as a conduit to early help.

1.10 Health visitors undertake regular drop-in sessions at local domestic abuse refuge premises. In this way they provide a proactive service to families who have experienced domestic abuse, many of whom are from out of the area or from migrant communities. Practitioners also maintain strong links with the independent domestic violence advisors (IDVA) working from the acute trusts and attend meetings of the Multi-Agency Risk Assessment Conference (MARAC). This places health visitors in a unique position to co-ordinate care for such families by liaison with GPs and with schools through the school nurses. This ensures that women and children in this vulnerable group get access to universal services and any needs for early help can be readily identified.

1.11 The school nurses provide drop-in clinics in high schools with good uptake from children and young people reported in the five to 16 age group. The drop-in service helps to increase the visibility and accessibility of the school nursing service and to enable public health opportunities. For example, school nurses provide advice and support on sexual health and contraception including the provision of condoms, pregnancy tests and chlamydia screening. However, there is a gap in support for young people in the 16 to 19 cohort. This has been drawn to the attention of Cheshire East Council's Public Health Directorate as the commissioner of the school nurse service.

1.12 The CAMHS service provided by Cheshire and Wirral Partnership NHS Foundation Trust employs community primary mental health workers to work with children and young people in relation to anxieties and emotional wellbeing. This enables young people who have mental health needs that do not require more specialist support, and their families, to receive help to help manage their thoughts, feelings and behaviour.

1.13 In the east of the area, a service known as 'Visyon' is commissioned to provide support for young people aged 16 to 19 who require a lower level of intervention normally described as being at Tier 2 of the National Framework for Child and Adolescent Mental Health Services. No such service is commissioned in the south of the area, although the Cheshire and Wirral Partnership NHS Foundation Trust primary mental health worker will work with some of those young people who are prioritised as being at a higher level of need. We learned anecdotally that this often results in discussions with GPs or other referrers in relation to referrals being declined. This means that, whilst some young people with behavioural and emotional needs have those needs met, others do not. Cheshire and Wirral Partnership NHS Foundation Trust acknowledge that the current service is not resourced to consistently provide such lower level interventions and that this is a service gap. As an example of this differential level of service, we learned from a Healthwatch consultation with families living with Autism (Living with Autism in Cheshire East, Healthwatch, 2015) about the service provision across Cheshire East. Children and young people awaiting assessment for autism report that they receive a different level of service in the Eastern Cheshire CCG area as they do in the South Cheshire CCG area, both in terms of waiting times and the involvement of specialist CAMHS in the assessment. [Recommendation 7.1](#). We have also drawn this to the attention of Cheshire East Council's Public Health Directorate.

1.14 The Community CAMHS service for young people aged 16 to 19 with more complex mental health problems is provided by a dedicated 16 to 19 team and this enables practitioners to develop expertise in managing the care of this older cohort. Moreover, it provides age appropriate arrangements for transition between the adolescent and the adult service where young people's needs evolve during this period. For example, joint transition work between the adolescent team and the adult service commences six months before the young person reaches 19, a year later than is common elsewhere. This means that the young person can continue with their care plan for longer, supported by care co-ordinators who know them well and who they are familiar with and this is a positive step.

1.15 Information sharing by both East Cheshire NHS Trust and Mid Cheshire Hospitals NHS Foundation Trust with community and primary health services about emergency department (ED) attendances is well developed. Paediatric liaison nurses at both Leighton and Macclesfield District General hospitals review attendances of all children on a daily basis and ensure that these are communicated to the Wirral Community NHS Foundation Trust universal health services. Additionally, discharge summaries for each child who attends each ED are sent to each child's named GP. The paediatric liaison function provides oversight of all attendances and ensures all potential risks have been identified. It also means that children and families who might benefit from additional early support are signposted to relevant practitioners in good time.

1.16 The sexual health service provided by East Cheshire NHS Trust is delivered through two primary hubs with peripheral clinics running at various times throughout the day at a number of different locations. This allows young people to get access to this key service at locations convenient for them, such as GP practices and a children's centre, and increases the opportunities for targeted early help

1.17 Cheshire and Wirral Partnership NHS Foundation Trust substance misuse service has well established pregnancy liaison meetings. The monthly meeting reviews all cases of pregnant women known to the service and attendance includes the case holder, specialist midwife and health visitor. This approach supports coordinated care and management of cases where the risks to the unborn baby are high but also provides opportunities to consider whether additional support would be required.

1.18 'Catch 22' have been commissioned by Cheshire and Wirral Partnership NHS Foundation Trust to offer one-to-one work with consenting young people seen in ED with substance misusing behaviours. The referrals are received from ED practitioners or directly from young people who self-refer. One of the intended outcomes of this arrangement is to reduce young people's attendance at ED for substance misuse related presentations. This is a positive step, although we were unable to determine the impact of this work during our review.

1.19 Since the beginning of the year the CCGs have deployed a dedicated Child Sexual Exploitation (CSE) nurse. The nurse reviews all CSE referral forms emanating from health practitioners that are submitted for the attention of the monthly multi-agency CSE operational meetings. The nurse contacts health practitioners to gather information for the monthly meeting and also offers advice about work that might be undertaken with the young person whilst waiting for any planned health interventions arising from the meetings. This is good practice as it supports early intervention and focuses on the needs of the young person.

2. Children in need

2.1 The case records we looked at in the Leighton hospital maternity unit showed effective liaison between the midwife and children's social care for new-born children in need. For example, we saw evidence of joint discussion and decision making in relation to pre-discharge arrangements for a woman with particular needs. There was evidence of the service advocating on her behalf about the appropriateness of a proposed CAF and stepping up the level of intervention for her new-born to that of child in need. The midwifery team liaised with other health providers in relation to her medication for her specific condition and provided advice and interpretation to enable the social care case managers to take a holistic view of, and better understand the new-born child's needs.

2.2 In Leighton hospital, there are arrangements in place for expectant mothers with mental health needs and these are compliant with guidance issued by the National Institute for Health and Care Excellence (NICE). For instance, standard questions used to identify low mood are consistently asked and recorded in the records of identified pregnant women. If depression or anxiety is identified then the woman is supported by one of the safeguarding specialist midwives at Leighton hospital and is seen by a consultant obstetrician as part of the pathway. This supports the woman's mental well-being and helps to mitigate the risk to the unborn arising from mother's mental ill- health.

2.3 Leighton hospital midwifery service has developed a robust missed appointments guidance for pregnant women. The guidance and flow chart gives clarity to actions to take and the guidance offers a framework for when to raise concerns regarding non engagement. This is good practice as NICE guidance highlights that vulnerable women with socially complex needs are less likely to access antenatal care or attend appointments regularly.

2.4 In Macclesfield District General hospital, care pathways to support women with mental health needs are identified by the use of the East Cheshire Mental Health Maternity Proforma. This ensures a standardised approach and supports a woman with mental health needs in understanding how her care will be managed by remaining involved in decisions about that care. Where women with current or severe mental health issues are identified, a 'cause for concern' form is generated and held within both the paper and the electronic patient records where midwives who may be involved in delivering care at a later time can be fully informed of the woman's needs.

2.5 The East Cheshire NHS Trust midwifery department have fostered good relationships with the psychiatric liaison team. With the client's agreement, the psychiatric liaison team see women who have diagnosed mental health problems, just after birth, even if they have been presenting as stable and in order to offer a supportive visit prior to discharge. This is a further opportunity to identify any additional needs.

