

Review of health services for Children Looked After and Safeguarding in St Helens

Children Looked After and Safeguarding The role of health services in St Helens

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CCGs included:	NHS St Helens CCG
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Summary of the review

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

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

About the review

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

- The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.
- The focus was on the experiences of looked after children and children and their families who receive safeguarding services.
- We looked at:
 - the role of healthcare providers and commissioners.
 - the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
 - the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.
- We also checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, Working Together to Safeguard Children 2013.
- Where we found areas for improvement in services provided by NHS but commissioned by the local authority then we will bring these issues to the attention of the local public health team in a separate letter.

How we carried out the review

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

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

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

In total, we took into account the experiences of 85 children and young people.

Context of the review

St Helens is one of six local authorities in the Liverpool City Region. The Borough is home to 177,600 people and covers a total of 135 square kilometres, of which approximately half is rural and half is urban. Across St Helens, there are wide variations in health outcomes, lifestyle factors and determinants of health between different groups and between people living in different areas, often with a wide discrepancy over only a short distance.

The population of St Helens has increased over the last seven years and is predicted to increase year on year over the next 25 years. The current General Practice (GP) registered population of NHS St Helens CCG (Clinical Commissioning Group) is 195,523 (HSCIC, April 2016); this indicates that a number of residents from outside the Borough are registered with St Helens GPs.

St Helens has fewer people who are economically active than the regional and national average (69.4% St Helens, 71.2% North West, England 73.9%).

Deprivation is a key determinant of health, with people living in more deprived areas having worse health outcomes on average. St Helens is one of the 20% most deprived districts/unitary authorities in England and the percentage of children and young people under 16 living in poverty is 16.5% (before housing costs) and 26.3% after housing costs, compared with 15.9% and 25.1% nationally (2014). It is also recognised that children and young people exposed to poverty and socio-economic disadvantage are at increased risk of developing mental health disorders.

Smoking is the biggest preventable cause of death and costs the local economy £49m a year. Rates in St Helens have fallen in years but remain significantly higher than the national average.

In Year 6, 24.4% (386) of children are classified as obese, worse than the average for England. The rate of alcohol-specific hospital stays among those under 18 is worse than the average for England and represents 30 hospital admissions per year on average, 2013/14 – 2015/16. Levels of teenage pregnancy, GCSE attainment, breastfeeding initiation and smoking at time of delivery are worse than the England average.

St Helens Safeguarding Children Board (SHSCB) is a statutory body, made up of senior people from a wide range of local agencies such as Merseyside police, children's services and health agencies. The SHSCB leads on work that helps professionals to work together and keep children safe. Working Together to Safeguard Children 2015 is the guidance in place that tells LSCBs how they must work and where their responsibilities lie.

The SHSCB annual report dated 2015/16 identified that neglect of children remained a very important issue in St Helens with neglect and the 'Toxic Trio' being identified as a priority within the safeguarding children board business plan. Child Sexual Exploitation (CSE) also remained as a high concern, with increasing attention being paid to child CSE and a great deal of work being undertaken at local level to develop a more effective response to the issue.

The SHSCB had a number of cases referred to them by professionals that involved adolescents and risk taking behaviour during the 2015 period, including incidences of self-harm. The consequence of this was that the Board made the area of adolescence a priority for 2016-2017 with a view to finding ways to help professionals recognise, assess and reduce risk for this cohort of young people.

In the 2015-2016 SHSCB business plan the Board identified six priorities that it wished to address:

1. Leadership and Governance
2. Early Help
3. Child Sexual Exploitation (CSE)
4. Neglect
5. Domestic Abuse
6. Training

These priorities emerged from an Ofsted Inspection in November 2014 and from locally identified issues. Work was later noted to have been successfully progressed in the areas of; leadership and governance, CSE and training. Strategies were produced for early help and neglect and the Board decided that it wished to maintain oversight of the implementation of these strategies through the Development Priorities Group (a newly established group for 2016-2017).

A task and finish group was also established for domestic abuse and this was supported by an independent consultant who helped partners evaluate current practice and provided the opportunity for future planning in this area. The area of domestic abuse, however, was recognised as still requiring substantial work. This was taken forward by the People's Services Department of the Council, with SHSCB monitoring the development and implementation of strategies in this area.

During 2016/17 the SHSCB identified adolescence, children at risk of exploitation (including CSE) and promoting a learning culture as priority areas. The SHSCB also identified the voice of the child as a key cross cutting theme. A new approach to hearing the voice of the child was introduced 2015-2016 with the executive and SHSCB now undertaking meetings with a voice of the child item which reflects a child's perspective of how the safeguarding system has been for them.

As part of the identified local development of children and young people's mental health, the CCG is currently working with multi-disciplinary and multi-agency partners on a new model for mental health services with the aim of addressing some of the problems associated with the current model.

Plans to introduce the 'THRIVE' conceptual framework model (re-thinking approaches to the mental health system with the child or young person at the centre of the framework to ensure those young people 'thrive') are ongoing, with the aim to embed them through all present and future projects within the St Helens children and young people's mental health programme. This will ensure the implementation of an integrated and holistic approach within care service developments, which plans to address a number of key issues locally, including:

- Easier and earlier access to support at lower levels of need which will include specialist services working more closely with schools, increased access to evidenced based interventions and reduced waiting times.
- Easier access for vulnerable groups that do not meet current criteria but have difficulties attributed to contextual factors, such as poor attachment, unstable family circumstances or those with neurodevelopmental difficulties with associated mental health concerns.

Commissioning and planning of most health services for children are carried out by NHS St Helens CCG Integrated Children's Commissioning Team

Acute hospital services are provided by St Helens and Knowsley Teaching Hospitals NHS Trust

Some Community based services are provided by North West Borough HealthCare NHS Foundation Trust, which includes the 0-19 service.

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Other Community based services are provided by Bridgewater Community Health Trust, namely Community Paediatrics and Looked After Children's service along with the Speech and Language Service.

Child and Adolescent Mental Health Services (CAMHS) are provided by North West Boroughs Healthcare NHS Foundation Trust and at level two by Barnardo's

Adult Substance Misuse services are provided by Change Grow Live (CGL)

Some Looked After Children services are provided by Bridgewater Community Healthcare NHS Foundation Trust. Other functions are provided by the 0-19 Healthy Child Programme.

