Review of health services for Children Looked-after and Safeguarding in Blackpool

Children Looked-after and Safeguarding
The role of health services in Blackpool

Date of review:	8 May 2017 to 12 May 2017
Date of publication:	19 October 2017
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CCGs included:	NHS Blackpool CCG
NHS England area:	NHS England North Region North West Office
CQC region:	North
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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 Blackpool. 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 regional teams.

Where the findings relate to children and families in local authority areas other than Blackpool, 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 90 children and young people.

Context of the review

The latest published information from the Child and Maternal Health Observatory are those from March 2017. These figures are published by Public Health England and are used to set the context for the area.

The data shows that children and young people under the age of 20 years make up almost 23% of the population of Blackpool with 10% of school age children being from a minority ethnic group. Generally, the data indicates that the health of children in Blackpool is not as good as the England average with most of the attributes measured being significantly worse than the England average and some of these are summarised below. The exception to this is the rate of immunisations; this is generally better than, or similar to, the rest of England with the rate of immunisations for children in care being significantly better at 93.7%.

Whilst family homelessness is relatively low as compared with the rest of England, the proportion of children living in low income families is significantly higher, at 32%, than the England average at 20%. The number of children in care is also significantly greater with 164, as opposed to 60 per 10,000 for England.

The infant (aged 0 to 1 year) mortality rate is greater than the England average with 6.5 per 1,000 live births. The child (aged 1 to 17 years) mortality rate is slightly higher than the rest of England at 15.5 per 100,000.

Babies have comparatively healthy birth weights with obesity in younger children (aged 4-5 years) also being similar weights to the rest of England. There are more obese older children (aged 10-11 years), however than the England average.

Children's dental health is also significantly worse than the rest of England with 42.5% of children having one or more decayed, missing or filled teeth compared to 24.8% for England. There are three-and-a-half times the number of hospital admission of children aged 0-4 with dental caries that in the rest of England.

Under 18 conceptions are more than twice that of the England average at 43.8 for every 1,000 pregnancies whilst the rate of teenaged mothers is almost twice that of the England rate at 1.6%. There are 25% of new mothers who smoke at the time of delivery compared with 10.6% on average elsewhere.

Hospital admissions for young people under 18 with alcohol related conditions are around 90 for every 100,000 compared to around 37 for England as a whole. This figure is more pronounced for young people aged 15-24 admitted due to substance misuse where 345 for 100,000 admissions compares with 95 for England.

Hospital emergency department (ED) attendances for young children aged 0-4 years is better than England at 414, as opposed to 588 for every 1,000 attendances of children. However, attendances of children aged 0-14 and young people aged 15-24 with injuries are around twice that of England at 207 and 280 respectively.

Young people admitted to hospital with mental health conditions is at 150 for every 100,000 compared with 86 for England, whereas those admissions for young people over 10 years of age through self-harm are almost three-and-a-half times greater than England at 1,445 for every 100,000.

The Department for Education (DfE) provide annual statistics derived from outcomes for children continuously looked-after. As at March 2016, Blackpool had 470 children who were looked after, 315 children who had been continuously looked-after for more than 12 months (excluding those children in respite care), 45 of whom were aged under five.

The DfE data indicates that a greater proportion of Blackpool's looked-after children (94%) who had been looked after for 12 months or more had an annual health assessment than the rest of England (90%). The data also shows that 94% of those looked-after children were up-to-date with their immunisations, better than England with 87%, whereas only 81% had received a dental check compared with 84% in England as a whole. Further, 89% of the looked-after children aged under five had received an up-to-date development assessment, better than the 83% for the rest of England.

The commissioning and provision of health care services for children and young people in Blackpool is relatively straightforward with most services commissioned by one CCG and delivered predominantly by a single provider. Commissioning and planning of most health services for children, including looked after children, are carried out by NHS Blackpool CCG who collaborate with Blackpool Council Integrated Commissioning Team. It is of note that Blackpool Council Integrated Commissioning Team came into existence on the first day of this review and that prior to that Public Health services were commissioned by Blackpool Council.

Specialist health services for looked after children are provided by Blackpool Teaching Hospitals NHS Foundation Trust (BTHFT).

Acute health services, including emergency care and maternity are also commissioned by Blackpool CCG and provided by BTHFT.

Public health services for children and young people aged 0-19 (health visiting, school nursing and family nurse partnership), are commissioned via Blackpool Council Integrated Commissioning Team and provided by BTHFT.

The child and adolescent mental health services (CAMHS), including those for looked after children, are commissioned by the CCG and provided by BTHFT. The "Youtherapy" centre is part of the Children and Young People's Improving Access to Psychological Therapies programme and is part of the local CAMHS offer. A child psychology service and specialist facilities for children are provided by Lancashire Care Foundation trust (LCFT).

LCFT provide adult community mental health services including a consultant for peri-natal mental health. A primary mental health service for adults and the Improving Access to Psychological Therapies (IAPT) service are provided by BTHFT.

Contraception and sexual health services are commissioned via Blackpool Council Integrated Commissioning Team and provided by BTHFT through 'Connect', Whitegate Drive and by GP practices.

Child substance misuse services are commissioned by via Blackpool Council Integrated Commissioning Team and provided by 'The Hub' in partnership with Delphi Medical as part of the Horizon service delivered from a number of locations including 'Connect'. Adult substance misuse services are commissioned by via Blackpool Council Integrated Commissioning Team and provided by Horizon Drug and Alcohol Team.

The last inspection of safeguarding and looked-after children's services for Blackpool involving health services took place in November 2009; a joint inspection with Ofsted. Then, the effectiveness of arrangements for safeguarding children were judged to be 'adequate' and those for looked-after children as 'good'. Provider's recommendations arising from that review were considered during this review.

Ofsted carried out an inspection of the local authority and the safeguarding children board in July 2014 and were judged to be 'requires improvement'.

Emergency and maternity services at BTHFT were subject of a CQC focused inspection in September 2015 following a comprehensive inspection in 2014. The focused inspection rated emergency services as 'requires improvement' and maternity as 'good'. Community services (health visiting and school nursing) had yet to be inspected at the time of our review.

Health services in Blackpool follow the Blackpool Safeguarding Children Board (BSCB) procedures which are derived from the 'Pan-Lancashire' procedures. Referrals are made for children and young people who require additional services according to their level of need. Those levels are described by the BSCB guidance as 'Universal', 'Vulnerable', 'Complex' and 'Acute'. Referrals are made on a 'Getting it Right' (GIR) multi-agency form to the children's social care duty desk for subsequent decision making using a multi-agency model. Although the term 'GIR' is frequently used among practitioners to denote a referral, we have simply used the term 'referral' throughout this report. We acknowledge that since this review, the 'GIR' has been replaced by an Early Help Assessment or multi agency referral form.

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

We spoke with a number of young people and parents or carers.

Two people who live out of the Blackpool area who are the parents of a toddler brought into the emergency department told us:

> "It's not right dignified for the patients lying in their beds in the adult bit of A&E to have people walking through to get to the children's A&E area."
>
> "We are very happy about how we've been treated. We've been kept informed and we haven't waited long. Staff have been very helpful and attentive."

Some of the young people and care leavers we spoke with told us:

> "The only time my health assessments were bad was when they happened in school. It was better when I left school and they took place at home."
>
> "My GP is a male and I asked at the surgery if I could see a female doctor because it was about an intimate problem. The surgery said that I couldn't have a female doctor only a nurse present but this was not what I was asking for."
>
> "My looked after children nurse is helpful; if I don't want to go to Connect or the walk-in, I ask her advice and she tells me what she thinks and I do whatever she advises because I trust her."

Some of the foster carers we spoke with said:

> "The health visitor is very supportive of the children and me and my husband. One of the children that we look after is very poorly and we really feel that the health visitor supports us emotionally."
>
> "The review health assessments are very daunting but they go at his pace which is good."
>
> "The little boy that I care for has attachment problems and I don't know who to ask for help."
>
> "The child's GP was not very good but the health visitor helped us get sorted. We registered the child with our own GP and we get a good service from him."

Two new mothers we spoke with on the post-natal ward at Blackpool Victoria Hospital reported:

> "It's all been really good and I have had everything and all the support I have asked for (first baby). The breast feeding support was really helpful and my community midwife was dead helpful. Really good!"
>
> "I came in four days ago for …. The lovely midwife who looked after me on the day unit immediately picked up things weren't right. She got the doctor straight in and I was admitted straight away for … Everyone was all absolutely amazing; quick and responsive. I had great support in the delivery suite too."

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 It is established and routine good practice in most areas where we have undertaken reviews that midwives request key information from GPs, including information about a woman's social situation. Although the majority of pregnancy bookings are made through GPs, this information is not routinely requested by the maternity unit from GPs to support effective risk assessment carried out by midwives. This was previously identified as an action from a serious case review (SCR) but this has not yet been established as routine practice; this is a key area for development. In one of the cases we were tracking across services it was clear that this request, and information that was available to the GP about an older child in the family, would have affected the midwife's approach to risk in relation to the unborn infant. ***Recommendation 1.1***.