2.6 Within parts of Cheshire East covered by Mid Cheshire Hospitals NHS Foundation Trust, a community midwifery service is offered by an independent midwifery provider. In one of the cases we were tracking across services, there was evidence that a case where there were known complexities owing to potential substance misuse was being held predominantly by this service. This means the vulnerable family did not receive the additional expertise offered by the safeguarding midwives at Leighton hospital. In addition, the procedures for oversight of this case by the specialist midwifery team, including supervision and quality assurance were not clear. This could lead to delayed or inappropriate response to safeguarding concerns. [Recommendation 3.1](#)

2.7 At Leighton hospital and Macclesfield hospital maternity, all women are asked about whether they have experienced female genital mutilation (FGM). In the records we looked at relating to one woman we saw that information had been obtained about her experience, including the country where the FGM had occurred and her age at the time. The community midwife had spoken to both the woman and her partner and the woman was seen by a consultant obstetrician for clinical view and labour management. Although the trust policy to support staff action is basic in its nature, the management of this case met the woman's needs and record keeping evidenced clear actions taken. The policy on FGM is undergoing a re-draft and this will include a clear decision pathway to support staff in this complex area.

2.8 Each GP practice in the Eastern Cheshire and South Cheshire CCG areas benefits from the appointment of a named, link health visitor. The link health visitor has a specific role description aimed at improving the quality of care for vulnerable children and families through enhanced dialogue between the GP and the community child health teams. The link health visitor attends the practice clinical or management meetings, usually monthly, in order to discuss current work with particular families. The health visitor has an updated list of vulnerable children who are known to the service, either because they are subject of a child protection plan, a child in need plan or are subject of a CAF plan where there may be additional concerns. In this way, health visiting and primary care services share good quality, current information to support the evolving needs of families and young children.

2.9 This information sharing arrangement with health visitors was evident in our visits to two GP practices during the course of our review although the named GP reported that communication between GPs and the community health teams was variable and not as robust as it might be. For example, school nurses are not routinely invited to GP safeguarding meetings nor do they have the capacity to attend. This restricts the opportunity to share information, and understand and co-ordinate early help for school-age children. This has been drawn to the attention of Cheshire East Council's Public Health Directorate as the commissioner of the school nurse service. [Recommendation 4.1](#)

2.10 In the emergency departments (ED) of both Leighton and Macclesfield hospitals, limited efforts are made to identify the 'hidden child' of adults who attend with risk taking behaviours or mental health needs. The current adult paper record, known as a 'casualty card' provides practitioners with prompts and space to record details of any children in the family or with whom they have contact. However, this information is not consistently recorded and does not demonstrate that staff are professionally curious about such children. This could lead to those children who might be in need or at risk as a result of parental behaviour being overlooked and their needs not being identified. [Recommendation 1.2](#)

2.11 In Leighton hospital ED, children are booked in using a generic, as opposed to paediatric specific casualty card. This does not support staff in gathering key information about a child's social history, including full details of siblings or of parents or other adults in the household. In turn, this limits the opportunity to consider potential risks to the child or other children in a household arising from a child's social history. [Recommendation 3.3](#)

2.12 In Macclesfield hospital ED by contrast, children under 16 are booked in using paediatric documentation that follows them on their journey through the department. However, details about adults in the household and other family members were not recorded in most records we saw. Once again, this does not demonstrate the professional curiosity of staff in exploring social histories in a way that helps to establish potential risks. Furthermore, young people aged 16 or 17 are booked in using adult forms and so there is no scope to gather this information at all. [Recommendation 2.1](#)

2.13 In addition we saw variable standards of recording in relation to ethnicity and language in both hospitals. This is important information, as the recording of basic demographic details can help ensure that ED practitioners are able to provide culturally sensitive care for both adults and children. [Recommendation 1.3](#)

2.14 Children and young people who attend the ED at Leighton hospital are first of all subject to the trust's streaming process at reception where they are either directed into the paediatric ED proper or, in the case of minor illnesses or injuries, streamed into the GP led urgent care centre located in the department. The streaming decision is made by a nurse who determines which walking or chair-bound patients are suitable for streaming into the urgent care centre based on their clinical presentation. This facilitates less waiting time for those children who can be seen quickly.

2.15 Younger children wait in a children's waiting room which is well equipped for children to play while they wait. There is also a discrete area where older children can wait. In both Leighton and Macclesfield hospital waiting areas, families waiting to be seen are in view of the ED reception areas. This helps to enable any deterioration in a child's physical condition to be noted and concerns about personal interactions to be observed.

2.16 In both Leighton and Macclesfield hospitals, children and young people under 16 who attend ED with risk taking behaviour, such as deliberate self-harm, are admitted to the paediatric wards to await an assessment by the CAMHS service depending on the immediate care needs of the patient on presentation. We learned that this assessment happens very quickly with most children being assessed and promptly discharged, with support, within 24 hours. This is due to the presence of a CAMHS duty clinician every week day between 9am and 5pm. Outside of these times a consultant psychiatrist is on-call to advise hospital staff about appropriate care for young people admitted to the wards overnight or over a weekend. In this way their care is planned and managed by paediatric staff with close monitoring by the CAMHS service.

2.17 This is not the case for the 16 to 19 CAMHS service. Although the CAMHS psychiatrist is available for advice if necessary, the trust's liaison psychiatry team, an adult service, provide the initial response and assess the young person in the ED before discharging them with a referral into the 16 to 19 community service or the young person's GP. We acknowledge that this practice is well established and that the liaison psychiatry team have received an appropriate level of safeguarding training. However, there is a risk that such assessments may not fully take account of the child's family, social situation and safeguarding concerns as outlined in the relevant NICE guidance on self-harm. For example, in one of the cases we were tracking across services we saw that issues about the young person's capacity to consent to information being shared with a parent had not been effectively dealt with. We asked the CCG to carry out a review of this particular case to ensure that the young person's plan of care was robust and had an outcome driven focus.

[Recommendation 5.1](#)

2.18 Young people using the sexual health service are asked detailed questions relating to their capacity to consent based on established guidelines. This helps practitioners to obtain important information about a young person's circumstances and to better identify their needs or any risks to them

2.19 In the adult substance misuse service, a standardised risk assessment tool known as 'Clinical Assessment of Risk to Self and Others' (CARSO) is intended to be completed as part of the initial assessment of clients. However, completion of this template in the electronic patient records system is variable with much information not being updated. Overall records are descriptive and the assessment of risks to children is under developed. For example, one record had missed the opportunity to fully consider the 16 year old sibling of the baby of a client although there was positive work seen in respect of the baby. This prevents practitioners from fully understanding risks in a client's family. [Recommendation 5.2](#). This has been drawn to the attention of Cheshire East Council's Public Health Directorate as the commissioner of the substance misuse service.

2.20 There is a lack of evidence of timely home visits being undertaken on clients who store medication at home even though the safe storage boxes are issued by the service. There is no specific guidance on when a visit should be undertaken although there is a recognition that they should be carried out at least annually. Furthermore, there is an assumption that social care, where they are actively involved, will ensure medication safety is checked during their visits. Without a clear agreement or criteria against which social care should check safe storage boxes there is a risk that this will not be addressed. [Recommendation 5.3](#). This, too, has been drawn to the attention of Cheshire East Council's Public Health Directorate as the commissioner of the substance misuse service.

3. Child protection

3.1 The Leighton hospital and Macclesfield hospital midwifery safeguarding teams have developed effective processes for ensuring information is available within records and is shared with key colleagues when safeguarding risks have been identified. Safeguarding alerts on the electronic patient records system identify vulnerability and supports this good practice.