Some review Health Assessments for Looked After Children are provided by 0-19 services in North West Boroughs Healthcare NHS Foundation Trust but others are provided by the Looked after children's Service by the Community Paediatrics and Looked After Children's service from Bridgewater Community Healthcare NHS Foundation Trust.

Specialist facilities are Alder Hey Children's Hospital with the Specialist Vision Service being provided by St Helens and Knowsley Teaching Hospital

The last inspection of health services for St Helens children took place in July 2012 as a joint inspection, with Ofsted, of safeguarding and looked after children's services. The report was published in August 2012.

The report

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

What people told us

We spoke with young people who were currently looked after or that had recently left care who were also part of the St Helens Children in Care Council. This is a group of children and young people who meet once a month to make changes for all Looked After Children from St Helens. When asked what changes they had brought to young people in the borough one young person told us:

“We have done lots of things here. One was called ‘ditch the bin bag’. Basically, when I used to move from one placement to another, I had to put all my things in a black bin liner. It was embarrassing arriving at the new place holding onto black bin liners full of my stuff. It looked like I was off the streets. Now we only use bin bags to put big stuff in like bedding. For our personal belongings we are given proper holdalls and cases. It's much better that way, I feel much better about it.”

When asked about their help in the development of the leaving care ‘health passport’ one young person told us:

“We were asked what we wanted to know about when we leave care, so we helped put those things that we thought we all need to know about, including stuff about our background on there. It's nice to know we might be helping out other kids.”

We asked at what age young people were aware of the health passport process and if they were they involved in completing it themselves. One young person told us:

“I'm still in care but won't be for long but I haven't been told about it. I assume it's something you just get given. It would be good to at least know it is being thought about a while before we leave care.”

When asked about the health assessment process one young person told us:

“I have my health assessments but I am fed up with them (health professionals) asking questions to my foster carers and not asking me. It’s my assessment so why can’t they talk to me. They have never asked me if I don’t want my foster carers in the room at the same time.”

Another young person told us:

“It all seems pretty pointless to me. They presume too much and almost answer the questions for me. Foster carers only want to be seen in the best light anyway, like they are a perfect family. I gave up a long time ago and always just want to get it over and done with. It’s not really my health assessment; it’s just a process you have to go through.”

We spoke with a young care leaver who told us:

“I’m quite shy so I never used to say or ask a lot. Because of that, I really didn’t know what my rights were. I don’t think I ever had an assessment on my own and I don’t remember if I was given any personal health information when I left care although I did get a lot of leaflets.

They went on to tell us of their experience of the CAMH service:

“When I was 17, I was told I would be moving to the adult service for mental health. I did meet with them (adult mental health) but they basically told me that they only really dealt with people with major mental health problems and not depression like I had. That really put me off. I had a load of issues with my prescription from CAMHs too. So much that I went without my anti-depressants for a long time and when I went back to CAMHs to try and get back on them they told me I had to go and see my GP. In all honesty it’s easier going to a GP because they just repeat the prescription without question. It was a bit scary the thought of being in adult mental health anyway.”

Another young person told us:

“I was assessed by CAMHs. I spoke to them for about five minutes and was then told to go and wait in the car while they spoke to my carer. They didn’t seem interested in me. I felt that I didn’t need to go back to them so I didn’t. It wasn’t worth it”

One young person told us:

“I had a CAMHs assessment. It was OK actually and I didn’t have to wait too long. It was my decision not to go ahead with it though. They did tell me I could contact them if ever I changed my mind.”

We met with young people who used the Contraception and Sexual Health Service as provided by St Helens and Knowsley Teaching Hospitals NHS Foundation Trust. We spoke with young people who make use of the contraception and sexual health services ‘Teen Advice Zone’ (TAZ).

One young person told us that TAZ is a well-advertised and promoted service and that, *“Information is everywhere”*. They also said, *“Staff here are friendly, you can talk to them”*.

Another young person told us:

“You hear about TAZ from your friends.” They went on to tell us that this had prompted them to contact the service.

At the Whiston Hospitals maternity unit we spoke one new mother who told us:

“Everyone has been amazing. I was so anxious about having my baby because of my experience last time but they (the staff members) spent so much time reassuring me. The midwives are so lovely and caring and even though they are busy they never make you feel like they are rushing your care. The consultant even came to speak to me to calm my nerves and offered to stay on shift to carry out my caesarean-section. They also made it clear that I will not be discharged unless I feel ready to go home and have a pain management plan in place. I would not want to have a baby anywhere else.”

Another new mother we spoke with told us:

“During my pregnancy if I had any concerns I could just pick up the phone and get advice. Every midwife I came across was kind, knowledgeable and I felt that they really cared about me and my baby.”

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 The St Helens Multi Agency Safeguarding Hub (MASH) is set up to provide the highest level of knowledge and analysis of all known intelligence and information across the Borough's safeguarding partnership to ensure all safeguarding activity and intervention in relation to vulnerable children and young people is timely, proportionate and necessary. It is designed to streamline the routes for referral and notifications of concern in respect of children referred into local authority children's services departments.

Health representation at the MASH is provided by North West Boroughs Healthcare NHS Foundation Trust (NWBH). Representation consists of a full time children's safeguarding nurse with administration support and oversight from the named nurse for safeguarding children. All referrals into the MASH are currently screened by a social care team who then make a decision as to whether health input is further required. This is a missed opportunity to involve health practitioners at the earliest stage in the assessment process.

1.2 Health practitioners and managers at the MASH we spoke with were passionate about their role and positive that those will expand as part of the long term vision for the Borough. This includes the current project underway to transfer the MASH to a 'One Front Door' model. The model aims to identify and safeguard vulnerable children and young people at the earliest opportunity, creating an integrated response for all safeguarding concerns. The specialist, multi-agency team will consist of children's social workers, domestic abuse professionals, including for example an Independent Domestic Violence Advisor (IDVA), health (including mental health), substance misuse services and police. The team will work together to identify risk to all members of a family at the same time and then co-ordinate appropriate interventions according to those needs identified.

However, the current risk remains that those social care professionals currently undertaking the initial screening process might not spot important information contained within the referral that a health professional could better consider and thus better inform the safeguarding decision making process. (**Recommendation 5.1**)

1.3 Where health practitioners within the MASH and the NWBH are advised of referrals made to the MASH then they can and do ensure appropriate agencies are involved in the care and support of vulnerable children and young people. This includes being able to signpost young people and families to other support mechanisms where child protection measures might not be deemed appropriate.