1.2 In records we looked at we saw that ethnicity and first language is captured and recorded at pregnancy booking appointments and that staff proactively secure interpreting support. However, there is limited written information available in different languages and formats and this could be strengthened to support new mothers-to-be from particular groups to initiate conversations with midwives about their needs.

1.3 There is a clear expectation that midwives will see a woman alone at least once during pregnancy and that a routine enquiry about domestic abuse is made at the first and each subsequent contact. An electronic proforma for recording contacts with women asks the midwife to record each time whether they have concerns about a number of potential risks. However, there is no section or field that requires midwives to note explicitly whether domestic abuse is asked about and this could lead to this key question being overlooked. An audit of maternity cases in 2016 to ascertain how established the routine enquiry on domestic abuse showed that this took place only 50% of the time. We were told that contributing factors included practitioners' lack of confidence in making the enquiry and a failure to make a record when the question had been asked. Our review of cases and discussions with practitioners shows that additional training and a re-emphasis of the trust's expectations has not made a significant improvement. Case recording and oversight by frontline operational managers is not robust or effective in ensuring case records are complete and comprehensive and this may lead to risks not being identified. ***Recommendation 1.2***.

1.4 The full-time paediatric liaison nurse role at Blackpool Victoria Hospital ensures that attendances of all children and young people under 18 years old at the emergency department (ED) are reviewed the next working day. This enables any community follow-up to be initiated without delay and for appropriate referrals to be made to children's social care when more serious concerns are identified. This was borne out by health visitors and school nurses who reported that they experienced excellent communication with the paediatric liaison nurse. This is a strength and a valuable aspect of safeguarding arrangements in BTHFT.

1.5 Where children present at the ED with substance misuse, the referral pathway is robust and in line with best practice. The paediatric liaison routinely refers such children and young people to 'The Hub' and this ensures they offered support for substance misuse at the earliest opportunity.

1.6 The health based Independent Domestic Violence Adviser (IDVA) has had a beneficial impact on raising staff awareness in acute and community settings of the indicators and prevalence of domestic abuse. In addition to providing training, the IDVA engages promptly with victims when they are identified in any department at the hospital, quickly establishing trust and ensuring prompt and effective follow-up to support safety planning of the victim and child in the community on discharge.

Good practice example

On attending the Emergency Department at Blackpool Victoria Hospital having taken an overdose, a woman disclosed to staff that she had experienced domestic abuse and that family relationships had broken down. She was reluctant to discuss issues in any further detail with practitioners but agreed to meet with the health IDVA.

The health IDVA responded promptly on the day of the woman's attendance and met with her, quickly developing rapport and establishing more details of the violence and abuse.

With the woman, the IDVA formulated a supportive plan for when the woman was discharged the following day.

This resulted in the timely implementation of community based multi-agency support so that the woman was discharged to a refuge and supported to end the abusive relationship.

1.7 Children attending ED walk through the adult ED to get to the children's ED area. This is recognised by staff as not being ideal as it exposes children who are sick to a more anxiety provoking environment. Timescales to create a separate children's entrance are not clear but we are advised that there are plans in hand and that work is due to begin imminently. The children's waiting room is well equipped but is not observable by nurses and this presents a risk to children who might rapidly deteriorate. ***Recommendation 1.3***.

1.8 At the reception for the ED and the adjacent urgent care centre (UCC), registration documentation asks for ethnicity, religion and language and this supports the delivery of culturally sensitive care. Numbers of previous attendances and the routine recording of the names and relationship of the person who accompanied the child to the ED or UCC is good practice as it supports effective risk assessment and this was evident in the cases we looked at.

1.9 There is good use of alerts about vulnerable children in the ED at Blackpool Victoria Hospital and the trust is live across unscheduled care settings with Child Protection Information System. However, the registration documentation does not prompt practitioners in the adult ED or the UCC in identifying hidden children at potential risk of harm due to adult mental ill health, substance misuse or domestic abuse. Adult patients at the ED or UCC are not routinely asked about parental responsibility or their access to children and this may mean that some children at risk may remain unidentified. ***Recommendation 1.4***.

1.10 Further, there is no differentiation between adult's and children's registration and assessment documentation. For example, there is no routine use of a children's safeguarding risk assessment that we would expect to see as part of the children's ED triage template. Therefore, identifying children at risk relies on the professional curiosity, knowledge and awareness of staff. In one case we were tracking across services the record showed a lack of professional curiosity although potential child protection concerns and risk of child sexual exploitation (CSE) should have been evident to, then explored and recorded by the practitioner. ***Recommendation 1.5***.

1.11 Families with children aged under five living in Blackpool benefit from good delivery of the Healthy Child Programme. This will be enhanced through a current service redesign that will see an increase of home visits from six to eight. This will increase the capacity of the service to monitor families and identify opportunities for early help although at the time of our inspection this was not yet fully implemented.

1.12 Health visitors make use of other opportunities to identify children and young people or their families who might benefit from early help and this includes generally good liaison with GPs. For example, health visitors receive a weekly transfer-in list from GPs for newly registered families who move into the area. All new families are contacted within one week and a visit to the home made. This good practice ensures that families new to the area are identified and located and also increases the opportunities to identify additional needs.

1.13 Furthermore, health visitors are notified by the maternity unit when women are 16 weeks pregnant, earlier than we generally see elsewhere. This enables health visitors to plan to visit expectant families in good time. All expectant parents receive an antenatal home visit at 28 weeks. This ensures pregnant women are engaged with community health services from an early point, helps to build relationships and increases the opportunities to observe and identify additional needs.

1.14 For those children who require more than a universal service provision there is a face-to-face handover between health visitors and school nurses in preparation for each September school term. This ensures that children are able to transfer into their new school environment with minimal disruption to their health care routines.

Good practice example

During our visit to the health visiting service we noted a number of examples of the health visitors going 'the extra mile' to ensure vulnerable families receive appropriate help and support.

For example, one new mother who was struggling to cope was supported by a health visitor to attend a local drop-in group for mothers with young babies. At the group, the health visitor looked after the baby for a short time to enable the mother to speak privately with a primary mental health practitioner about her anxieties. The increased confidence enabled the mother to engage fully with mental health services for more longitudinal support.

In another case, a mother who was experiencing difficulties obtaining suitable foods for her baby that had a food intolerance was met at the local supermarket by a health visitor. The health visitor helped the woman to identify and choose suitable foods ensuring she could successfully wean her baby.

Both of these examples illustrate simple but effective individual acts that helped the families achieve significantly better outcomes.

1.15 There is an established pathway in the school nursing service for children who transfer into the area and for those children who join or leave a school. This makes use of the local authority's migration report for children who are leaving or joining schools and health questionnaires sent to parents by the school nurse team. If limited information is received from the parents the school nurses initiate contact with professionals in other areas in order to gather key information about families new to the area. This is good practice, demonstrates professional curiosity and ensures prompt engagement and notification to mobilise local services for families.

1.16 There is a good early help offer to support young people in Blackpool with their emotional health and wellbeing. A variety of services provide therapeutic and counselling support to young people, including the youth therapy services targeted at young people between the ages 11 to 25 and the 'Headstart' service aimed at young people between 10 and 16 in schools. *We will bring these examples of good work in the foregoing paragraphs to the attention of Blackpool Council Integrated Commissioning Team as commissioners of the health visiting and school nursing service.*

1.17 There are close links between young people's mental health services and schools. For example, CAMHS practitioners have provided training and support to school staff to better equip them to support young people with emotional wellbeing. In addition two primary mental health workers attend schools, either to see and provide support to individual young people on request, or to identify young people requiring support at scheduled drop-in sessions in the schools. Youth therapy services also carry out drop-in sessions to schools at the end of each day so that this support is available to young people who might prefer not to attend during school hours. Lastly children's and adults primary mental health teams have bi-monthly meetings with the Youth Offending Service (YOS) and discuss individual cases to help address the emotional wellbeing needs of young people in contact with the youth justice system.

1.18 This strong, diverse emotional wellbeing offer ensures that children and young people have a greater range of local services that support them to build resilience. A good pathway into community CAMHS ensures that young people who have more complex or acute needs are referred to the most appropriate level of intervention and that they can access local therapeutic services if necessary to help manage anxieties whilst waiting to be seen.

1.19 We have seen further evidence of this strong early help offer from Blackpool's primary adult mental health services who provide a range of services for young people aged 16 and over. The diverse configuration of the service enables young people and families, and in particular, older children, young adults and young people who are also parents themselves, to build resilience through access to emotional health and wellbeing support.

1.20 Some examples of this array of services include the drop-in sessions in children's centres and baby clinics aimed at young parents; the range of services available to young adults with ADHD or ASC including the transition of their care and treatment from paediatric services; the availability of a very visible IAPT service; the liaison with the Youth Offending Service; links with the youth therapy services and the processes for identifying and managing the transition of young people into the most appropriate mental health service that meets their needs.