3.2 Colour coded blue 'cause for concern' forms are generated at 21 to 28 weeks pregnancy and shared with GPs, health visitors and the neonatal intensive care unit. This process is quality assured by peer review with oversight from the named midwife. An admission plan is created for all unborn children subject of a child protection plan and filed in the medical records at 36 weeks pregnancy. We saw evidence of these consistently in records we reviewed. The system could be enhanced, however, by a further updates being shared with key practitioners by 37 weeks for those women where a 'cause for concern' has been raised by the lead specialist midwife involved in the case as this does not currently happen.

[Recommendation 3.2](#)

3.3 Both the Leighton hospital safeguarding midwives and the Macclesfield hospital vulnerable families midwife consistently attend child protection conferences and core group meetings. Reports are detailed and effectively use the midwives expertise to support multi-agency analysis of risk. Furthermore, information emanating from multi-agency child protection processes is shared effectively with the rest of the midwifery team. For example, in Leighton hospital, although conference outcomes or minutes are not routinely held in the woman's record, we saw that birth plans are created for all women whose unborn child is subject of a child protection plan. Evidence of these was consistently seen in the records we reviewed. In Macclesfield hospital maternity, however, conference minutes and other multi-agency documents such as MARAC risk assessments are embedded in the electronic patient records system. Both of these arrangements ensure that all maternity staff who might use the records have a complete picture of risks to support arrangements that might be required for the baby at birth.

3.4 The health visiting service, including the family nurse partnership, routinely and actively engage with child protection processes. In cases we were tracking across services and those we randomly sampled, we saw that information was shared with children's social care to a consistently good standard. This is the case for referrals made to ChECS and information supplied for strategy meetings as well as for reports for child protection conferences where risks are set out using the established assessment framework format. This approach assists social workers to understand the context of the risks in a familiar format. This is further supported by the Wirral Community NHS Foundation Trust safeguarding team who supply a person each day on a rota, and in collaboration with East Cheshire NHS Trust, to the ChECS to act as an information conduit from the community health teams.

3.5 Case records of practitioners' engagement with families are detailed and are reproduced in reports for conferences including by an analysis of risks. This ensures that the recipient of the report or referral is clear about the context of the risk and is better informed to take action where necessary. For example, in one case held by a family nurse, we saw that the practitioner had visited the family's home and had discovered an ordinary household object in circumstances, and in a particular location, which meant it was a potential weapon. The nurse considered her knowledge of the family, in particular the child's father. She had drawn the conclusion that this potential weapon represented a risk to both the child, who was subject of a child protection plan, and other practitioners who might visit the home. This was communicated to the family's social worker and followed up in writing as part of the report to the review child protection conference that was due to be held. The records of the conference showed that the nurse's information had led to action by the social worker, had formed a large part of the discussion about ongoing risks to the child and contributed to the decision to strengthen the child protection plan.

3.6 We saw some good examples of cases referred to ChECS by the school nurses that were supported by robust evidence and analysis. However, in one case we noted that, although the case had been effectively escalated, it had not been subsequently followed-up to establish an outcome. This is a gap as it means the practitioner cannot take account of the outcome in further work with the young person.

3.7 School nurses attend all initial and review child protection conferences and we saw some good evidence of written reports in the records we looked at. In one child protection report we saw that the school nurse had challenged the category for the child protection plan based on her interpretation of information arising from her work with the child. This indicated that the practitioner was actively and dynamically engaged in the child protection process and could contribute positively to decisions made about the young person.

3.8 The Wirral Community NHS Foundation Trust safeguarding team provide quality assurance of reports from the health visiting and school nursing service submitted for child protection meetings. Feedback is given to staff where reports require further strengthening or amendments, and support is offered for this. However, referrals to children's services are not routinely quality assured unless the practitioner seeks this support independently and there is a potential that shortfalls in the quality of referrals might be missed. [Recommendation 6.1](#). This has been drawn to the attention of Cheshire East Council's Public Health Directorate as the commissioner of the sexual health service.

3.9 All initial child protection conference reports and all child protection referrals emanating from the CAMHS service are scrutinised by the trust's safeguarding team to ensure that their quality is monitored. In the cases we sampled we noted that this has led to consistently good quality information about risks being communicated to children's social care.

The CAMHS learning disability service have been using a licensed programme, known as 'signposts' to analyse and understand the needs of children with a learning disability. The programme is also used to educate parents in proactive skills to support their child and mitigate any harmful behaviours. Moreover, the use of the programme enables the service to identify, not only strengths in parenting capacity, but also evidence that shows deficiencies. In one of the cases we were tracking we saw that the programme had enabled the child's care coordinator to establish evidence for the child protection review conference that had also been key to assisting the local authority in proceedings for an interim care order and so the child was properly protected.

3.10 When young people with mental health needs are transferred to the paediatric ward at Leighton hospital for further medical intervention or to wait for assessment, they do not benefit from any formal assessment of the risk they might pose to themselves or to others. Their physical environment is assessed but this is a generic and superficial assessment. Furthermore, whilst health professionals working on the paediatric ward have completed on-line training modules, there is no offer of additional joint training with CAMHS on working with children and young people with additional mental health needs that would strengthen the staff understanding of such risks. This means that risks to the safety of those patients or to other children and young people on the ward might not be properly considered.

[Recommendation 3.4.](#)

3.11 At both Macclesfield and Leighton EDs we found clear guidance to staff on how to respond to any safeguarding or child protection concerns. The safeguarding teams at both the East Cheshire NHS Trust and the Mid Cheshire Hospitals NHS Foundation Trust are very visible and supportive of ED staff in ensuring that thresholds are understood and indicators of abuse are easily recognised. In some case this was evident; for example, we noted good use of the child sexual exploitation (CSE) and trafficking template in use at Macclesfield hospital ED.

3.12 All referrals to ChECS from Macclesfield and Leighton hospital EDs are copied to the children's safeguarding teams at both trusts for review and quality assurance. However, as we have outlined in 'Children in Need' above, there are inconsistencies in the way that the booking-in documentation is used to support professional curiosity and the exploration of social histories in a way that helps to establish potential risks to children (see also recommendations 1.2, 2.1 and 3.3). We could not be assured, therefore, that the oversight of these referrals had made any improvements to the overall quality of referrals made by ED practitioners in either of the hospitals. [Recommendation 1.4](#)

3.13 In both GPs we visited we saw that there was a good understanding of the local thresholds for intervention and of the role of the GP in collating information about, and providing information for, different multi-agency processes. We saw evidence of information being contributed to the MARAC to support risk decisions about domestic abuse. In one practice we saw information being collated about children who had frequently or persistently failed to attend appointments or those who were subject of a CAF. This ensures that GPs have more information at their disposal during consultations with children in order to consider risks.

3.14 In one of the GP practices, we saw that concerning information about the current relationship of a young person who was known to have a history of sexual offending was promptly passed on to the ChECS. However, this was not followed up in writing by use of the multi-agency referral form on advice of the ChECS practitioner receiving the referral. This is contrary to the LSCB procedures. It is also not effective practice as it means there is no shared record of the discussion, the risks identified and the agreed actions. [Recommendation 7.2](#)

3.15 We learned that attendances at child protection conferences by GPs in Cheshire East are infrequent, although in one practice we saw that the lead GP attended whenever they were able to if they had direct involvement with families. All practices, however, routinely submit written reports. Although there was generally plentiful information supplied, we found the quality of reports provided for conference to be variable. Clinical, factual information is predominantly submitted rather than a holistic picture of risks to the child. This could be improved by the use of an assessment model in written reports, such as the assessment framework, so that information is presented to conferences in a format that supports effective decision making. [Recommendation 7.2](#)

3.16 Sexual health service staff participate fully in multi-agency child protection processes such as child protection conferences and CSE meetings and produce written reports about their involvement for those meetings. In one case we looked at we saw that detailed information had been provided to a CSE meeting about a particular cohort of young people who had been using the service. This enabled the meeting to better understand the links between the group and contributed to the multi-agency management of the risks that arose as a result of their association.