In one case examined we saw how a referral was made by the St Helens young carer's team into the MASH. A decision was made following the referral that NWBH should provide an overview of the case in relation to the possibility of fabricated or induced illness being indicated. The parent of the children subject of the referral had disclosed that they were living with a life limiting, serious illness. They had also shared this information with their children. However, further enquiries made by the NWBH named nurse for safeguarding children with the parents GP disclosed that the parent was not actually living with a life limiting illness.

The result of this information was that it was considered possible that the children were the subject of emotional abuse. A multi-agency containment plan was put in place between the young carer's team and the children's school nurse to determine support requirements for all the children or all the family. School nurses engaged with the parent and would advise and challenge them as required.

An Early Help Assessment Tool (EHAT) is a tool used for gathering information and a standard approach in assessment for the identification of early help needs. With consent, the parent agreed to an EHAT assessment taking place to identify need and the parent is continuing to engage in the process and the children are monitored to ensure risk of emotional abuse is reduced.

1.4 The Emergency Department (ED) at Whiston Hospital (St Helens & Knowsley Teaching Hospitals NHS Trust (STHK)) remains the busiest in Merseyside with in excess of 105,000 patients attending the unit every year.

The paediatric ED is separate to the adult unit and appropriately staffed by paediatric trained nurses and consultants to provide care and support to children and young people. Safeguarding support and supervision is provided to practitioners by named professionals within the Trust. Staffing levels within the department are good and this ensures that those young people are assessed and treated by staff that are trained to meet their specific needs.

1.5 Adults and children book into the ED via the main reception desk (single booking point for all patients). Reception staff book in children using prescribed guidelines and those aged 0 to 18 are then asked to wait in the dedicated children's waiting area before triage takes place. This means that those children and young people are not overly exposed to adult attenders at the unit.

1.6 The paediatric ED is a self-contained unit consisting of two triage bays, four single room treatment cubicles and a High Dependency Unit (HDU). Children can access it without entering the adult areas at any time. The decoration is suitable for children with paintings and wall art. Health promotion and safeguarding information aimed at young people and children were clearly visible. This provides an environment that is focussed on the needs of younger children whilst they wait to receive further care and support.

1.7 Women with known additional vulnerabilities benefit from access to a range of specialist midwives who are in post within STHK, including specialist midwives for mental health and substance misuse. These posts are well established and play a central role in supporting vulnerable women. In one case examined we saw how a referral to the drug and alcohol/substance misuse midwife was made, using the cause of concern form, for a woman who had a history of alcohol abuse and was identified as a high risk patient. This ensured that appropriate support could be offered and risk to the unborn child considered and mitigated.

1.8 Specialist midwives work closely with the consultant lead for substance misuse within the Trust and also with local substance misuse services to support women throughout their pregnancy. This means that risks are identified early, vulnerable women supported and unborn babies kept safe.

1.9 We found that chronologies were not present in the patient records examined within midwifery services, especially where complex family histories were noted. Although we would not expect the model to be employed in all cases, the use of chronologies in complex cases can further strengthen assessment, intervention planning and communication. **(Recommendation 2.1)**

1.10 The health visiting service, as commissioned by Public Health and provided by NWBH, is a team of specialist public health trained nurses who hold qualifications and skills in child health and development. Health visitors will visit families and children aged from 0 to five years at home and in community venues such as health centres and children's centres.

Although health visitors already work closely with GPs, midwives, hospitals, schools and voluntary services, the service has now improved processes to increase antenatal contact with pregnant women. Midwifery services now notify health visitors of all expectant mothers and this is evident in the rise of the number of antenatal contacts completed. Visits are not routinely conducted jointly with midwives but can be arranged where it is identified as being beneficial, for example where high level safeguarding concerns or risks are noted. This ensures that pregnant women are engaged with community health services at the earliest opportunity, promotes the health and well-being of the unborn baby and allows for any early concerns to be identified and addressed.

1.11 The St Helens health visiting team are offering the full universal healthy child programme to families. They are compliant for nine to 12 months and two to two and a half year development reviews. However, the birth and six to eight week contacts are slightly below target. This delivery is monitored by managers and relevant actions are agreed and documented in an action table from which team managers are held accountable at performance meetings for undertaking those actions, but those practitioners we spoke with were unclear at the time of our review what actions are being taken to ensure that targets are being consistently met for all mandated contacts during a baby's development. **(Recommendation 4.1)**

1.12 Health visitors routinely make enquiries of women about the risk of domestic abuse at the 'healthy child programme' birth contact but do not consistently ask again during other visits. It is clearly documented at the birth visit as part of the assessment template with detail of the father or partner's presence noted if it was not appropriate to ask the question with him there. However, in records examined it was less evident that domestic abuse enquiries were made at other mandated contacts due to lack of prompts in the assessment tools used.

In one case examined we did see that there was some evidence of discussion about the mother's partner, healthy relationships and exploration where there was indication of any concern, but this was not robust or easily identifiable in the paper records held. The lack of routine prompts does not support health visitors to consider that risks of domestic abuse can evolve due to changing family dynamics brought about by a new baby and nor does it ensure that health visitors are always asking the question in the first place by prompting them to record an answer. **(Recommendation 4.2)**

1.13 Health visitors are made aware of families moving between localities in St Helens and handovers are either completed verbally by telephone where there are concerns or with a synopsis if there are no presenting issues. Health visitors also report good relationships with primary care who notify of any new families registered so that contact can be made. There was evidence of transfer summaries in case records examined which ensured that the new health visitor was able to promptly be aware of key issues, service plans and activity.

1.14 For children aged four years and under in St Helens, health visitors use the Ages and Stages (ASQ) assessment process to assess emotional health needs. School nurses (as commissioned by Public Health and provided by NWBH) use strength and difficulty questionnaires (SDQs) for children aged four years and over to support their assessment of children's emotional and mental health. Responses can be tracked to aid the early identification and appropriate response to emerging mental health concerns.¹

¹ On the SDQ assessment, there are 25 items divided between five scales; emotional symptoms, conduct problems, hyperactivity and inattention, peer relationship problems and pro-social behaviour. The higher the score the more likely it is that interventions are required.

On the whole the use of SDQ's was evident in records examined within the school nurse service, but in one case an elevated score was not responded to in a timely manner. However, this was mitigated in this case by the later actions taken.