1.21 Young people have good access to a range of clinical and non-clinical sexual health and wellbeing support through the Wellbeing and Sexual Health (WISH) service, 'Connect', the integrated sexual health and genito-urinary medicine service provided by BTHFT and Whitegate Drive. 'WISH' effectively supports young people, both on a one-to-one basis and in groups, including work with looked after children in residential homes. This helps young people to be more informed and empowered to safeguard their sexual health and wellbeing and make informed choices.

1.22 The 'Connect' services are centrally located and accessible, operating both open access drop-ins and booked appointments. There is daily extended opening tailored to young people's use of the service. Locally, the well-known 'Connect' brand means that word of mouth helps encourage young people to access the services when they become sexually active of if they have sexual health concerns. This increases the opportunities for the identification of additional need or vulnerability.

Good practice example

The provision of the sexual health service outreach youth bus is a strength. Young people access the bus within their local communities by appointment and the bus is equipped with IT facilities enabling health staff to have read-only access to the children's social care record system. This facilitates the early and effective identification of risk or vulnerabilities for young people who might be hard to reach or otherwise have difficulty attending the central location.

1.23 The ‘Think Child’ approach is well developed in the Horizon substance misuse service through the use of standard assessments of clients who may be parents or have access to children. Where children under the age of five are identified by the service a home visit is undertaken. This ensures that the needs of children are identified and planned for early in the assessment process. Strong relationships between the service and the specialist substance misuse midwife enables early preventative work to commence with pregnant women. *We will bring these examples of good practice in the foregoing paragraphs to the attention of Blackpool Council Integrated Commissioning Team as commissioners of the sexual health and substance misuse services.*

1.24 Both GP practices we visited hold practice meetings to which link health visitors and other health professionals are invited and sometimes attend. However, neither practice holds routine vulnerable families meetings that include health visitors and other health professionals with the express purpose of sharing and co-ordinating information on families and children at risk. Where these are established in other areas they are effective forums for enabling understanding of children’s needs and facilitating the provision for early help. The absence of these meetings means that health visitors and those working more closely with families, as well as GPs as the primary care providers and record holders, may not have full insight into families’ needs. ***Recommendation 2.1***.

1.25 We have seen some case examples of good practice in GPs in identifying children and young people who would benefit from early help.

Good practice example

In one of the cases we looked at in a GP practice we visited, a notification had been received from the hospital about the attendance at ED of a child aged three having ingested liquid paracetamol. The patient services manager at the practice (one of the practice’s identified safeguarding team) reviewed the notification and as a result of the nature of the ED attendance, looked back over recent family history and contact with the GP.

The patient services manager identified a recent attendance at ED of the child’s older sibling with an injury. An attendance at the GP of the child’s mother with an ostensibly unrelated issue was also identified, but which was significant in relation to the family’s social situation and the attendance the children at ED. Lastly, a history of the children regularly not being brought for immunisations was also deemed to be relevant.

As a result of this, a referral was made to the health visitor, setting out the recent medical history of the family, for a follow-up visit to determine whether the family may have needs that could be met with through Early Help.

This demonstrates good, professionally curious practice by the staff member and highlights the effectiveness of good quality information from the hospital ED in enabling GP practices to consider the needs of a child in the context of what they know about a family.

2. Child in need

2.1 All case-holding community midwives are allocated cases where vulnerabilities have been identified in order to build and sustain skills, knowledge and promote continuously improving practice in working with vulnerable families. Where the highest levels of complexity or risk have been identified, cases are allocated to the Complex Social Needs (CSN) midwifery team, although it is also common practice for cases to be co-worked by a community midwife and a CSN practitioner. We reviewed and heard of more case examples that demonstrate that this well-established positive practice leads to effective targeted delivery of care and good outcomes for mothers and babies.

2.2 Midwives routinely attend child in need meetings and play an active role supporting the expectant mother as part of child in need plans. Midwives generally liaise well with most other professionals, routinely undertaking joint visits with colleagues and other professionals where appropriate. We noted examples of joint visits with health visitors, police and social workers. Discharge planning meetings involving relevant professionals are routinely held on the ward for children subject of child in need and child protection processes. This enables those professionals to be clear about a family's needs and for the continuity of the delivery of effective care and interventions in the community.

2.3 Where young people are admitted into the paediatric ward as a result of serious self-harm or mental health concerns, a highly comprehensive risk assessment proforma is completed for each child. The proforma in use at BTHFT is an excellent example of this type of tool which encompasses an extensive range of risks, prompts and actions to guide staff practice. This is used effectively to inform the care plan for each child and is reviewed regularly in conjunction with CAMHS duty practitioners who review children on the ward as required. The depth of the information presented enables clear understanding and supports good decision making about a young person's care and safety.

2.4 School health nurses provide weekly drop-in services to all high schools with each session lasting for three hours; young people can see the nurse either by previous appointment or on an *ad-hoc* basis. All health issues can be discussed including sexual health and contraception, bullying, substance misuse and emotional health and well-being. Since school nurses also remain actively involved in team around the family (TAF) arrangements to support child in need processes, the drop-in sessions and appointments provide the means by which such children can have their health needs planned for and met.

2.5 'Diversity' school nurses work closely with the Education, Inclusion and Access worker as part of the pupil tracking services for those young people who are not in education, employment or training. This involves collation of records and home visits to children and their families until they are enrolled in school and supports the ability of services to meet both health and educational needs.

2.6 In conjunction with the CAMHS, school nurses have developed a self-harm assessment toolkit to help young people and staff that work with them to understand and assess risk. A safety plan is produced for the young person to help identify warnings signs and triggers that may lead to them self-harming and options for self-help. The plan is personal to the young person and deliberately does not include a name so that if lost or mislaid they cannot be identified from it. A comprehensive pathway checklist helps staff to identify indicators of levels of risk or protective factors and actions to be taken at each stage. 'National Self-Harm Network' leaflets are provided as part of the process that include advice for young people, parents, family, carers and friends in supporting young people who self-harm. These are sound arrangements that enable targeted work to understand and meet the needs of this vulnerable group of children and young people. *We will bring these examples of good work in the forgoing paragraphs to the attention of Blackpool Council Integrated Commissioning Team as commissioners of the school nurse service.*

2.7 We have seen excellent examples of the work of the child and adolescent self-harm emergency response (CASHER) initiative in the ED, the adolescent ward, CAMHS and adult mental health services during our visits to those locations. These arrangements are not often seen during our reviews and they provide the opportunity to relieve the burden on core CAMHS services at evenings and weekends. The initiative has resulted in young people in distress having their mental health needs assessed promptly. It also facilitates the child's discharge from hospital and prevents them from remaining as an in-patient for longer than is medically necessary. Ultimately, this leads to better outcomes for young people with emotional or mental health needs and reduces the deficit to other young people on the paediatric ward.

2.8 The strong links between the CASHER team and the CAMHS and therapeutic services available to young people (as outlined above in 'Early Help') mean that their care and support can be transferred to the most appropriate professionals in a safe and timely way.

Effective practice

CAMHS staff are fully engaged in child in need processes and participate actively in TAF meetings. In one case we were tracking across services, a child that also had physical and learning disabilities, we noted that the TAF meetings were timed to coincide with the CAMHS reviews of the young person and included the child's therapeutic services. This effective approach to case management ensured that the child's needs were considered holistically by each service, thus reducing the need for multiple health appointments.

2.9 Transition for young people between the CAMHS and the adult services is well managed in both the primary adult mental health team provided by BTHFT and the complex care and treatment team provided by LCFT. There are dedicated staff with additional skills and training to equip them to support and plan the care of younger adults and produce care management plans through joint work with CAMHS staff. This ensures that additional needs of young people with enduring mental ill-health are met appropriately at this vulnerable time.

2.10 'Think Child' is a well-developed principle in both BTHFT and LCFT mental health services. However, we noted that this was not always strong where the focus of the work was on the young person who was transitioning from adolescent services to the adult services in either of the provisions. In each of these cases the focus on the young person who was the client (which was good) had led to a reduced or limited focus on the needs of the child with whom the client was associated (a four month-old child of a teenaged mother in one case and the 10 year-old sister of a more acutely unwell young client in the other). In each of these cases the needs of the child associated with the client were not well understood or articulated and did not feature in the client's care plans ***Recommendation 3.1***.

2.11 There is a strong peri-natal mental health pathway managed by the mental health service. This utilises good assessment tools and a peri-natal mental health management plan setting out symptoms, triggers and solutions that sits prominently in the record of the mother-to-be to help maternity staff with the woman's and baby's care. The pathway is augmented effectively by an outreach service that helps to support this vulnerable group of new mothers and their new babies. The BTHFT primary mental health service team also work alongside the Local Authority's Families in Need (FIN) team to carry out effective work through the production of management plans, to tailor support given to families with children subject of child in need or child protection plans. During our visit we reviewed several cases where this had led to effective ongoing work, sometimes alongside other key professionals such as the IDVA. In summary, the work of the peri-natal and FIN teams means that Blackpool children with additional needs related to parental or carer mental ill-health are well supported.

Good practice example

An older mother aged 38 pregnant with her first baby who was under consultant ante-natal care showed signs of significant anxiety when attending the hospital for a consultant appointment. A peri-natal mental health risk assessment was carried out by the midwife and the woman was referred into the specialist peri-natal mental health service.