3.17 The electronic patient records system in use at the sexual health service has a number of templates that staff can use to support them in assessing risks to young people coming into the service. One template is intended to be used for young people under the age of 16 and staff are obliged to use this for every child under 16. Generally these are helpful as they support the professional curiosity of staff by ensuring relevant questions about risk are asked and responses recorded. In one particular case we saw that a thorough examination of a young person's situation had led to a robust risk analysis relating to CSE which was shared with the young person's social worker. The practitioner was subsequently able to contribute to the resulting strategy meeting and the later child protection conference.

3.18 The electronic patient records system is cumbersome to navigate, however, and the templates require the same information to be repeated in a number of different places. As a result, safeguarding information is not easy to isolate so it can be used to direct subsequent safeguarding activity. This was evident in one particular case where safeguarding information was sparsely recorded and it was not clear whether key action had been taken in relation to a disclosure of a serious sexual offence. We have since been reassured that action was properly taken and that the matter was being investigated by the police under child protection procedures. The arrangements for management oversight of complex cases requires strengthening to ensure such shortfalls in records are picked up and that appropriate information sharing takes place for similar cases. [Recommendation 2.5](#). This has been drawn to the attention of Cheshire East Council's Public Health Directorate as the commissioner of the sexual health service.

3.19 The adult substance misuse service have an effective process for ensuring practitioner participation in case conferences, a process which is overseen by the trust's safeguarding team. Generally, a standard information sharing template is completed and the specialist safeguarding nurse is consulted prior to attendance to ensure that information is correctly identified and shared. Records we looked at showed commitment to attendance at meetings and reports were of a reasonable quality although analysis of risk could be strengthened.

3.20 There is more to do to ensure links are made between the adult substance misuse service and community child health services to fully support children who suffer the impact of parental addiction. Liaison with community health practitioners is undertaken through child protection core group meetings where both services are involved. Opportunities to share information outside of this arrangement are underdeveloped although managers expressed an expectation this was happening. [Recommendation 5.4](#). This has been drawn to the attention of Cheshire East Council's Public Health Directorate as the commissioner of both the substance misuse service and the community child health services.

3.21 Although contribution to, and attendance by adult mental health practitioners at child protection conferences was good, there is a gap in the understanding of the necessity for accurate records to be maintained about safeguarding issues within client's records. We acknowledge that the Cheshire and Wirral Partnership NHS Foundation Trust are in the process of developing a safeguarding screening tool to enable the more effective collation of safeguarding information. However, this is not yet in place. For example, in one of the cases we were tracking across services, the single point of assessment practitioner had not been made aware that between the referral and the assessment the client's children had been made subject of a child protection plan. This has an impact on the understanding of the risk to the client's children during assessment. [Recommendation 5.3](#)

4. Looked after children

4.1 Cared for children specialist nurses are co-located at council premises with other cared for children practitioners within the local authority. Ordinarily we would expect this to enable effective partnership working and information sharing but it is recognised that there has been an ongoing shortfall in the timescales for notifications to the health team in relation to the date children enter care. In the last quarter the number of notifications received within two days, with appropriate signed consents in place was at 68%. Whilst we are advised that this represents a recent improvement to the acknowledged shortfall, the rate is nonetheless still low and there is some way to go to ensure timescales are more easily met.

4.2 The timeliness of Initial Health Assessments (IHA) is poor. None of the IHAs we saw were completed within statutory timescales. It is evident that the Cared for Children specialist nurses notify those responsible for completing the initial health assessments with a letter identifying the statutory required date. Irrespective of this letter, the completion of IHAs remains over the statutory time frames for the majority of children, with the current reports showing a compliance rate of less than 30%. We recognise that many of these children's assessments might be just outside the timescales and that work has recently been undertaken to assure the accuracy of the reporting of the timescales. However, more needs to be done to ensure all children entering care have their health needs considered in a timely way. [Recommendation 8.1](#)

4.3 Similarly, the process for notifications to other health practitioners for review health assessments are not robustly developed and this has an impact on the number completed on time. At the time of our review around only 70% were completed within timescales. As before, we recognise that many of these assessments are just outside the timescale but the low compliance rate means some children have to wait to have their health action plans adjusted as a result of changing health needs. [Recommendation 8.1](#)

4.4 Currently, a choice of location for initial health assessments is only offered to those characterised as 'hard to reach' children, such as children who frequently miss appointments, children not in education and children in residential accommodation. There is no similar opportunity for all cared for children and this is not an equitable offer. [Recommendation 8.2](#)

4.5 Despite evidence that initial health assessments are being quality assured by the designated doctor the quality of the information within those assessments remains variable. For example, health action plans are not SMART or attributed to specific, identified responsible health professionals, and timeframes for completion of actions are consistently shown as 'ASAP' and 'Ongoing'. Parts of the initial health assessments in many records we sampled were left blank, many of these areas being significant issues for cared for children, such as emotional and behavioural features, sexual health and lifestyle.

4.6 There was consistently limited or no information about parental medical history. Generic terminology was used to describe individual children such as 'no concerns' or 'age appropriate'. In one of the cases we were tracking across services we noted that there was contradictory information about dental hygiene. The health assessment noted that dental health was good whereas the information for the school nurse indicated that the young person needed extractions and orthodontic work. This observed general poor quality in health assessments means that cared for children's health needs are not identified accurately. As a consequence, their health needs cannot be properly planned for or other risks identified.

[Recommendation 1.6](#)

4.7 The quality of health assessments of children who are placed out-of-area is also reviewed by the specialist cared for children team and the quality issues are addressed directly with the assessing practitioner under an out-of-area protocol. However, we did not sample any such cases during our visit.

4.8 The designated nurse for looked after children has provided training for GPs in relation to their responsibility for providing health information to inform initial health assessments. Whilst this information sharing does not yet happen in every case, it is now becoming established practice, although we have been advised that the quality of this information is variable.

4.9 School nurses do not have oversight of the overall numbers of looked after children in the 5 to 19 population or those held in school nursing caseloads. Further, not all school nurses have received recent training or updates about achieving any expected standards for completing health assessments. For example, we identified in some cases that the 'voice of the child' was not fully captured in review health assessments. This is important because it enables practitioners who view the assessments to have a clearer picture of the child's wishes and feelings about their health. [Recommendation 8.3](#)

4.10 Health professionals who are responsible for the health needs of cared for children contribute to the cared for children statutory reviews. If practitioners are unable to attend reports are provided. We noted that actions from reviews are recorded on the child's electronic health record file. We saw that these had been followed up to ensure that outcomes in line with the child's health plan are being met.

4.11 All looked after children who attend the ED at Macclesfield or Leighton are routinely referred to children's social care to share information about the reason for attendance and any concerns identified during their presentation. This ensures the cared for children social work team are provided with key, up-to-date health information directly.

4.12 The electronic patient records system used by GPs in Cheshire East has alerts to identify children who are cared for. The system also enables GPs to link information about adopted children with their pre-adoption health records. This supports GPs during consultation and enables them to consider if they are meeting the cared for, or adopted child's health action plan.