1.15 St Helens school nurses offer holistic advice and support in the promotion of public health whilst also addressing the five outcomes of Every Child Matters (2003).²

This academic year the St Helens school nurse service reported they have increased their universal checks of school aged children to include year six as well as at school entry. They further reported plans to increase this to include checks at the mid-teens stage and transition into adulthood.

1.16 The school nurse service has identified a gap in their oversight of children and young people that are home educated or attending alternative provision as opposed to mainstream education. As a result they have since developed stronger links with the local authority to support the identification of this population. Whilst this work is in its early stages, it has the potential to support children, young people and families to access health services who might otherwise not routinely do so.

1.17 Chronologies of significant events when included within school nurse records were not seen to be used or updated to reflect known escalating or de-escalating risks to children and young people, especially in complex cases where its use would be more useful and appropriate. This limits effective tracking of changes to risk so that children can be safeguarded at the earliest opportunity.

(Recommendation 4.3). This matter will also be brought to the attention of the local authority public health commissioners.

1.18 Children and young people in some high schools benefit from school nurse drop-ins that young people can attend to access contraception and sexual health advice and other services, including Clinic in a Box; a confidential young person's sexual health service in secondary schools and community settings. Whilst the offer is universal, not all children are able to access this service because either their school do not support the service or because of a lack of trained practitioners.

It is recognised that it can be difficult to offer clinic in a box in some faith schools and, despite lack of trained practitioners, it is unlikely that 100% of schools will accept this service. Therefore, St. Helens Public Health team have worked to ensure a comprehensive universal offer outside of schools via the St Helens CASH service Teenage Advice Zone (TAZ) offered in Town centre six days per week.

² The 'Every Child Matters' report was published alongside a detailed response to Lord Laming's Report into the death of Victoria Climbié, and also a report produced by the Social Exclusion Unit on raising the educational attainment of children in care. The five outcomes that mattered most to children and young people who were consulted as part of the reporting process were; Being healthy, staying safe, enjoying and achieving, making a positive contribution and economic well-being.

1.19 The Child and Adolescent Mental Health service (CAMH) as provided by North West Boroughs Healthcare NHS Foundation Trust (NWBH), is a service that works with children and young people (and their families) up to the age of 18 when they have problems which have a serious effect on their daily life - this can include anxiety, depression, eating difficulties and coping with traumatic experiences that are causing difficulties in their school, family or social life. In St Helens children and young people cannot currently self-refer into the CAMH service referrals being made for example by GPs, health visitors, school nurses and social workers.

1.20 The CAMH Assessment Response Team (CART) practitioners provide cover at the Whiston ED between the hours of 9am to 9pm with additional physical cover on-site between the hours of 8pm and midnight. Between midnight and 9am a 'sleeping on-call' service is provided on call for psychiatric emergencies such as urgent mental health assessments. The service is provided every day of the year, including weekends and Bank Holidays. They also receive referrals into the service and make decisions about what actions to take on a case-by-case basis.

The CAMH CART team will, where possible, provide emergency mental health assessment in the community to help prevent inappropriate use of the ED, but if a young person attends the ED following self-harm for example, then once their immediate medical needs are met the CART team will assess them within 24 hours. Once a young person has been assessed by the CART team and is assessed as 'fit for discharge' then a community follow up appointment will be provided within three days. This means that risks can be reviewed and, where appropriate, a plan of care implemented.

1.21 In St Helens, the CAMH CART team use a referral pathway which dictates that referrals marked as priority 'emergency' receive a response within 24 hours, those marked as priority 'urgent' are responded to within 72 hours and those referrals marked as priority 'routine' are responded to within 10 days. All referrals are screened by a duty clinician on the same day as receipt of the referral. The screening process decides if the needs of the child or young person can be met by alternative services outside of CAMHs, or if a specialist mental health service assessment is more appropriate. This includes referral to, where appropriate, the current 'tier two' emotional health service as provided by Barnardo's. This ensures that young people's mental health needs are assessed and met at the earliest opportunity.

1.22 Paediatric wards at Whiston Hospital have been adapted to meet the additional needs of children and young people in mental health distress admitted to await a CAMH assessment. Practitioners have access to a comprehensive admissions check list to reduce risks posed to those young people on admission, but also to other children and young people located on the wards. Agreements are put in place between parents, carers and ward staff to help prevent those young people in mental health distress absconding from the ward. These agreements are completed at the earliest opportunity which ensures all parties concerned are aware of their responsibilities to protect vulnerable young people.

1.23 The Contraception and Sexual Health (CASH) service is an open access service based across St Helens and Halton that is provided by STHK. The service provides sexual health advice and information, as well as contraception, emergency contraception, pregnancy testing, screening for sexually transmitted infections such as chlamydia, gonorrhoea and HIV and termination referrals. There are five mainstream clinics with two hubs (one in the town centre and one based at the St Helens Hospital site) that young people can access according to personal preference. At every meeting CASH practitioners will consider safeguarding risk to young people in their care.

1.24 For those young people aged between 13 and 19 years, the St Helens CASH service Teenage Advice Zone (TAZ) hold drop in clinics at the town centre location delivered by the clinical team and supported by the local authority outreach team. This effective joint working enables a responsive service to young people where they can access clinical advice and treatment as well as support for their wellbeing.

1.25 Although the 'think family' model is established within adult mental health services as provided by NWBH, it could be strengthened further. Client electronic records have dedicated templates to aid the identification of children and young people linked to adult service users and further complete relevant safeguarding information, such as links to children's social care. When completed, this information helps to increase the visibility of vulnerable and potentially hidden children. However, in cases examined we saw that these fields were not always completed therefore vulnerable or potentially vulnerable children were not highlighted. **(Recommendation 4.4)**

1.26 Referral templates used to refer adults in mental health distress to adult mental health services prompt the referrer to complete key information which includes details of children and young people in the care of the adult being referred and also highlight if there are any recognised safeguarding risks to children. However, the completion of these fields was seen to be varied in those cases examined. This hinders the assessment team having access to key information about children as adults enter the service prior to their undertaking an assessment and might cause delay in reporting risk accordingly. **(Recommendation 6.1)**

1.27 Referrals to the adult mental health assessment team are made via a single point of contact. Referrals are reviewed by experienced practitioners and prioritised based on the presenting needs of the adult. Where appropriate and required a same day appointment can be scheduled to meet need and undertake an assessment that might further identify vulnerable children and young people.

1.28 The adult mental health assessment and home based treatment team reported good links with the Change Grow Live (CGL) adult substance misuse service and the 'Mindsmatter' talking therapies service who attend weekly multi-disciplinary team meetings. This approach supports information sharing and joint working for those in their care. We are also aware of links to probation and the youth offender service.