Joint work by the peri-natal mental health practitioner and the midwife ensured the development of a mental health management plan in order to best support mother and baby and delivery suite staff through the birthing process.

The peri-natal mental health assessment identified domestic abuse; a 'Safer Lives' assessment was undertaken and this resulted in a referral to multi-agency risk assessment conference (MARAC).

This case showed good joint work and liaison between the midwife and peri-natal mental health practitioner to ensure the previously unidentified needs of a woman and her unborn baby relating to domestic abuse and mental-ill health were met.

3. Child protection

3.1 The jointly agreed pre-birth protocol between the maternity service and children's social care has been strengthened as result of a SCR, to include photographs in the birth plan, where available, of any people posing risk. This includes consideration of potential risks to delivery suite staff. Additionally, appropriate flags on the maternity electronic case recording system and a purple-edged chronology of significant events at the front of the case record are effective in immediately alerting midwives and delivery suite staff accessing the case record that this is a vulnerable mother or unborn baby. We saw a case example where this had worked well, with delivery suite staff being well sighted on the risks posed by newborn baby's maternal grandfather.

3.2 The protocol also allows BTHFT midwives to refer cases of unborn babies at significant risk of harm at 16 weeks pregnancy. This early date of referral is positive as it gives the opportunity for early pre-birth assessment and the provision of effective jointly agreed birth plans well ahead of the expected date of delivery.

3.3 However, we learned that it is not uncommon for significant delays in the completion of pre-birth assessments and the provision of birth plans. Although practitioners and service leads chase up any outstanding assessments and plans with children's social care we saw case examples where these had not been completed before the baby was born. Therefore, the effectiveness of the pre-birth protocol is limited. ***Recommendation1.6***.

3.4 Midwives prioritise and routinely attend initial child protection conferences and participate in core group meetings. The production of a written report as well as personal attendance is well-established in the service; this is in accordance with best practice as it ensures key information, particularly from ante-natal contacts, is made use of by the conference. Where case-holding midwives are unable to attend, cover is put in place and we saw case evidence showing that where midwives or practitioners stood in for the case-holder, they were knowledgeable about the case and contributed well to conference decision-making.

3.5 The maternity service and other BTHFT services are also well engaged with multi-agency risk assessment conference (MARAC) arrangements. The trust's safeguarding team routinely monitor and quality assure all referrals made to the MARAC and a member of the team attends the conference. Additionally, an identified exemplar referral from a safeguarding practitioner is being used effectively to support practitioners in making good quality MARAC referrals. After each MARAC meeting the safeguarding practitioner shares information appropriately across BTHFT services with the relevant individual staff member. This ensures case-holding staff are fully sighted on evolving risks.

3.6 We saw evidence of good child protection referrals being made by midwives. Those referrals we reviewed set out key factors giving rise to the safeguarding concerns. However, referrals did not always contain robust analysis of those key factors to demonstrate the impact on the unborn baby and what level of risk they present. ***Recommendation 1.7***.

3.7 In one case we reviewed we noted evidence of a good identification of a physical assault to a young child by the urgent care centre at the Blackpool Victoria Hospital through use of the local guidance for assessing bruising. This resulted in an appropriate referral and the subsequent prosecution of a relative for assault. However, due to the number of cases we could sample in the urgent care centre, we have been unable to identify any other cases that would indicate whether this is consistent practice.

3.8 BTHFT practitioners in ED and the paediatric wards use the multi-agency referral forms to make referrals to children's social care. However, we were advised that when practitioners make a verbal referral, different local authority managers have varying approaches as to whether or not these referrals should be followed up in writing. Where there is such flexibility or variability in referral pathways and agency expectations, this does not support continuous improvement in the quality of referrals and inhibits any formal monitoring. ***Recommendation 1.8***.

3.9 A full-time paediatric liaison nurse at the hospital reviews all under 18 attendances at the ED in the next working day and ensures any community follow-up is made and that appropriate referrals are made to children's social care. In addition, there are two advanced health practitioners in the MASH who review all referrals made by health practitioners and are available to provide advice regarding the quality of the referral. These arrangements are strong and a valuable part of safeguarding oversight for the trust. The effectiveness of this is hampered by shortfalls in the system. For example, referrals made by ED staff are not routinely loaded on to the electronic patient records system as the system is not sophisticated enough to enable this to happen. ***Recommendation 1.9***

3.10 The BTHFT safeguarding team and senior nurses in ED report that, where strategy meetings are held in the hospital, ED staff are beginning to be involved where appropriate. This is emerging good practice which will be strengthened once the practice becomes fully embedded.

3.11 There is no formal 'did not wait' (DNW) protocol in place at Blackpool Victoria Hospital. Managers have clear expectation that decisions about responses in individual cases rests with the nurse in charge but recognise that without a clear protocol, the trust cannot be fully assured of effective practice. In addition, the information leaflet given to parents and adults accompanying children about what they can expect from the ED does not include information about how a DNW will be responded to or that information may be shared with other agencies if concerns are identified. This could mean that some children about whom there are concerns may be overlooked. ***Recommendation 1.10***

Effective identification of risk

We also saw good examples of the identification of risk and appropriate referral by health visitors. In one case we looked at, diligent observation and recording of the interaction between mother and a very young baby and the conditions of the family home at an ante-natal visit, enabled the health visitor to identify risks of significant harm. The health visitor comprehensively recorded the assessment of risk in the referral form and a referral was promptly made to children's social care.

This supported good decision making by children's social care and ensured that timely action was taken and that the family were well supported.

3.12 Health visitors attend child protection conferences, core groups and child in need meetings. They provide written reports and updated reports for each meeting. Reports we reviewed in records provided details of their involvement, often including helpful chronologies from health information with a clear analysis of risk and this supports good accountable decision making.

3.13 CAMHS and therapy services staff attend child protection conferences and provide written reports to support their attendance. In cases looked at in the CAMHS, although reports for conference contained detailed information from the clinical records, there was limited analysis of the risks to the young person and the practitioner's recommendation for conference was not recorded. This creates delay in the conference process and can lead to key information being misinterpreted if practitioners cannot attend. ***Recommendation 1.11***

3.14 CAMHS and therapy services professionals are fully engaged in core groups for children who are on a child protection plan. This is good practice as it ensures key information about a child or young person's emotional wellbeing is taken account of when measuring progress against the plan.

3.15 Written referrals made by the CAMHS team were completed well with sufficient detail and analysis to enable risks to be understood. This is also a strength and supports good, accountable decision making.

3.16 However, the approach to identifying risks of CSE is not well developed in the CAMHS. In cases we looked at, including those we were tracking across services, we noted that opportunities to explore features of young people's lifestyles that might identify potentially exploitative situations were not taken and a standard CSE assessment tool was not in use. ***Recommendation 1.12***.

3.17 In primary mental health services staff attend child protection conferences and provide reports when they cannot attend although best practice should be that they do both. In the services provided by LCFT, reports are not always sent to conference. This is not consistent with trust policy and the absence of information about an adult's mental health can lead to inaccurate judgements of the conference about the impact of the adult's mental health on the child. ***Recommendation 4.1***.

3.18 The quality of referrals made by both adult mental health services was good with detail and analysis of risk clearly shown. In the peri-natal mental health team we noted a good identification of potential risks of domestic abuse to a client and her children of domestic abuse. The subsequent involvement of the IDVA showed good knowledge of local processes and appropriate local support to assist in assessing risk further.

3.19 The template in use in the LCFT service for assessing the impact of a new client's mental health on children they have access to is not always used according to trust procedures. This can lead to a failure to identify a child who might be at risk. ***Recommendation 4.2***.

Awaken team – good practice example of professional curiosity

The Awaken team is a well-established multi-agency Blackpool resource for young people who are at risk of CSE. The team provides the means to enable the partnership to monitor and act on intelligence, respond to higher risks through participation at the multi-agency child sexual exploitation (MACSE) meetings and to support young people who are at risk through a range of direct interventions or links with other services.

Dedicated health practitioners are an integral part of this process and we have seen case examples of exceptional work by this team to support young people at risk.

In one case we looked at, a 13 year-old girl who was pregnant had been referred by a sexual health and pregnancy advisory service out of the area due to her failure to attend an appointment for a termination.

Initial enquiries by the Awaken practitioner failed to establish contact with the girl and so an immediate joint visit the girl's home was carried out with the social worker and the police. Entry was gained and the girl was found to be safe and well.

Although subsequent investigations revealed that the girl was safe, supported at home and not at risk of exploitation, this case demonstrates the effectiveness of the practitioner's professional curiosity and judgement. The subsequent swift action enabled the authorities to establish without further delay the level of risk to the girl in question.

3.20 Staff at the integrated sexual health service have good awareness of the female genital mutilation (FGM) policy and referral pathway. Practitioners have undertaken bespoke training from the BTHFT safeguarding team and the issue has a high profile in supervision; this is supported by effective risk assessment documentation which has been strengthened through the recent inclusion of FGM as routine enquiry and this helps to identify potential risk at an early stage.