4.13 An assessment tool has been devised to track and identify the mental health needs of cared for children aged 16 and over. There is still some developmental work required before this tool can be launched, notably in assessing the availability of services that might arise from an increased demand. However, this is an encouraging development and will provide a means of enabling young people who are cared for to get access to appropriate treatment.

4.14 Health passports are developed with cared for children with learning disabilities and this is good practice as it provides them with clear and meaningful information about their health histories and enables ease of communication during urgent care contacts. However, the passports are currently not routinely provided to all children leaving care. This is a missed opportunity to support this cohort of young people as they transition into independent living. We have been advised that plans are in place to provide this to all care leavers although this has not yet been implemented. [Recommendation 1.5](#)

4.15 A positive development is the recent employment of a specialist 16 plus transition nurse who will ensure young people who are about to leave care have access to support and guidance in meeting their health needs as an adult. The post holder has just been appointed at the time of our review and so we have not been able to assess the impact.

4.16 Through the Children in Care Council, cared for children in Cheshire East are involved in the interviewing process for new staff for the looked after children specialist nursing team. It was reported that their involvement has been valuable and had helped the team to recruit suitable staff members.

4.17 The sexual health service link effectively with the cared for children service to manage risks to young people who are looked after. In one case we looked at, the risks to a cared for young male arising from increased sexual activity were identified and communicated to the cared for children service. This enabled the specialist cared for children nurse to present a comprehensive picture of the risks to this person to the local authority. This also enabled the local authority to plan to manage these risks whilst the sexual health service provided support in relation to sexually transmitted infections.

5. Management

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

5.1 Leadership and management

5.1.1 Throughout our review we found evidence of a strong safeguarding culture at all of the providers we visited, and a strong will to improve, develop practice and assure quality both as separate organisations and collaboratively with each other and with commissioners. Other than where we have reported, safeguarding practice is generally well developed with each provider having an established safeguarding team and clear processes for quality monitoring, reporting and supervision. We have also found examples of innovative or robust practice and we have set out some of these below.

5.1.2 The two CCGs covering Cheshire East share the responsibility for the designated clinical professionals. The designated nurse for safeguarding children is highly visible and proactive. She leads on the development of policy for both CCGs, co-ordinates the section 11 Children Act audit processes, supports the named professionals in each of the health providers and takes a lead role in the joint safeguarding assurance agenda in the area. This is done by way of the Safeguarding Children and Adults Assurance Group meetings for each trust, which are held quarterly. These are co-ordinated by the designated nurse so that overall safeguarding performance across the Cheshire East area can be monitored to the same consistently applied standards. For example, at the most recent meetings for East Cheshire NHS Trust and for Cheshire and Wirral Partnership NHS Foundation Trust we noted that shortfalls in level three training had been identified as a cause for concern. The trusts' action plans to address this were monitored with improvements expected to be reported at the next meeting.

5.1.3 The designated nurse for looked after children is not employed directly by either of the CCGs but is employed by East Cheshire NHS Trust working as a specialist cared for children nurse for part of the working week. We have commented on the efficacy of this arrangement under 'Governance' below.

5.1.4 The CCGs, together with the local council, are proactive in engaging young people and families about their health needs and in providing information about local services. For example, the co-produced leaflet 'Your Health, Your Life, Your Choice' is aimed at providing cared for children and care leavers with information about how to access the whole range of local health services, such as contraception and sexual health, dentists, GPs and mental health services. This leaflet is available in health premises throughout the region and has also been developed into a smart-phone application with the same title. Further, a smart-phone application known as a 'CatchApp', produced by the CCGs, provides advice and guidance to parents and young people about the current and planned development of health services. The electronic leaflet, 'Your Mind Matters' for example, accessed through the application lets parents and young people know about the mental health transformation plans and how they can be involved in contributing to the service design. These innovations have recently been set in train so their impact is yet to be measured; however, we consider them to be examples of the vision and willingness of the CCGs and the council towards improve access to information about health for young people.

5.1.5 As we have reported above, the team of six specialist midwives at Leighton hospital is well-resourced and adopt robust procedures to support safeguarding practice, such as clear and detailed record keeping that highlights risks effectively. , record keeping was clear and risks highlighted appropriately. Record keeping processes are well developed; staff recognise the importance of auditable record keeping and the documentation in use supports good practice in this area. However, there was no process for ensuring an audit trail was maintained for email communications with social care and there was opportunity for such communications to be missed or not filed. [Recommendation 3.5](#)

5.1.6 At Macclesfield hospital, the integrated safeguarding team senior leads attend all MARAC meetings on a rotational basis to both share hospital held information and to cascade information and actions back to clinical teams. The team actively support shadowing at MARAC by midwives in order to increase their understanding of the process. This is a positive step in supporting midwives to understand the role they have in identifying and supporting women who are victims of domestic abuse.

5.1.7 The Macclesfield midwifery service has developed a robust approach to maintaining knowledge to assist in supporting vulnerable women. Team leaders, the antenatal clinical manager and Head of midwifery have enhanced safeguarding expertise, all having undertaken a university level six child protection module. This indicates a trust commitment in time and money to ensuring safeguarding expertise is available across the midwifery departments and is good practice.

5.1.8 The head of midwifery at Macclesfield hospital has recently worked with the consultant for public health for the local authority to secure medium term funding for a new post of Mental Health Midwife. This example of good collaborative working to enhance a service has resulted in the new post being developed. The post will shortly be recruited to. It is intended that this role will strengthen mental health pathways and improve care for this vulnerable group and their unborn children.

5.1.9 The Cheshire and Wirral Partnership NHS Foundation Trust operate a 9am to 5pm duty desk which acts as a point of contact for all staff in CAMHS and in adult services about safeguarding issues. The trust also hosts a weekly safeguarding meeting involving all safeguarding nurse specialists during which new cases, referrals and safeguarding risks are discussed. This is in addition to the layer of scrutiny provided by the safeguarding team for each referral and for reports submitted to conference. This provides robust management oversight and helps ensure good quality information is shared with partners.

5.1.10 The Wirral Community NHS Foundation Trust safeguarding team also operate a duty desk for each of the regional centres, staffed each working day between 9am and 5pm. The duty staff member considers all new cases of concern and has direct links with the CAMHS duty desk and the adult mental health resource centre. This arrangement enables discussion and advice on safeguarding matters to occur with minimum delay.

5.1.11 As reported above under 'Child Protection' Wirral Community NHS Foundation Trust and East Cheshire NHS Trust safeguarding teams collaborate to supply a person each day on a rota to the ChECS to act as an information conduit from the hospital and community health teams. This role will shortly be developed into a whole-time equivalent band seven nurse who will be co-located with ChECS. The nurse will participate in multi-agency safeguarding decision making in what will become a more integrated multi-agency front door.

5.1.12 There is effective, regular liaison between the health visiting service and the GPs about vulnerable families through the nominated link health visitor as reported above under 'Early Help'. For most practices, the monthly practice clinical or management meetings which the link health visitor routinely attends are the focal point for this information sharing arrangement. We were told that the health visitor provides information to each GP practice on all children who are accessing the 0 to 19 universal health services or who are looked after. Although there is good information being supplied about children under five, however, this is not always the case for school aged children where the information from the school nursing service is limited and we have reported on this above.

5.1.13 The services models for Health Visiting and School Nursing are developing well through the new commissioning arrangements. Senior managers are supportive and demonstrate a commitment to the continuing improvement agenda for universal services.