1.29 Pregnant women in St Helen's are starting to benefit from access to a recently implemented specialist multi-disciplinary perinatal mental health service. This is a recent development, but cases examined demonstrated that involvement of the team supports women to receive appropriate care based on their needs. Early signs in the cases seen demonstrated some improved outcomes for those in their care and as such better early identification of safeguarding concerns for unborn children.

1.30 The 'think family' approach to safeguarding adults, children and young people is well embedded within CGL adult alcohol and substance misuse services. CGL offer a substance misuse service that includes; clinical services, recovery support, criminal justice and GP shared care. There is also a prescribing service that includes drug and/or alcohol detoxification, undertaken in a variety of settings according to service user need.

We heard that practitioners within CGL describe themselves as 'family workers with a special interest in substance misuse.' CGL offers an integrated think family service which is co-ordinated by the designated safeguarding lead. The service provides outreach support for parents in six children's centres across St Helens. This provision ensures that parents with young children are not isolated and excluded from receiving one-to-one psychosocial treatment and support.

1.31 The think family service also provides a ten week Moving Parents and Children Together (M-PACT) programme which allows children affected by parental substance misuse to talk about their feelings and experiences to their parents in a safe environment facilitated by trained volunteers and supported by CGL practitioners.

The MPACT programme has achieved positive outcomes in helping parents to understand the impact that substance misuse is having on the emotional health and wellbeing of their children. The programme has also helped motivate substance users to remain in recovery and make positive changes to their lifestyle and parenting and thus safeguard potentially vulnerable children and young people.

1.32 The CGL adult substance misuse service offers some low-level mental health support to service users who have mental health concerns. Some service users find accessing mental health services problematic due to factors such as having no fixed address and due to the entrenched nature of their substance misuse.

There is a psychological therapy lead in post who manages a team of counsellors and volunteers recruited from local universities to deliver cognitive behavioural and psychodynamic therapies. Practitioners will also refer clients who present with enduring mental health problems to mental health services as appropriate

Providing targeted mental health support as part of the service offer means that those clients who have been unable to seek support previously, are able to access interventions that may prevent their mental health from deteriorating and lessen the need for any further mental health interventions. It is also an opportunity for early interventions to take place to safeguard children and young people in the care of adults who might not otherwise be accessing mental health interventions.

1.33 At CGL, we saw that home visit risk assessments are being carried out in instances where there are children living with the service user or if children are regularly attending the address where the service user resides.

A standardised assessment form is used which takes into account the conditions of the home, if the home environment is suitable for children and it also prompts exploration in relation to medicines and paraphernalia such as needles being safely stored. When a service user has children in their care and are known to social care, practitioners will undertake joint initial assessments and home visits with social workers. This is good practice in identifying risk and early help needs.

1.34 CGL has a good understanding of the demographics of their service users, and as a result have identified that problematic alcohol use is particularly prevalent amongst women and further that many of these women may have children residing with them.

As a result clinics have been set up in 15 GP practices across St Helens in an attempt to engage women who are alcohol dependent in an environment where they might feel more comfortable and less stigmatised and so better engage with practitioners.

2. Children in need

2.1 Whiston Hospital has classified children to be aged between 0 to 15 years. All children and young people between these ages are seen in the children's ED. Young people aged between 16 and 17 years are triaged in order to capture their social care information and are then seen with the adult unit unless they are a known patient or attend in mental health distress or had special educational needs or disabilities.

2.2 STHK has a dedicated paediatric liaison team which ensures information in relation to attendances for all children and young people up to the age of 18 are shared with relevant community practitioners, including school nurses and health visitors, as well as social workers when indicated. The team also processes information from the maternity department when a safeguarding cause for concern has been raised and across the trust when adults present and concerns are raised in relation to their children.

We examined safeguarding information sharing forms completed in the ED and saw that they contained relevant and sufficient detail regarding those concerns. The form alerted the safeguarding team and anyone reading them to the background of the child and any recommended treatments/actions going forward. A senior staff member was assigned from the ED to ensure they followed up the outcomes following information sharing on a daily basis. This safeguarding form is kept within patient notes and also uploaded into the electronic patient record ensuring records are complete and up-to-date.

2.3 There is a well embedded culture of safeguarding across midwifery in St Helens. For example, where a woman books her pregnancy with her GP midwives are proactive in making contact with the identified GP and, where appropriate, social care to obtain pertinent information relating to the woman's social history. This enables them to accurately identify and assess vulnerabilities and associated risks.

2.4 Communication between safeguarding midwives, specialist midwives, public health and community midwives is strong. We examined evidence of prompt and effective information sharing between midwifery teams. This ensures that all practitioners are aware of any safeguarding concerns and are able to plan and provide appropriate responses to the identified level of risk. The paediatric liaison team within Whiston hospital further facilitates communication and information sharing between midwives and health visitors.

2.5 There is a clear Did Not Attend (DNA) policy in place which midwives follow when a woman fails to attend ante-natal appointments. We saw evidence of midwives being proactive in following up missed appointments and liaising promptly with other professionals to notify them that appointments had been missed. Having a clear DNA policy in place reduces the risk of cases drifting and safeguarding concerns not being identified in a timely way.

In one tracked case examined, we saw that a young teenage expectant mother, who was identified as being at risk of CSE and DVA, had missed a number of antenatal appointments and scans.

Recognising the increased vulnerability of the young person, we saw evidence of community midwifery being persistent in their attempts to re-engage with her via telephone calls and unannounced home visits. There was also strong evidence of missed appointments being discussed and shared with social care, GP's and the safeguarding midwife so that risk could be escalated when considered necessary.

The expectant mother has now re-engaged with the service and risk can now be more closely monitored.

2.6 Maternity staff in St Helens routinely enquire about domestic abuse using a mandatory question on the electronic patient record. This takes place at booking and is repeated at later appointments. When a positive response is identified the safeguarding team and operational managers expect midwives to assess risk using further questions as well as individual professional curiosity. This further exploration of the nature of the disclosure was evident in records examined. This supports the early identification of safeguarding risks to women and the unborn baby.

2.7 The Family Nurse Partnership (FNP) service in St Helens is well established. Specially trained family nurses support teenage women and young families with additional vulnerabilities from the early stages of pregnancy until their child is two years of age. This targeted service helps to meet any additional needs of this vulnerable cohort of young mothers through focussed interventions.