3.21 When young people have undergone an examination as the result of sexual assault, there is a well-established and effective pathway of referral from the examination centre into the sexual health service. This ensures young people receive good community-based sexual health follow-up support.

3.22 The sexual health service uses the electronic patient records system pop-up alert facility well to alert practitioners and managers accessing an individual case record to concerns, known risk factors or specific actions to take if a young person at risk attends the service. As a result of learning from SCRs, serious incidents and individual cases, the service is continuously evolving and strengthening the alert options. This is very positive, helping to ensure continuous improvement in safeguarding risk assessment and practice with this service.

3.23 The risk assessment proforma used for all young people under 16 using the sexual health service, and increasingly for 16 to18 year-olds is bespoke but based on the well-established 'Spotting the Signs' framework. The assessment is comprehensive, facilitating good risk assessments to be undertaken thought the use of mandatory questions and the opportunity for the practitioner to reflect on and evaluate the information they are gathering.

3.24 The sexual health service is well engaged at a strategic and operational level with the CSE arrangements and the Awaken team. Excellent use is made of the lists of young people known to be at risk of CSE discussed at the multi-agency child sexual exploitation (MACSE) meetings, with those who have not previously accessed the service being given a 'ZZ' case record on the records system. This is good practice as it alerts the clinician to a new client who might be at risk.

3.25 Information about children and any safeguarding status is immediately accessible to all staff in the substance misuse service through alerts on the electronic client records system. Staff attend all initial and review child protection conferences as well as and providing a written report to support that attendance. Staff also participate in core group and child in need meetings. Reports are compiled on a specifically developed template for drug and alcohol services which helps practitioners to understand the risks in the context of the client's substance misuse and to provide the conference with meaningful information. *We will bring these examples of good work in the forgoing paragraphs to the attention of Blackpool Council Integrated Commissioning Team as commissioners of the sexual health and substance misuse services.*

3.26 In primary care the electronic patient records system common to most practices in Blackpool enables alerts to be displayed for children who are subject of a child protection plan to enable the GP to tailor the consultation. In one of the GPs we visited we saw there was an effective system to alert the child's GP and safeguarding lead to any child on a child protection plan who was not brought to a hospital appointment. This enables clinicians to explore the reasons for non-attendance and to consider this when reporting to conference.

3.27 Child protection referrals are not commonly made by GPs in Blackpool and so we were unable to look at a large sample to determine their quality. However, one written referral form we reviewed in one of the GP practices that was completed by a practice nurse practitioner was of good quality with the risk of harm to the child clearly articulated. It was clear from the document that the practitioner had spoken directly with the child (aged eight) and the strong voice of the child was reflected well in the referral. This is good practice although we are unable to say whether this is consistent across all primary care in Blackpool.

3.28 Although records of child protection conferences are routinely requested and chased, there are inconsistencies in the way GPs provide information for conferences and in general the process is not well developed. For example, in the first practice we visited we noted that the GPs sometimes attend child protection conferences, although this is rare. In the second practice conferences are not attended at all. This means that conferences are obliged to rely on the quality of information submitted by GPs in the form of reports.

3.29 We are advised that an e-template has been devised to enable GPs in Blackpool to submit meaningful information to conferences. However, not all GPs are using this so we have been unable to see any examples and assess its benefits. In the first GP we visited we noted cases where reports are submitted in the form of a letter. Whilst this provides some clinical detail for conference the use of the template would strengthen the way such information is presented and analysed.

3.30 No reports are sent at all from the second GP despite the clinical lead having developed chronologies of significant health events for individual children that are held on file. This is a missed opportunity to use information that has already been gathered and organised for this purpose. The lack of attendance and written information from this practice means that the child protection conference cannot rely on any information from the GP about a child or family's situation and this is a gap. ***Recommendation 2.2***.

4. Looked after children

4.1 The quality of initial health assessments (IHA) for looked after children is variable. All IHAs are completed by the paediatrician or registrar for looked after children at any of a number of dedicated initial health assessment clinics held at venues across Blackpool. In the records we looked at the quality of initial health assessments was inconsistent with generally superficial detail and limited evidence of the voice of the child. In some cases we noted that aspects of the child's health needs arising from the health assessment had not been reflected in the health action plan. In most cases the health action plans themselves were not SMART. This means that the health needs of looked after children who are new to care are not properly understood, recorded or planned for. ***Recommendation 1.13***

Initial Health Assessment example, missed opportunity to identify and meet needs

One initial health assessment of a two and-a-half year-old child carried out by a registrar had superficial information.

There was limited information recorded about physical and dental health.

There was also no family history shown – the child had been present with the foster carer.

There was no evidence of the voice of the child and no personalised information that would enable the reader to get a picture of the child.

The health action plan was rudimentary and contained no clear outcomes or timescales.

The IHA, therefore, had limited value in ensuring the child's health needs were identified and met adequately and this was weak practice.

4.2 Although there is generally no choice other than to attend the dedicated clinics when seeing the doctor for an initial health assessment, staff who are undertaking Review Health Assessments (RHA), particularly for young people who may be hard to reach, offer a choice of venue negotiated with the young person. This means that young people are seen in a venue in which they are most comfortable and encourages continued engagement with health services in preparation for independent living.

4.3 Other than those for young people aged between 16 and 18, hard to reach and not in education or training, RHAs are completed by health visitors and school nurses depending on the child's age. Those assessments are generally of a better quality than the IHAs. Nonetheless, those we reviewed contained aspects that were sometimes superficial although the voice of the child was much stronger. Actions plans were generally SMART but some had not identified all of the health needs set out in the assessment. ***Recommendation 1.14***. *We will bring this to the attention of Blackpool Council Integrated Commissioning Team as commissioners of the school nursing and health visiting service.*

4.4 The looked after children specialist nurses complete the RHAs for young people who are aged 16 to18, hard to reach or those not in education or training. Those RHAs we reviewed were of an excellent quality and portrayed a good sense of the child.

Looked after children specialist nurses – good practice example

Where specialist nurses are involved in the assessments of looked after children there is a marked difference in the quality.

Owing to the paediatrician not being available, one initial health assessment of a four year-old child and two siblings placed with the same carer, was carried out jointly by a locum doctor and looked after children nurse.

The nurse and the doctor saw all three children together; the nurse was able to interact and speak with the children whilst the doctor obtained relevant history from the carers.

Drawings done by the child were included as part of the assessment and portrayed a strong voice and sense of the child.

Comprehensive information was recorded including references to information gathered from where the children previously lived.

The health action plan was detailed and SMART and contained good, achievable, time-bound outcomes.

4.5 School nurses attend looked after children reviews and maintain regular contact with looked after children that they are involved with at other times in order to build trust and maintain a rapport. This is good practice as it helps to build confidence in accessing health services in preparation for adulthood.

4.6 Strengths and difficulties questionnaires (SDQ) are not routinely used to inform either the RHAs or those IHAs where complex mental health needs have been identified. This is a missed opportunity to identify any emotional wellbeing issues and any emerging mental health needs. A dedicated psychologist for looked after children has recently been commissioned by the local authority who will oversee SDQ scores as part of their remit and share these with staff undertaking health assessments but this is not yet in place. ***Recommendation 1.15***.

4.7 Although there is no specific looked after children CAMHS offer, all looked after children who require a mental health assessment are 'fast-tracked' into the CAMHS through the single point of access. In addition all referrals made to Clinical Psychologists for looked after children are offered a consultation and Youtherapy (IAPT) has 'fast tracks' for looked after children in order to prioritise their appointment. This is good practice as it means the particular risks for this vulnerable group of children are acknowledged and prioritised.

4.8 Staff are required to complete a self-evaluation audit as part of the administrative tasks for both the IHAs and RHAs. Completed forms are quality assured by a member of the looked after children nursing team and the practitioners are provided with feedback on any shortfalls identified. Evidence of the quality assurance process was present in case records; in general this works well with robust application of the assessment criteria and clear shortfalls identified in the cases we looked at.

4.9 However, in a minority of cases the process was not robustly applied. For example, in one record the self-audit tool had not been completed by the doctor undertaking the assessment yet it had been countersigned as compliant by a 'bench' nurse acting in the role of looked after children nurse (in Blackpool, bench nurses are those who act as an additional resource to the looked after children nurses and where they carry out the role as part of their development). In this case, the quality of the assessment was poor and not compliant with the expected standard, issues that had not been picked up by the reviewing nurse. ***Recommendation 1.16***.

4.10 Although GPs in Blackpool are provided with a copy of the completed health care assessment, they are not routinely consulted prior to the appointment taking place. We were told that this is because GP records are held on the same electronic patient records system which can be accessed by the paediatrician if required as part of the information gathering process. However, this was not evident in the records we looked at and this means that key health information from primary care may be overlooked. ***Recommendation 1.17***.

4.11 All looked after children in Blackpool have access to a dedicated looked after children dental service. The looked after children admin staff maintain a spreadsheet and escalate the issue if children have not seen a dentist within the last year. This ensures engagement in dental services at the earliest opportunity of a child becoming looked after. It is particularly relevant given the high numbers of children in Blackpool with dental decay.