5.1.14 School aged children and young people who are home schooled or young carers are not easily identifiable to the school nurse team. There is a reliance on information being shared to inform them of this but there is no clear formal process to proactively identify them. These children and young people do not benefit from the offer of the healthy child programme provided by the school nurse team and may have unmet health needs. Managers are aware of these gaps and are engaged in seeking solutions to close them. We have brought this to the attention of the public health directorate of Cheshire East Council.

5.1.15 An increased demand on the immunisation programme together with prioritised involvement in safeguarding procedures and a reduced general capacity has meant that the school nursing service in East Cheshire is stretched in delivering other commissioned services such as delivery of the PSHE component. It is unclear whether this number of staff are able to deliver their core universal service as there is no organisational risk information or detail on whether the caseload sizes and workforce complement meets the relevant guidance. Once again, we have brought this to the attention of the public health directorate of Cheshire East Council.

5.1.16 In both the Macclesfield and Leighton hospital EDs, we noted that there is a shortage of paediatric qualified nurses to cover all relevant shifts. Both trusts have identified the shortfall and are currently mitigating this with the use of senior nurses who have completed emergency paediatric life support training and additional paediatric learning modules. Whilst this might be a satisfactory interim measure, it this does not meet with the appropriate guidance on staffing for paediatric urgent care settings and is unsuitable as a long term solution. [Recommendation 1.7](#).

5.1.17 Strong leadership in safeguarding practice in primary care in the Cheshire East area has evolved since the appointment of the current named GP. This is evident in the enthusiasm shown for engagement with GPs we noted from staff in the various health providers we spoke with through the course of our visit. Further, in the two GP practices we visited we learned that the visible and proactive leadership of the named GP, supported by the designated nurse, has led to a general uplift in participation of GPs in safeguarding processes and a clarity about their role. For example, one GP practice, supported by the named nurse, had been in discussions with the local authority about the routine receipt of minutes from child protection conferences. As well as ensuring the GP has all information about any particular case, this also serves to remind other agencies of the importance of the role of the GP in the partnership.

5.1.18 In both GP practices we visited, there are effective administrative systems in place to record and monitor information about vulnerable children and young people. This includes the means to record alerts on the electronic patient records system for children subject of child protection plans, child in need plans, common assessment framework processes or children for whom there might be a cause for concern where no such plans currently exist. This enables GPs to consider safeguarding information in the context of a consultation with the child or young person.

5.1.19 The administrative systems also use a sophisticated spreadsheet database that records information about all vulnerable children whose electronic patient records have a safeguarding alert. The database has the capacity to track and record key activity and dates and ensures that, for example, dates of child protection conferences are not missed and that GPs have the opportunity to contribute.

5.1.20 There is also a dedicated safeguarding administrator in each practice we visited. This is a staff member with additional knowledge and understanding about safeguarding who has responsibility for maintaining the database and the practice electronic patient records system. This arrangement ensures the safeguarding systems operate effectively and that GPs are alerted to all matters of concern about vulnerable children and their families. For example, the administrator in one practice checks the NHS 111 notifications for any calls to the service involving a child where the caller is advised to take the child to ED. In these cases the administrator checks the corresponding ED notifications for any anomalies in the history given or any other issues that might require closer scrutiny by a GP.

5.1.21 Both CCGs have collaborated to take positive steps to support the involvement of health disciplines in the joint approach to CSE in Cheshire East by appointing a dedicated CSE nurse in January 2016. Already this role is having an impact on the work of health practitioners in regard to CSE. For example, the CSE nurse has worked with the named GP to develop a proforma to support information sharing at the monthly CSE operational meetings. Encouragingly, the last two months have seen a fully compliant (100%) response rate to requests for information from health practitioners. This ensures that the partnership can take full account of health information and can consider recommending health led interventions with young people. At present, the role is contracted for 20 hours each week. It would be expected that, as the role develops and becomes embedded, the demand on this resource will increase. Therefore, any review of the service should reflect on whether the deployed hours adequately meet the need given the geographical footprint and extent of the CSE nurse's role.

5.2 Governance

5.2.1 Our interviews with key staff and our review of annual reports show that there are clear lines of accountability in each of the CCGs with the Lead Nurse having executive level responsibility to the CCG governing bodies. The Lead Nurse represents the CCG at the Cheshire East local safeguarding children board (LSCB). The designated nurse for safeguarding children is accountable to both CCGs through a hosting arrangement. Until just before our review there was no Designated Doctor in post but this has now been recruited to with the new post holder beginning during the week of our review. We are unable to assess the impact of this at the time of our review. The named GP is employed by NHS England but is accountable to the CCGs for improvements in safeguarding performance in primary care.

5.2.2 Both CCGs are required to provide assurances to NHS England in relation to safeguarding performance. Our review of the action plans for both CCGs shows that good progress is being made against those key attributes of NHS England's Safeguarding and Accountability Assurance Framework. No significant areas of risk are identified and where actions are still outstanding we saw that steps are in train to ensure all areas of the framework are met during 2016. For example, a safeguarding training strategy that encompasses all roles identified in the relevant inter-collegiate guidance has been developed and is due for sign-off and implementation in August 2016.

5.2.3 If lines of accountability for safeguarding are clear and well established, this is not the case for cared for children. The roles of designated and named nurses for cared for children are not resourced in accordance with the national model. This has led to a blurring of the tiers of managerial responsibility. The cared for children provider, East Cheshire NHS Trust, does not employ a named nurse to provide key operational oversight of the activity of the specialist cared for children nurse team. In addition, the CCGs do not have full-time responsibility for the nurse carrying out the designated role. Instead, the nurse carrying out this function works three days each week as a designated nurse employed directly by the CCGs and two days each week within the provider's cared for children team as a specialist nurse. Each role has a different focus and both we, and NHS England consider that the current arrangement creates a conflict of interest. For instance, the current role holder receives two forms of supervision. Supervision in the designated role is provided by the designated nurse for safeguarding children within the CCG; supervision within the specialist nurse role is provided through the trust's safeguarding team. The CCGs are aware of this conflict of interest and will be addressing this.

[Recommendation 2.2](#) and [7.3](#)

5.2.4 Each of the trusts serving Cheshire East are accountable to the CCGs through the previously mentioned individual trust based, quarterly Safeguarding Children and Adults Assurance Group meetings during which their performance dashboards are reviewed and any shortfalls are subject of an ongoing action log.

5.2.5 Both acute trusts in Cheshire East have clear lines of accountability to their respective boards and to the LSCB. The East Cheshire NHS Trust report to the trust board through the Director of Nursing Performance & Quality. The Mid-Cheshire Hospitals NHS Foundation Trust report to the trust board through an executive safeguarding group. Both trusts are represented on the Cheshire East LSCB. All statutory named roles are fulfilled and this provides effective operational governance for acute and maternity services.

5.2.6 Both the Cheshire and Wirral Partnership NHS Foundation Trust (CWPFT) and the Wirral Community NHS Foundation Trust (WCFT) have larger geographical footprints. The Director of Nursing, Therapies and Patient Partnership is accountable to the CWPFT board whilst the Director of Nursing and Performance is accountable to the board of the WCFT. Both trusts are also represented on the LSCB.

5.2.7 We have reviewed the most recent trust annual safeguarding reports for all four providers and we are satisfied that the arrangements for data collection and reporting enable the providers to have effective oversight of safeguarding performance and to use this information to tailor their service or identify areas for improvement. For example, data collection in the adult substance misuse service by the Cheshire and Wirral Partnership NHS Foundation Trust safeguarding team has given an overview of the level of activity. This has supported the trust in ensuring child protection cases are managed equitably across practitioners so staff capacity to manage their case loads is not adversely affected.