Records examined evidenced how practitioners and expectant mothers had worked together to promote healthy pregnancies, focused on improving their children's health and development and included plans for the parent's own futures and how to achieve their aspirations. The family nurses were able to provide emergency hormone contraception to help prevent future unplanned pregnancies.

2.8 Health visitors are linked to all GP surgeries in St Helens and participate in practice meetings to discuss vulnerable families. This ensures that information is shared between disciplines, risks are considered jointly and plans can be put in place to support ongoing care. In the absence of school nursing at these meetings, health visitors report that they discuss any relevant siblings and relay this information to ensure that the family's needs are considered holistically.

In one tracked case examined, we saw that the health visitor had holistically assessed the needs of the family and made appropriate referrals to services that included Portage (a home visiting educational service for preschool children and their families when the child has Special Educational Needs and Disabilities (SEND)), home start and the re-enablement team. An EHAT assessment was completed in this case and referrals to services thereafter were seen to contain a good level of detail, outlining the presenting concerns and protective factors under common assessment framework domains.

There was evidence of effective multi-agency working and joint home visits to ensure that engagement was maintained and that services were in place to fully support this family's needs. The health visitor was proactive in following up when appointments were missed and details were communicated to the social worker concerned. Safeguarding supervision was documented on the child's record and plans from this were seen to be clear, with SMART (Specific, Measurable, Agreed upon, Realistic and Time-based) actions to improve the outcomes of this vulnerable family.

2.9 The paper based record system is not supporting St Helens health visitors to easily identify risk and share information with partner agencies. In an attempt to highlight families on Family Action Meeting (FAM), subject to child protection measures or those children and young people who were looked after, each record is stored in a specific coloured folder. However, there is no 'file' binding it all together or dividers to outline different sections of information. Some information is held in a separate safeguarding section within the overall folder however this means that the reader must navigate through two bound packs of papers to gain a full picture of the current events.

Plans are in place for the service to move to an electronic patient record system but at present the records are sometimes hard to navigate, time consuming and present additional barriers for professionals to effectively carry out their day to day practice in an efficient way and identify risk at an early stage. **(Recommendation 4.5)**

2.10 The health visiting service capture the voice of the child and the child's lived experience well and this was clearly documented in records examined, in addition to advocating for the needs of the parent where appropriate. In all records seen the demeanour of the child and interaction with parent was captured with analysis being provided when considering interventions to support their needs. This means that health actions can be targeted to meet the needs of child and in takes into consideration their wishes and feelings.

2.11 In school nursing, the voice of the child was seen to be recorded in some case records examined although this was not consistent. When it was seen, it helped to convey the child's feelings well and inform the ongoing care process. However, the different assessment templates used and the need to navigate different sections of paper records reduced the visibility of this important information. **(Recommendation 4.6). This matter will also be brought to the attention of the local authority public health commissioners.**

2.12 Relationships between school nursing and GPs are less well developed than those in health visiting. As a consequence, there is a risk that the exchange of information between these disciplines may be impeded and limit the effectiveness of joint working to safeguard school aged children and young people.

(Recommendation 4.7). This matter will also be brought to the attention of the local authority public health commissioners.

2.13 Arrangements to transfer and share information about children with additional needs or vulnerabilities from health visiting to school nursing were not always robust and in school health records examined we saw little or no evidence of a handover between the services. Consequently, school nurses may not be alerted to the needs of children as they move into their service which may contribute to delay or drift. **(Recommendation 4.8). This matter will also be brought to the attention of the local authority public health commissioners.**

2.14 Transition arrangements between St Helens CAMH services and adult mental health are generally effective. Transition generally starts at age seventeen and a half or earlier if required. The process includes the sharing of information and face-to-face joint meetings, especially where there might be some disparity in the way that services are provided between the two disciplines. This means that those young people transitioning between the two mental health services will have their needs identified and met by the adult service where equivalent service is available.

2.15 It is generally recognised that young offenders have higher levels of health need compared to their peers who are not engaged with offending services in relation to several areas: Mental health, learning difficulties, substance misuse and social issues. It is also recognised that this population also experience high levels of dual diagnosis, in which young people experience both mental health and substance misuse needs.³

However, St Helens CAMHs do not currently provide a service to the St Helens YOS to recognise the additional vulnerabilities of young people within the criminal justice system. There is risk therefore that those young people's mental health needs are not being readily recognised and met at the earliest opportunity. **(Recommendation 5.2)**

2.16 The existing CAMH service in St Helens, both at tier two as provided by Barnardo's and at tier three as provided by NWBH, has found it challenging to meet the increasing and identified needs of children and young people from the Borough in a timely manner despite additional investment. This is mainly as a result of staffing capacity issues and the number of current practitioner vacancies.

³ In their 2015/16 annual report the St Helens Safeguarding Children Board (SHSCB) note that; as of January 2016, 19 young people of the Youth Offender Service (YOS) cohort of 34 had re-offended with a total of 34 further offences. All of the reoffenders were boys (the cohort included six girls, none of whom reoffended). The majority of further offences committed (19/34) were more serious and 24/34 occurred three to six months after the initial offence was handed down. The re-offending frequency for looked after children was much higher (2.0) than for those children who have never been looked after (0.76).

Those children and young people who have been referred to the Barnardo's service have, due to those ongoing capacity issues, historically experienced long waiting times for both assessment and before receiving care and support. This can be exacerbated if the Barnardo's service feel that the child's mental health has deteriorated during the wait and they now need to be referred back to CAMHS for the assessment of tier three interventions from the CAMH community teams.

(Recommendation 1.1)

2.17 A re-structuring of the Barnardo's assessment process means that children are, upon 'opting into' the service offered a face-to-face assessment within two weeks. Then, if accepted into the service, children, young people and families can be directed to other support where appropriate while they wait for therapeutic interventions to commence. The backlog of some 90 cases still waiting to be assessed by Barnardo's is being cleared at the rate of approximately six per week. Barnardo's and CAMHs managers meet on a weekly basis to share information to minimise risk to children and young people waiting to enter service and escalate individual cases where necessary.

2.18 Although during the course of our review we did not examine any cases where delays in accessing young people's mental health service provision demonstrated that risks were not being managed, we were advised by CAMH practitioners and managers alike that the current situation is of concern and that there are and have been extended waiting times for some children and young people in receiving appropriate care and support.