4.12 There have been historical problems around the timeliness of the completion of IHAs. The looked after children team have worked with the local authority to identify obstacles to completion of the processes including tracking meetings and escalation. This work has had a positive impact. Data we have reviewed shows a reduction in out-of-date IHAs over the preceding 12 months with only one overdue at April 2017.

4.13 We have mentioned elsewhere on the range of services available to young people across Blackpool. Young people leaving care are further supported to through the offer of health passport at their last health assessment prior to leaving care. This is followed up with a discussion after the passport is issued, through the innovative practice of ‘drop-in’ sessions for young people placed in children’s homes, to ensure the young person understands their health plans. This helps to equip young people to manage their health care needs independently after leaving care.

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 Generally, throughout our week in Blackpool we noted effective, visible safeguarding leadership both within the CCG and the providers. Safeguarding leaders are proactive and work co-operatively across organisational boundaries to improve practice and this has been evident in our interviews with staff and in the cases we have tracked across services. Below are some of the areas where we have noted largely good leadership and those areas that we consider require additional action, much of these being in relation to recording systems.

5.1.2 BTH community midwives rotate into the hospital for one or two shifts each quarter as established practice and there is a rota in place where all community midwives support home births. This helps to ensure a well skilled, knowledgeable and flexible workforce providing midwifery support to women across Blackpool and this, in turn, supports an uplift in safeguarding experience.

5.1.3 Children's social care have been invited to meet with the complex social needs midwifery team with the intention of jointly monitoring and improving the effectiveness of the pre-birth protocol between children's social care and the midwifery service. However, to date, this meeting has not yet taken place and this has led to a delay in resolving the key issue as set out below.

5.1.4 As we have reported above in ‘child protection’, there are some emerging issues preventing the effectiveness of the pre-birth protocol and the reported timeliness of pre-birth assessments. Although the BTHFT safeguarding team has escalated concerns verbally about cases where pre-birth assessments are delayed and birth plans have not been in place prior to the baby’s birth, it is not clear how the provider and children's social care are working together to address this and ensure the protocol is operating effectively. BTHFT has not, to date, quantified the number of cases where this has happened, what the current picture is or tracked performance over time to help identify the size of cohort of infants affected and evaluate the impact on outcomes. This issue requires further dialogue with the local authority and the BSCB in order to resolve. ***Recommendation 1.6***.

5.1.5 There is a concerns resolution protocol in place as part of the local safeguarding procedures and BTHFT managers and the safeguarding named nurse report that this is used appropriately.

5.1.6 All nursing staff on the Blackpool Victoria Hospital paediatric ED are trained in paediatric nursing. This is in line with guidance and best practice and ensures that children are assured of receiving care and treatment form appropriately qualified and knowledgeable staff at all times.

5.1.7 The safeguarding team at BTHFT has read-only access to the children's social care electronic case records system. This is a potentially valuable source of information that can support initial assessment when BTHFT practitioners have concerns about a child and is an excellent example of partnership co-operation. .

5.1.8 BTHFT are currently working on replacing the current electronic system in use in the ED with a new patient record system and there is involvement of some clinical staff on the working group. However, there is no representation from the safeguarding team or from a senior ED paediatric nurse to ensure that the replacement system is fit for purpose for child safeguarding. Such representation will ensure that the new system will support good risk assessment and the effective identification of children at risk of hidden harm. ***Recommendation 1.18***.

5.1.9 We learned of some teething problems with the health visitors' use of the electronic patient records system that is used in GP practices in Blackpool. This has seen some challenges to practitioners in recording and accessing key information; without robust information sharing arrangements with GPs (see below) this means that health visitors may not be fully apprised of information that would help them to support families in their case-loads. ***Recommendation 1.19***. *We will bring this to the attention of Blackpool Council Integrated Commissioning Team as commissioners of this service.*

5.1.10 The electronic system has also been introduced in the last year to the school nursing service. School nurse records in paper format are no longer being used. Adapting to a new method of working with a new electronic system is challenging for staff as they are not yet fully aware of the functionalities of the new system. In records we reviewed we saw evidence of child protection documents having been uploaded but with key embedded PDF documents not yet accessible. As with health visitors, the system does not yet enable school nurses to be up to date with information about young people they are working with. We understand that this is a problem acknowledged by the trust but we are not clear on timescales for resolving the issue. ***Recommendation 1.19***. *We will bring this to the attention of Blackpool Council Integrated Commissioning Team as commissioners of this service.*

5.1.11 The school nursing service contract was re-evaluated and re-modelled last year such that much of the previous service offer is no longer commissioned to be provided in this way. School nurse practitioners report that resources have been correspondingly reduced although their perception is that the demand for the service as it was previously commissioned still remains due to an ongoing need to manage expectations of other professionals who do not fully understand the changes in service provision. For example, the school drop-in sessions are said to significantly overrun beyond the planned three hour time due to demand from young clients whilst the school nurse is on-site. We acknowledge that the service specification calls for a minimum of three hours but the school nurse are not currently clear how they would increase the time or frequency of the drop in sessions if there was evidence of demand.

5.1.12 Further, the high transient population with many transfers of children into and out of the area and across services creates additional record keeping and liaison tasks. As a result, the team see themselves as working beyond their capacity, particularly since the need to comply with safeguarding requirements, such as attendance at conferences, core groups and TAF meetings remains as it was. There is a dissonance between the service the school nurses are commissioned to provide and the perception of the team as to the resources they have available in order to deliver the service demanded by other partners. ***Recommendation 1.20***. *We will bring this to the attention of Blackpool Council Integrated Commissioning Team as commissioners of this service.*

5.1.13 Some paper records used in the CAMHS do not comply with good record keeping practice guidelines. Some clinical log sheets are filed out of sequence and in one case we saw that dated entries were made out of chronological sequence and sometimes on different log pages. This practice can lead to key information about risks being overlooked. Not all log entries reflected actions that had been taken. In one of the cases we saw there were no entries made about attendance at a child protection conference and the notes of the conference itself were not on file. We learned that conference notes are not always received from children's social care and this is a gap. ***Recommendation 1.21***.

5.1.14 There is good collaborative leadership in both CAMHS and the adult mental health service which has helped to ensure an integrated approach to service provision. For example, weekly MDT management of cases enables good oversight of cases and identification of risks within families in both services.

5.1.15 We have noted a good culture of safeguarding in Blackpool mental health services with effective dialogue and information sharing between all parts, including BTHFT and LCFT, of the young people's and adult services. Links with Police, the multi-agency safeguarding hub (MASH) and public protection unit (PPU) are also said to have improved. This augurs well for the safeguarding function in mental health teams as the service evolves through transformation in the future.

5.1.16 There is a prevailing challenge across the mental health services with different electronic client record systems. The system in use in LCFT does not enable effective attachments of documents or to collect good data about compliance with child protection processes which limits the ability to monitor practice. This is acknowledged by the provider as an area for ongoing development, which, disappointingly, has not moved forward since the recommendations of a previous CQC safeguarding inspection in neighbouring Lancashire in 2016. Although the trust has procured the development of an electronic patient record with a timeline for implementation, the record keeping challenges remained at the time of this review. ***Recommendation 4.3***.

5.1.17 The Blackpool multi-agency strategy for sexual health has been in place for some years. The partnership approach to meeting young people's sexual health and wellbeing needs was originally developed to address a range of local challenges relating to sexual health and behaviours, including the high incidence of teenage pregnancy; at one time, the second highest in the country. This strategy has resulted in a positive local culture of cohesive and co-operative multi-agency and multidisciplinary working and information sharing becoming well-established. This helps the local partnership to address, as collective, more recently emerging challenges such as CSE. The delivery of the action plan arising from the strategy is monitored through a bi-annual adolescent stakeholder forum attended by lead professionals and agencies. One of the reported positive outcomes from this partnership drive is a teenage pregnancy rate that has reduced significantly from 37 for every 10,000 towards the target of 35 although we have been unable to review any current data to confirm this.

5.1.18 The WISH sexual health support service reports most referrals to the service are made by schools and that rates of referrals from GPs are low. Although some GP practices are engaging with 'WISH' by requesting training, the overall engagement and awareness of this service in primary care generally is not well developed. ***Recommendation 2.3***.

5.1.19 Other than the recently completed quality assurance framework for GPs, there has been limited central leadership activity in relation to standardising and assuring the quality of safeguarding practice in primary care. For example, there are no regular, bespoke safeguarding events for safeguarding lead GPs; there is no monitoring of the numbers and quality of GP referrals to children's social care or of their contribution to child protection conferences; there is no clear understanding of the nature and take up of the role of the lead GP in each practice. As we have already reported in 'Early Help' and 'Child Protection', although there are health visitor liaison staff aligned to each practice and informal information sharing takes place, there are no formal arrangements for this. Nor is there any evidence of a focus from the CCG on supporting practices to implement regular, formal information sharing arrangements about vulnerable families, which is a national standard. This is an area which requires a stronger grip to ensure safeguarding practice in GPs is standardised and that processes are effective. ***Recommendation 2.1*** and ***2.4***.