5.2.8 Overall, we have found a positive safeguarding culture in the CCGs and in all providers in Cheshire East with a strong will to improve and to invest in staff expertise.

5.2.9 During our review we have seen examples of children and young people being engaged in helping providers to improve services, such as the previously reported involvement of cared for children to interview prospective nursing candidates for the cared for children service and the inventive 'CatchApp'.

We have been impressed by the way that the CAMHS service has employed young advisers to develop a variety of aspects of the service and to communicate learning about young people's mental health. For example, the involvement of young advisers in presenting information about their experiences to staff groups from different agencies and to young people themselves; the involvement of young people in the design of literature to communicate aspects of the My Mind service; and the active participation of young advisers in the steering group to design the new tier 4 inpatient facility are all examples of listening to the child's voice and we commend the service for this approach.

5.3 Training and supervision

5.3.1 The Cheshire East LSCB have not been subject of any serious case reviews (SCR) since the most recent SCR of 2011. However, the LSCB have an additional review process, called a reflective review, where particular cases that do not meet the threshold for SCRs are nonetheless subject of a multi-agency review to identify any learning. We saw that health agencies had participated fully in the most recent of these reviews of November 2015 and January 2016, relating respectively to bruising in non-mobile infants and children with complex needs. Learning from these reviews has been disseminated and has affected practice. In the latter case, for example, we saw that procedures in GP practices for receiving, noting and acting upon notifications or reports of children in need had been embedded into the procedures of both practices we visited, demonstrating the added value of this review process.

5.3.2 The Leighton hospital Named Midwife supports the safeguarding team to deliver level three training to all midwives and maternity supporting staff. Current levels of compliance are 96% for level three within the maternity unit. However the rolling programme does not meet the minimum requirement (12 to 16 hours) over a three year period as set out in the inter-collegiate guidance and so the percentage figure is likely to be inaccurate. [Recommendation 3.6](#)

5.3.3 The midwifery service at Leighton hospital has not established a safeguarding supervision model or documentation that comprehensively supports the current process. Actions from supervision are not routinely recorded in the midwifery record. The named midwife offers monthly supervision during team meetings and ad hoc supervision when required. She also aims to offer three-monthly individual supervision to midwives but recognises this standard is not always met. [Recommendation 3.7](#)

5.3.4 The Macclesfield hospital midwifery service training framework meets the level three requirements. However compliance is at 70% for level three and so the trust cannot be assured that staff are equipped with safeguarding knowledge or understanding specific to their roles and responsibilities. [Recommendation 2.3](#)

5.3.5 Arrangements to support safeguarding supervision in midwifery at East Cheshire NHS Trust are robust. Regular supervision sessions are made available to midwives and we saw evidence of safeguarding being discussed in the cases reviewed. In addition, midwives are expected to provide regular updates on all cases where vulnerability has been identified, which enables professional challenge ensures that potential risk or drift is not overlooked

5.3.6 Macclesfield maternity service has established a group supervision process where the named midwife provides supervision to the team leaders (who are the case holders), the vulnerable families midwife and antenatal managers. The team leaders undertake three monthly group supervision with the community teams and antenatal midwives with a process for monitoring attendance. One-to-one safeguarding supervision has not been developed for non-case holding community midwives although *ad hoc* sessions are available when requested by the midwives. Managers recognise that the monitoring of attendance at group supervision sessions should be strengthened to ensure all midwives regularly receive support for their practice in this way. [Recommendation 2.6](#)

5.3.7 Health visitors and school nurses have completed their level three safeguarding training in line with inter-collegiate requirements. Training information shows that all relevant staff (100%) have received this.

5.3.8 Although the safeguarding team have a specialist nurse to support work around CSE, there has been limited follow up to date to check the impact of training in helping to drive improvements in school nursing practice to protect children from CSE. Similarly, the school nursing team have not had update training in relation to supporting young people with anxieties and emotional wellbeing. This is an area staff identified for further development. [Recommendation 6.2](#). We have brought this to the attention of the public health directorate of Cheshire East Council.

5.3.9 In cases we sampled in the health visiting service we saw evidence of the effectiveness of robust, one-to-one case specific safeguarding supervision, which is provided three-monthly to each health visitor and family nurse practitioner by the trust's safeguarding team. Each new client family where there are ongoing safeguarding concerns, or where new concerns are identified in existing client families, are reported to the trust's safeguarding team for initial review by the use of an 'activation' form. After initial support and guidance is given, this then triggers or 'activates' the safeguarding supervision process for that family and the health visitor. Thereafter, the health visitor is required to apprise the safeguarding team of developments at each of their subsequent safeguarding supervision sessions so that there is effective oversight of the child's evolving needs and any escalation or de-escalation can be dealt with appropriately. Further, practitioners can contact the safeguarding team for supervision on a particular case as and when new concerns arise that require more immediate decisions. Records of the supervision are made in a supervision template held in the child's file.

In one case we looked at we saw that a child who was living with suspected domestic abuse and who was already subject of a child protection plan had been discussed during a supervision session. This was due to heightened concerns about the behaviour of one of the parents identified during a visit by a family nurse practitioner. This was very much a 'live' issue and was in the process of being escalated to the child's social worker on the day we visited the service. This demonstrated, not only the effectiveness of the supervision and support offered to the practitioner, but also the timeliness of the response by the service.

5.3.10 The newly implemented one-to-one safeguarding supervision process in the CAMHs service is a strong model. We saw evidence of detailed discussion about individual cases with records being made in both a staff supervision log and in the electronic patient record.

5.3.11 Safeguarding Practice Leads have been appointed within each Adult Mental Health, adult substance misuse and CAMHS team providing a link and additional support for practitioners.

5.3.12 ED practitioners at Macclesfield and at Leighton hospitals have access to in-house level three safeguarding training. Practitioners also have access to multi-agency level three training. Currently, 85% of staff in Leighton ED and the Paediatric unit have received level three safeguarding training whereas this is at 97% for Macclesfield.

5.3.13 However, the numbers of eligible staff completing level three training in the rest of East Cheshire NHS Trust is consistently below the trust's target of 80% for both urgent care and women and children's services, with a compliance rate of between 65% and 77% month by month. The effect of this is that the knowledge and understanding of more than a quarter of the staff who require this enhanced level of training is not updated and so the trust cannot be assured of their level of safeguarding competence at any given time The CCG are monitoring progress against the trust's projected timescale for improvement through the quarterly safeguarding assurance meetings. [Recommendation 2.3](#).

5.3.14 The named GP provides regular level three training to GPs through six training events annually. Recently, training has included emerging learning from the Public Enquiry into historical child abuse, FGM, CSE and issues around hidden harm. The topics are very much focused on the 'think family' agenda. The training involves case review and facilitated peer discussion and supports the online level three component that GPs are required to complete in addition to this.

5.3.15 Sexual health staff receive mandatory and thematic annual training at level three which takes account of serious case reviews and national learning, delivered on a single agency basis. Key facilitators from different disciplines or agencies provide expertise for discrete themes. For example, the local police facilitated a session on CSE and a named midwife on FGM. Moreover, reception staff also participate in this training and this is a strength. This enables them to be confident in identifying potential risky situations through recognising certain behaviours or associated young people at the point of entry to the clinic. This was borne out in one particular case where such information had been helpful to the service in linking a small cohort of young people who were at risk of CSE.