2.19 There is good attendance by adult mental health managers to multi-agency risk assessment conferences (MARAC) meetings.⁴ However, case examples examined within adult mental health services demonstrated that the use of tools such as the Merseyside Risk Identification Tool (MeRIT) to measure those at risk of abuse was variable. When completed, this assessment tool supports tracking of risk to underpin professional judgement and decision making in safeguarding practice.

(Recommendation 4.9)

2.20 CGL adult substance misuse services and the young person's substance misuse service as commissioned by Public Health (within St Helens local authority) and provided by St Helens Council Young People's Drug and Alcohol Team, are not directly integrated together in the borough. However, CGL have well established links with this service to negate any potential risk that might arise from this fact. These links have been reinforced by the employment of a transitional worker who works closely with the young person's drug and alcohol service to identify and support young people who are likely to require transition to access on-going support from the CGL adult service. This ensures appropriate information sharing where risk is identified, such as in complex families, and it further assists transition of young people into the adult service where necessary.

⁴ The MARAC is a local, multi-agency victim-focused meeting where information is shared on the highest risk cases of domestic violence and abuse between different statutory and voluntary sector agencies. This supports the exchange of information to inform multi-agency decision making and ongoing frontline practice.

CGL's transitional worker accesses young adults on a case by case basis and a care plan is formulated by the young person's key worker, the transitional worker from CGL, and the individual young person. We saw evidence of care being well planned and person centred. We saw that when young adults transition into adult services, consideration is given to the fact that they may be especially vulnerable to exploitation from other adult service users. We saw that there is a risk room away from the main reception area where vulnerable clients can wait for their appointments safely.

2.21 Where GPs are informed of concerns to children and young people by health visitors linked to their practice, then GPs are proactive in following up that information to ensure the safety of those young people.

In one case examined we saw how a GP was informed of missed health visitor appointments. The health visitor had concerns regarding a child's developmental delay. The GP was seen to be pro-active in making an appointment to see the mother, child and maternal grandmother at the surgery where they made the mother aware of the importance of attending appointments with health professionals and they further engaged with the grandmother as a protective factor.

Since the GP took action the child has been taken to various health appointments by the mother and their health needs are now being met.

3. Child protection

3.1 The reception staff at the Whiston Hospital ED book in children and young people and pass the paperwork to practitioners then undertaking assessment and triage. The triage staff use the online Child Protection Information Sharing system (CP-IS)⁵ to check for data relating to children (including unborn children) currently subject to a child protection plan, or who are looked after. This is presented as an alert on the record indicating the patient is recognised as being vulnerable.

This means that health and social care staff in St Helens have access to a more complete picture of a child's interactions with health and social care services which in turn enables them to provide better care and earlier interventions for children who are considered vulnerable and at risk.

3.2 The CP-IS system is only used by the ED. To safeguard children further, the hospital safeguarding team are still using the 'Safe Alerts' electronic process. Safe Alerts is a trust-wide system that can be accessed by all staff and includes protection plans, case conference details and safeguarding alerts put onto the system by the paediatric liaison team. A letter template is attached and an alert added to the system to further highlight potential risk and vulnerabilities.

3.3 The ED admissions Casualty Card (CAS) system for children in use at Whiston Hospital has sections within it to record social and family history. We saw the completion of this was however, variable depending on the clinician completing them and further that it was not always completed to its fullest. We spoke with the paediatric consultant who told us it was used as a prompt rather than it having to be always completed. However, a more robust approach to obtaining this information would facilitate a holistic approach to care and management of the child and their family and further strengthen child safeguarding procedures at Whiston Hospitals ED. **(Recommendation 2.2)**

3.4 The CAS card used at Whiston Hospital ED includes areas for the practitioner completing it to explore previous attendances but in cases examined we saw that this wasn't always completed fully. In one example seen we saw how a young person had attended the ED twice during the previous month and although the examining consultant knew this personally the CAS card had not been completed to show this. This means that other professionals examining the CAS card and who come into contact with the child might not be made immediately aware of the previous ED attendances. **(Recommendation 2.2 as at paragraph 3.3 above)**

⁵ CP-IS is a system that shows that if the child attending an NHS unscheduled care setting, such as an emergency department or a minor injury unit, then the health team is alerted if that child is the subject of child protection measures or is a looked after child. The health team will also then have access to the contact details of involved social workers. Children's social care are also automatically notified that the child has attended a care setting, and both parties can further see details of the child's previous 25 visits to unscheduled care settings across England

3.5 If any safeguarding issues are noted at examination at Whiston Hospital ED, then the child or young person will be automatically seen by a lead paediatric consultant. A junior consultant might assist in the examination, but the senior practitioner will take the lead especially if, for example, any safeguarding issues are raised in the booking in process.

3.6 The 'Think Family' model is well established within St Helens midwifery services. We saw evidence of midwives taking a holistic view of the entire family unit as opposed to being solely focused on the mother and unborn child.

In another tracked case examined, we saw that the midwife had identified that the expectant mother was presenting as having significant learning difficulties and that her current living conditions were also a cause of concern.

The antenatal clinic midwife completed a learning disability maternity needs assessment form. This comprehensive tool facilitates midwives to assess parent's life skills, familial history and access to support and resources.

The outcome of this assessment was shared with the expectant mothers GP, community midwife, health visiting services and the maternity safeguarding department. A referral was also made to the learning disability social work team, as there was no social care involvement already in place due to needs not previously being identified.

The Public Health midwife completed a further assessment of the father of the unborn child and identified that he also had some previously unidentified learning needs.

Midwifery worked closely with all key professionals and it was agreed that the parents would benefit from a programme of support and education and that it was likely that they would be able to parent their baby. Both parents developed a good rapport with multi-agency services due to practitioners engaging with them to build their trust.

Prior to birth a foster placement for the family was put in place to support the new parents with looking after their new-born child. A robust discharge plan was agreed and implemented which allowed the family to remain together.

3.7 During our review, we examined examples of referrals midwives in St Helens had made to children's social care. They demonstrated that midwives clearly set out concerns and the expected outcome within referrals made so as to inform the decision making process.

Safeguarding referrals completed by midwives are retained and visible within the patient's paper record. Midwives proactively contact social care to establish the outcomes of referrals submitted. We heard how referrals to children's social care are routinely copied to the safeguarding specialist midwives to review with issues identified in these reviews incorporated as learning in the maternity services level three mandatory training. This supports an internal quality assurance arrangement where good practice is acknowledged and weaker practice is challenged.