5.1.20 Throughout this report we have noted various examples of innovative practice that should be mentioned here as evidence of the proactive approach in Blackpool to improving safeguarding work. For example, the health based IDVA has led to an improved service for women and their children who have experienced domestic abuse; the CASHER service has provided increased support to children and young people who have self-harmed so that their access to care and treatment in crisis is not delayed; a national multi-agency conference on modern slavery and human trafficking facilitated and hosted by BTH attracted an audience of over 300 people, many of who were practitioners in Blackpool, has led to a general increase in knowledge of this issue locally; drop-in sessions in children's homes have provided the means to support young people with their health needs as they are about to leave care.

5.2 Governance

5.2.1 Safeguarding governance in Blackpool's health organisations is according to a defined reporting structure with ultimate accountability lying with the CCG's governing body. The CCG's Director of Performance and Delivery has executive responsibility for safeguarding children and adults in an integrated arrangement, with day-to-day responsibility falling to the CCG's Head of Safeguarding. The Head of Safeguarding also carries out three key internal roles within the CCG; Designated Nurse for safeguarding, Designated Nurse for looked after children and Designated Manager for safeguarding adults. We will discuss the capacity of this role later in this section.

5.2.2 The Director of Performance and Delivery, the Chief Nurse and the CCG head of safeguarding attend the bi-monthly Quality and Engagement (Q&E) committee that has overall responsibility for managing safeguarding performance on behalf of the CCG governing body. This group has oversight of the safeguarding performance of individual providers and a direct line of communication to each provider's quality assurance processes. Processes are in place to address non-compliance with safeguarding arrangements although none such instances have been reported to us during the course of this inspection.

5.2.3 Providers are required to submit an annual safeguarding self-assessment audit tool to the CCG as part of the contractual arrangements. There have been some changes to the timing of requests from the CCG to providers to complete this audit to avoid duplication with Section 11 requests from the Safeguarding Children Board. Monitoring arrangements have been strengthened. Key to this is face-to-face dialogue and so a 'safeguarding leads' bi-monthly meeting is due to be implemented in the month following our inspection. This will feed directly into the CCG's planning, commissioning and delivery meeting which in turn reports to the Q&E committee. In this way the CCG has an improving picture of oversight and scrutiny of provider safeguarding performance.

5.2.4 The CCG and the providers are active members of the Blackpool Safeguarding Children Board (BSCB). The Designated Doctor and the Head of Safeguarding for the CCG are active members of the BSCB as well as the Blackpool Safeguarding Adults Board (BSAB). They are also chair and vice-chair respectively of the BSCB SCR group. The Head of Safeguarding also represent the CCG on a variety of other BSCB, BSAB or joint sub-groups including the Child Death Overview panel, the BSCB Finance sub-group and chairs the Training sub group. They are also the CCG lead for PREVENT.

5.2.5 The Head of Safeguarding for BTHFT is also similarly extensively involved in the BSCB, the BSAB and their sub-groups. Further, the post holder also participated in a central government sponsored consultation event in early 2017 intended to make recommendations for improving safeguarding outcomes for vulnerable people and will continue in this role. In this way, health services are well represented in the local partnership and are key influencers in strategy and policy, both locally and nationally.

5.2.6 As mentioned, the Head of Safeguarding has an integrated role and is responsible for safeguarding both children (including looked after children) and adults for the CCG. This brings a range of different functions for each role, including the Designated Nurse roles that the post holder carries out as described above. For example, the post holder's representative functions on the BSCB and the BSAB as well as their quality monitoring and auditing activity. The capacity of both the designated nurse and the designated doctor have been highlighted as an issue in three assurance framework audits carried out over the last two years. In their audit comments, NHS England have acknowledged the limited capacity of both the Designated Nurse and the Designated Doctor as an issue. At the time of our inspection the arrangements for this role were as they were at the time of the initial self-assessment audit in September 2015 when this was first identified and there is a risk that this continued limited capacity will have an impact on the effectiveness of this role in enabling practice improvement. This is particularly relevant since the principal provider, BTHFT, also have issues in relation to capacity (see below). ***Recommendation 2.5***.

5.2.7 The safeguarding governance arrangements in BTHFT are more complex than we would ordinarily expect to see in a single trust. However, the complexity of need in Blackpool's population and the extensive range of services provided by BTHFT mean that safeguarding has a high profile in the trust. The Director of Nursing and Quality has overall responsibility for safeguarding in the trust through the quarterly 'Safeguarding Children, Young People and Adults Committee'.

5.2.8 There is an additional layer of management in the form of a Head of Safeguarding who manages a team of named nurses. Each of the named nurses has a topical portfolio and line-manages a team of safeguarding practitioners and liaison staff. So, for example, the named nurse for looked after children is part of this team whilst other named nurses have responsibility for CSE health practitioners, the MASH health liaison and the ED liaison post. In addition, three of the named nurses have responsibility for supervision of health visitors, school nurses and family nurses. As with the CCG, safeguarding in BTHFT is an integrated function that covers both children and adults.

5.2.9 Ostensibly this is a well-resourced team. However, there is significant demand on safeguarding resources due to the nature of the existing safeguarding work in Blackpool, the number of looked after children and the number and scope of the new referrals to children's social care. All of these are higher than the national average and Blackpool's statistical neighbour. This level of need and the line management roles of the named nurses creates a demand on the time of the team and has an impact on their ability to monitor the quality of referrals (see above in 'Leadership and Management') and to make standard entries in records for safeguarding supervision (see below in 'Training and Supervision'). This became evident during our discussions when it was reported that the extent of the work prohibited such supervision records being made. The quality monitoring role of the safeguarding team and their capacity to record and follow-up supervision decisions is of concern as it means that some risks to children may be missed or not properly understood. ***Recommendation 1.26***

5.2.10 The CCG report that performance in relation to carrying out initial and review health assessments within statutory timescales has been a variable but generally improving picture, particularly in the last 12 months. The provider, the CCG and the local authority have worked to identify blockages to the completion of health assessments and a narrative has been produced for each occasion when there has been delay so that the obstacles can be understood. The recently implemented tracking meetings and a successful escalation process have reduced the rate of delay significantly and this is evidence of good partnership work between health and the local authority.

5.3 Training and supervision

5.3.1 There is strong focus in BTHFT on achieving compliance with safeguarding training targets throughout the services we visited. Effective monitoring arrangements are in place and regularly reported through clinical governance. Operational managers are diligent in ensuring staff undertake appropriate training and practitioners are well supported to attend multi-agency safeguarding training on a range of appropriate and topical issues. This is a strong safeguarding training offer.

5.3.2 For example, the looked after children nursing team have completed level three safeguarding training and are up-to-date with the requirements of the relevant intercollegiate guidelines. In addition they have completed topical training in CSE, PREVENT, Modern Slavery, Domestic Abuse and, more recently, have attended specific training on supporting transgendered young people. This staff group in particular are well supported and knowledgeable about a range of issues that affect children and young people who form their client group.

5.3.3 Similarly, there is good compliance with attendance at relevant level three training in mental health services provided by LCFT that we visited during the review. This ensures a consistent level of safeguarding insight in all the mental health teams across Blackpool and this was evident during our interviews with staff in both trusts.

5.3.4 Paediatric ward staff at Blackpool Victoria Hospital are well supported to develop knowledge and understanding of mental health and other issues likely that affect young people in their care. The core group of nursing staff receive regular training on mental health, CSE, eating disorders and sexual health; an arrangement that has been established for some years. Ward managers feel that this contributes to maintaining good awareness of these issues among ward staff, which in turn helps them to support young people more effectively.

5.3.5 Practitioners we spoke with across the BTHFT services report good support from, and availability of, the BTHFT safeguarding team for advice and guidance when safeguarding concerns are identified on an *ad hoc* or occasional basis. We also noted that the reflective practice supervision sessions provided to groups of staff in response to serious incidents was valued highly by staff.

5.3.6 Throughout the services provided by BTHFT we have seen that records of supervision discussions are not made fully on patients' records. In some cases there is a reference to supervision being held but no detail of the discussion or actions agreed. This is particularly the case with advice and guidance provided on an occasional basis by the safeguarding team. We are advised that the number and frequency of such calls prohibit the accurate recording by the safeguarding team in patient or client records and there is an expectation that staff members receiving the guidance will make such records for themselves. The effect of this approach is the limited nature of supervision records we noted during our inspection. This does not enable accountability for decisions in complex or difficult cases, is not in line with good practice and is an area for development across the trust. ***Recommendation 1.22*** and ***1.23***

5.3.7 Safeguarding supervision arrangements in the BTHFT midwifery service are sound. All community midwives receive three-monthly one-to-one supervision. The trust's safeguarding team facilitates quarterly group supervision, which includes the MASH health practitioner. CSN midwives also receive regular supervision as established and routine practice and this provides opportunities for staff to sense check their work with particularly vulnerable families.