5.3.16 Safeguarding supervision is offered to staff in East Cheshire NHS Trust every three months and we were advised that the take up of this is around 80%. However, staff in the sexual health service receive only informal supervision as and when it is required. We are aware that operational managers from the service attend the trust's bi-monthly safeguarding meetings to share learning from audits and on topical issues. This helps them to delivering day-to-day support to staff. However, sexual health staff would benefit from scheduled, one-to-one supervision that provides support for both their personal welfare and their decision making in difficult cases. [Recommendation 2.4](#)

5.3.17 In Cheshire and Wirral Partnership NHS Foundation trust 66% of eligible staff have accessed level 3 training, which falls below an acceptable level of assurance. The trust safeguarding team acknowledge this is a gap and have implemented another full day of training from September which, it is hoped, will improve this take up rate. The CCG are monitoring progress against the trust's action plan for improvement through the quarterly safeguarding assurance meetings. [Recommendation 5.6.](#)

5.3.18 Substance misuse and adult mental health staff eligible for level three training are required to attend the LSCB training on domestic abuse, mental health and substance misuse, which is jointly delivered by the nurse specialist. This is good practice as multi agency training enhances practitioner awareness of roles across agencies and promotes the importance of joint working to protect children.

Recommendations

- 1. East Cheshire NHS Trust and Mid-Cheshire Hospitals NHS Foundation Trust should:**
 - 1.1 Implement a process in the hospital maternity units to ensure that a routine enquiry about the risks of domestic abuse is made more than once during pregnancy to ensure any evolving risk is understood.
 - 1.2 Ensure that emergency department staff are aware of the importance of establishing the identities of children of adults who attend with potentially harmful behaviours and that they adopt good record keeping practices to support this professional curiosity.
 - 1.3 Ensure that staff in the emergency department adopt good record keeping practices about patients' ethnicity and language to support the delivery of culturally sensitive care.
 - 1.4 Ensure that processes designed to quality assure referrals to ChECS made by ED practitioners are effective and drive improvements.
 - 1.5 Implement plans to introduce health passports for all children leaving care so that they have access to their health histories.
 - 1.6 Implement an effective process for quality assuring the standard of initial health assessments to ensure the quality of information supports timely and effective health action plans and the assessment of any extraneous risks.
 - 1.7 Ensure that there are sufficient suitably qualified (paediatric trained) nurses on duty in the children's emergency departments for the whole of the time that the department is operating in accordance with national guidance.

- 2. East Cheshire NHS Trust should:**
 - 2.1 Ensure that paediatric booking-in documentation is available for all children and young people up to the age of 17 who attend the ED at Macclesfield emergency department, and that this documentation is used effectively to support staff in establishing key social history information about children to help determine potential risks.
 - 2.2 Ensure that a named nurse for cared for children is employed to lead the operational delivery of the service that is separate from the quality monitoring role carried out by the designated nurse.
 - 2.3 Ensure that all eligible staff across all services have access to level three training so the trust can be assured of staff knowledge and understanding.

- 2.4 Develop a system of safeguarding supervision for sexual health staff that enables them to receive regular, scheduled one-to-one sessions.
- 2.5 Develop and strengthen the arrangements for management oversight of records of complex cases in the sexual health service so that appropriate action is taken, information is properly shared with other agencies and robust records are kept.
- 2.6 Ensure that the attendance of midwives at scheduled group safeguarding supervision is monitored effectively.

3. Mid-Cheshire Hospitals NHS Foundation Trust should:

- 3.1 Develop a system that enables effective supervision and monitoring of maternity cases held by external providers so that any vulnerabilities or complex features can be identified and appropriate steps taken to ensure the woman has access to specialist midwifery support
- 3.2 Implement a system that provides key practitioners and health partners with updates of evolving risk for expectant mothers by 37 weeks when the admission plan is added to the file in the same way as is already carried out at 21 to 28 weeks.
- 3.3 Introduce the use of paediatric booking-in documentation that supports ED staff in establish key social history information about children to help establish potential risks.
- 3.4 Ensure that young people who are transferred to the paediatric ward to await a CAMHS assessment and those other children and young people on the ward are safeguarded through the implementation of robust risk assessments and improved training for ward staff that involves input from the CAMHS service.
- 3.5 Introduce a method of monitoring and tracking key email communications between the maternity unit at Leighton hospital and social care about individual cases that forms part of the patient record.
- 3.6 Audit the content and duration of the current offer of level three training to midwives to ensure it meets the requirements of the inter-collegiate guidance.
- 3.7 Ensure that safeguarding supervision offered to midwives in Leighton hospital is fully recorded in client records and that supervision is offered at a frequency stipulated in the trust policy.

4. NHS South Cheshire CCG, NHS Eastern Cheshire CCG and Wirral Community NHS Foundation Trust should:

- 4.1 Develop the information sharing arrangements between community child health service and primary care by ensuring information of relevance to, or originating from, school nurses features in regular practice meetings.

5. Cheshire and Wirral Partnership NHS Foundation Trust should:

- 5.1 Ensure that young people who self-harm are assessed by healthcare practitioners experienced in the assessment of children and adolescents who self-harm as recommended by the relevant NICE guidance.
- 5.2 Ensure that the 'Clinical Assessment of Risk to Self and Others' (CARSO) risk assessment tool is fully utilised in the substance misuse service to incorporate an analysis of risks to all children in the client's family.
- 5.3 Develop guidance for use by the substance misuse service on the regular monitoring of the safe use of medicine storage boxes at client's homes to ensure that risks to children who have access to the premises are fully considered.
- 5.4 Strengthen the arrangements in the adult substance misuse service for routinely sharing information with the community child health teams about the risks to children of parental substance use. These arrangements should be over and above those that already exist during child protection conferences.
- 5.5 Develop an effective process for updating adult client's mental health records with safeguarding information about their children so that practitioners fully understand the risks within families.
- 5.6 Ensure that all eligible staff have access to level three training so the trust can be assured of staff knowledge and understanding.

6. Wirral Community NHS Foundation Trust should:

- 6.1 Provide routine quality assurance of referrals made to ChECS by the community child health teams in the same way as is provided for child protection conference reports in order to ensure consistent practice in information sharing.
- 6.2 Ensure school nursing staff have received update training in supporting young people with their emotional wellbeing.

7. NHS South Cheshire CCG and NHS Eastern Cheshire CCG should:

- 7.1 Work with public health partners to develop a cohesive strategy across the whole of Cheshire East for the provision of support for children and young people with emotional health and wellbeing needs that might not require specialist CAMHS support and for those that are living with, or awaiting assessment for Autism.
- 7.2 Develop consistent approaches to reporting information into child protection processes by GPs, such as use of the MARF for every referral and the use of a risk based reporting format when sharing written information with child protection conferences.
- 7.3 Ensure that the role of designated nurse for cared for children is carried out by a person who is not also employed by the provider as part of the service delivery.

8. East Cheshire NHS Trust, Mid-Cheshire Hospitals NHS Foundation Trust and Wirral Community NHS Foundation Trust should:

- 8.1 Develop the systems for notifying medical professionals of the requirement for both initial and review health assessments for cared for children, and for completing the health assessments within statutory timescales so that cared for children are not disadvantaged in having their health needs planned for, and met in a timely way.
- 8.2 Ensure that all cared for children and young people have the opportunity to choose where to have their health assessments carried out.
- 8.3 Provide information or training to all school nurses about expected standards for completing looked after children review health assessments, particularly in relation to capturing the wishes and feelings of children and young people.

Next steps

An action plan addressing the recommendations above is required from NHS South Cheshire CCG and NHS Eastern Cheshire CCG within **20 working days** of receipt of this report.

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