5.3.8 There is a positive culture in BTHFT midwifery service of making good use of peer support, advice and guidance. The experienced CSN midwives provide some supervision and 'buddy' support to less experienced or newly qualified midwives in the service. Experienced practitioners accompany colleagues to child protection conferences and support them to write safeguarding referrals children's social care. The practical effect of this is an increase in quality and skill, maintenance of good record keeping and robust information sharing practice.

5.3.9 Good use is made by ED practitioners of occasional advice and guidance from the BTHFT safeguarding team; reflective practice group sessions facilitated by the team are valued by staff. The senior ED nurses are also trained as supervisors. However, the offer of one-to-one supervision from one of the safeguarding practitioners is rarely taken up and there are no regular group supervision or psycho-social forums held in the ED where cases of concern or interest are discussed in order to validate decisions made or agree additional actions. Where we see these established in other areas, they are highly effective forums to facilitate and promote effective safeguarding practice. ***Recommendation 1.24***.

5.3.10 Health Visitors receive one-to-one supervision at a minimum of three-monthly intervals with a supervisor from a different team. All staff have had supervision training as both supervisors and supervisees. A contract of expectations is agreed as part of the supervision arrangement and reviewed annually. A template for family discussion and outcome planning is used as a basis for case discussion and this is good practice. Similarly, school nurses receive three-monthly one-to-one supervision every three months as a minimum. All supervision sessions are documented in client records although not always in sufficient detail and, as set out above, this limits accountability for decision making from these sessions. ***Recommendation 1.22***.

5.3.11 Staff in the looked after children team attend quarterly group supervision and also receive additional one-to-one monthly supervision with a line manager. Supervision is also offered by the safeguarding team on an occasional basis. We were advised that actions arising from supervision are recorded in case files although, as reported above, this was not evidenced in records we looked at. ***Recommendation 1.22***.

5.3.12 In the CAMHS provided by BTHFT staff receive one-to-one monthly supervision on all their cases where each case is considered according to the local area's safeguarding levels of need. Actions are agreed and followed up at each successive meeting through the use of a tracker grid and this ensures staff and their supervisors are clear about the actions required and their timescales. This is good practice as it prevents drift although, as we have noted above, supervision discussions are not routinely recorded on case records. ***Recommendation 1.22***.

5.3.13 Clinical and non-clinical staff in the 'Connect' and 'WISH' sexual health services undertake safeguarding training at the appropriate levels commensurate with their roles and safeguarding responsibilities. Reception staff at 'Connect' act as effective reporters of potential safeguarding concerns through their observations of waiting areas and the people who accompany a young person to the service. They are appropriately supported in this by safeguarding training at level 2 and in participating in the service's safeguarding discussions.

5.3.14 Supervision arrangements in both 'WISH' and 'Connect' are good although there is a stronger approach in 'WISH' to ensuring that all staff in the service benefit from regular, planned and documented one-to-one supervision in line with good practice. One-to-one supervision is explicitly on offer to 'Connect' practitioners in addition to the regular group sessions. However, managers do not monitor the take-up and this is a missed opportunity to improve and standardise practice in a service that has an important role in safeguarding young people.

5.3.15 Currently named nurses in BTHFT receive formal one-to-one safeguarding supervision through their line management structure and not from the designated nurse at the CCG. This is an unusual arrangement as it can be seen not to create a culture of appropriate professional challenge among the safeguarding leadership team. However, we have seen that there are opportunities for this challenge to take place in group supervision sessions and have been assured that they are robust. Of note is the fact that the named midwife sits outside this comprehensive safeguarding structure at BTHFT. This is also unusual and may potentially lead to inconsistent supervision among the safeguarding leadership in the trust. ***Recommendation 1.25***.

Recommendations

1. Blackpool Teaching Hospitals NHS Foundation Trust should:

1.1 Establish formal, systematic arrangements for midwives to request information from GPs about a woman's social and family circumstances at, or shortly after booking pregnancy care and use this information to support risk assessments.

1.2 Improve the processes in the maternity service to ensure midwives have the means, and are confident, to record on each contact whether or not they have asked the woman about the risks of domestic abuse, including the processes for managerial oversight.

1.3 Ensure that plans to reconfigure the children's ED area at Blackpool Victoria Hospital include arrangements to enable the children's waiting area to be observed by nursing staff.

1.4 Develop the ED registration templates so that staff are supported to identify children who might be at risk from particular risky adult behaviours.

1.5 Develop differentiated registration templates for children who attend the ED so that staff are supported to carry out risk assessments and are prompted to be professionally curious.

1.6 Work with the local authority to improve the timeliness of the completion of pre-birth assessments and pre-birth plans.

1.7 Strengthen child protection referrals to children's social care made by the maternity service to ensure that risk factors are presented in a way that demonstrates the impact on the unborn baby and the level of risk.

1.8 Work with the local authority to ensure that referral pathways are clearly understood and that local procedures for verbal referrals to be followed up in writing are adhered to.

1.9 Implement arrangements for referrals made by front line staff at Blackpool Victoria Hospital to children's social care to be uploaded onto the electronic patient records system enabling effective central monitoring and storage.

1.10 Implement a 'did not wait' protocol in the ED including the provision of information to parents about what might happen if a child is removed prior to being seen.

1.11 Strengthen the written contributions to child protection conferences made by CAMHS staff and the therapy services to ensure that the information contains a clear analysis of risks and sets out the recommendations of the practitioner for the conference.

1.12 Strengthen the approach to identifying risk of CSE in young people accessing the CAMHS, including the routine use of a CSE assessment tool.

1.13 Improve the quality of records of initial health assessments for looked after children so that they contain sufficient detail to describe a child's health needs and reflect the voice of the child. Ensure that health action plans reflect the assessment and contain outcomes that are SMART.

1.14 Improve the quality of review health assessments for looked after children that are carried out by health visitors and school nurses so that they contain sufficient detail to describe the child's health needs and that all identified health needs feature in health action plans.

1.15 Implement plans to make use of strengths and difficulties questionnaires in health assessments of looked after children.

1.16 Ensure that, where 'bench' nurses carry out audits of health assessment self-evaluations as part of their development, these are subject to an additional layer of scrutiny by the looked after children nurses in order to assure standards or assessment are maintained.

1.17 Ensure that effective arrangements are in place to obtain information from GPs as part of the health assessments process for looked after children.

1.18 Ensure that the safeguarding team are represented on the working party developing the new electronic patient records system for use in the ED at Blackpool Victoria Hospital to ensure it is fit for safeguarding purposes.

1.19 Expedite improvements to the electronic patient records system recently introduced into the health visiting and school nursing service to enable health visitors and school nurses to be apprised of all key information to support their safeguarding work.

1.20 Work with public health commissioners and schools to ensure the service offer is fully understood by school nurses and schools and that the school nursing team has sufficient resources to provide the commissioned service.

1.21 Ensure that good record keeping standards are maintained in chronological entries in paper records used by the CAMHS and that all information about safeguarding processes is fully recorded, including copies of child protection conference notes.

1.22 Ensure records of safeguarding supervision are consistently made in client or patient records to include discussion of the concerns precipitating the discussion and actions agreed.

1.23 Implement monitoring arrangements for supervision entries in patient or client records to assure consistency when occasional advice and guidance is provided.

1.24 Enhance the offer of reflective practice sessions in the ED through the introduction of scheduled group supervision sessions to discuss cases of concern and to validate decisions made.

1.25 Ensure the named midwife for safeguarding has opportunities for safeguarding supervision that is consistent with the safeguarding named nurses at the trust.

1.26 Review the role description of the named nurses, particularly in relation to their role in monitoring referrals and safeguarding supervision and ensure they have sufficient time and capacity to perform these key functions.

2. NHS Blackpool CCG should:

2.1 Work with partners to establish a formal approach for sharing information about vulnerable families and children between community health teams and GPs through practice based multi-disciplinary meetings.

2.2 Ensure GPs consistently prepare and submit information for child protection conferences in a manner that is meaningful and supports the conference to make good decisions.

2.3 Ensure that all GPs are fully informed about the availability of the range of sexual health non-clinical support services provided by 'WISH' and that they are enabled to refer young people to the service when appropriate.

2.4 Develop an action plan to standardise safeguarding practice in GPs. This should include the creation of a forum for dialogue with and between safeguarding lead GPs and a process for monitoring the quality of referrals made to children's social care and of information submitted for child protection conferences.

2.5 Review the role description of the 'head of safeguarding' taking account of audit findings in relation to capacity and ensure the role holder has sufficient time and scope to perform the statutory designated roles effectively.

3. Blackpool Teaching Hospitals NHS Foundation Trust and Lancashire Care NHS Foundation Trust should:

3.1 Ensure that staff who are supporting clients through transition from adolescent to adult mental health services are fully enabled to take account of the needs of other children in the same household or associated with the adolescent, transitioning client.

4. Lancashire Care NHS Foundation Trust should:

4.1 Ensure that written reports are submitted for child protection conferences in line with local and trust procedures and good practice.

4.2 Ensure staff use the template for assessing the impact of a new client's mental health on children they have access to in line with trust procedures.

4.3 Continue to progress the implementation plan for a complete electronic patient record to improve the trust's capacity to store safeguarding information and report compliance with safeguarding processes

Next steps

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