3.8 Health visitors are active participants in child protection processes. We examined evidence in cases seen of health visitors instigating strategy meetings and making appropriate challenge and escalation where necessary.

3.9 Practitioners across all health disciplines in St Helens including midwifery, public health and mental health services are well engaged in the child protection process, with routine attendance at initial and review child protection conferences for example. Reports are also submitted to assist in the decision making process and these were seen to be of a good standard, clearly articulating risk.

3.10 CAMHS services for St Helens have a DNA pathway for practitioners to follow should a child or young person fail to attend appointments for assessment or therapeutic intervention. The decision making process takes into consideration as to whether there are immediate concerns for the safety of the young person or no immediate concerns. This then dictates what actions to take including the offer of a further appointment, telephone calls and discussions, for example, with children's social care. The process has some level of flexibility that can be employed on a case-by-case basis before discharge from service.

3.11 In CAMHs, we examined cases where practitioners recognised well potential risk to children and young people even when there was no immediate concern regarding their mental health. In one tracked case examined we saw how the practitioner liaised with multi-agency partners and 'held' the case until further enquiries regarding the child's safety could be undertaken. This is effective practice to ensure the safety of those young people in their care.

A young person was referred to CAMHs for assessment following a head injury and apparent physical symptoms as a result. During the assessment process the CAMH practitioner ascertained that the child might be presenting with symptoms associated with fabricated or induced illness. These concerns were shared with the referrer who agreed.

Discussions were held with senior CAMH managers where, even though it was unlikely that the young person would require any CAMH therapeutic interventions, they would hold the case in the hope that the young person would disclose any information pertaining to their own safety. A plan of care was created with the young person and, as the service user/practitioner relationship developed, CAMHs were able to disclose their findings with the parent of the child and a referral was made to children's social care for further assessment.

3.12 In CAMHs we saw that referral made to children's social care did not always clearly articulate identified risk to the child or young person subject of the referral. Likewise, where practitioners are given the opportunity to state what outcome they would wish following the referral we saw that this was weak and would not influence the decision making process. There is a risk therefore that children's social care may decide that those children subject of the referral might not meet the thresholds for interventions even though there is identified need. (**Recommendation 4.10**)

3.13 Despite still being in a period of implementation, CGL adult substance misuse services have established good links with other services and partner agencies across St Helens. We saw evidence of liaison with children's social care, police and probation and also with midwifery and health visiting services to better protect vulnerable children and young people.

3.14 Multi-disciplinary working with midwifery is particularly strong in the adult substance misuse service. A family worker from CGL holds a clinic with the specialist substance misuse midwife on a fortnightly basis to provide intervention and support for pregnant mothers who are engaged in substance misuse.

The substance misuse family worker also carry out joint home routine visits when a woman fails to attend her clinic appointment. This provides them with an opportunity to observe the home environment, and facilitates the early identification of risk which can then be shared with social care, health visitors and other key professionals as required.

3.15 CASH services in St Helens use the 'LILLIE' electronic patient record system to maintain up-to-date and complete patient records. The system provides a dedicated risk pro-forma for children and young people under the age of 18 facilitating good risk assessments to be undertaken by practitioners. These are completed at the first appointment and reviewed and updated at subsequent meetings. Areas covered include safeguarding risks, CSE, relationships and drug and alcohol screening. All questions must be answered to complete the assessment with mandatory fields requiring completion before moving to the next stage.

We examined a number of cases during our review and found that the risk assessments were comprehensive with additional free text used by practitioners to give further important detail and narrative.

3.16 We heard that there is a structured process in the St Helens CASH service to respond to young people who do not attend arranged appointments. Every non-attendance is alerted to a CASH service practitioner who reviews the individual case assessing risk and then deciding on the most appropriate recall process for the young person. We heard that practitioners will also share information of non-attendance with the young person's school nurse if appropriate so that they can make contact with the young person and enquire about the non-attendance reason and arrange a further appointment if required.

This means that young people are kept safe by ensuring the reasons for non-attendance are valid and contact with them is maintained where requested.

3.17 Within St Helens CASH services, there is a robust pathway in place for those young people identified as being at risk of CSE. This includes identifying any concerns using the under 18 risk assessment proforma and the CSE alert placed on their electronic record which remains there until their 18th birthday.

All potential CSE cases identified by the CASH service are discussed at a monthly CSE meeting attended by the named nurse and a CASH practitioner. If necessary, a multi-agency action plan will be put in place depending on risks identified.

3.18 St Helens CASH services also receive a copy of Multi-Agency Child Sexual Exploitation (MACSE) meeting list of vulnerable children. If the young person is not known to the CASH service a temporary electronic record is created so this exists for any future possible attendance. This is good pre-emptive practice in identifying risk.

In one case example examined, we saw how a looked after child who was attending a CASH service clinic made a disclosure of possible CSE. The case was therefore appropriately referred to MACSE for their attention.

3.19 The quality and standard of record keeping within adult mental health was variable. The RIO electronic client system supports practitioners to record details of children linked to the adult and other professionals involved. Whilst the details of children were recorded in some format within the electronic record, this was not always fully completed and dedicated templates for children's details were not always filled in. In one record examined we saw that key information such as whether a child was the subject of a child protection plan was omitted; so too were any actions or outcomes specific to adult mental health to inform ongoing care and planning. This reduces the visibility of important information about children linked to adults accessing the service. **(Recommendation 4.4 as at paragraph 1.25 above)**

3.20 In adult mental health referrals made to children's social care were of a variable quality. Referrals examined lacked detail regarding identified concerns and did not sufficiently articulate risks and the voice or lived experience of children. In one case examined we saw that children subject of the referral experienced a significant delay of three months before the referral was accepted for screening as it was initially handwritten and this format was refused by children's social care. The delay was on the part of adult mental health in ensuring a type written version was submitted. This matter was raised as unacceptable at the time of our review. **(Recommendation 4.10 as at paragraph 3.12 above)**

3.21 In CGL adult substance misuse services, cases where there are safeguarding concerns identified are clearly identified on the data management system, including those pertaining to children and young people. This means that practitioners are readily informed of identified risks to vulnerable children and young people in the care of adults who misuse substances an alcohol.

3.22 CGL provide drug testing as required by social care, for example when a parenting assessment is being undertaken. We saw that many of the referrals received by CGL were from social care requesting substance misuse testing but that further information regarding psycho-social interventions were not necessarily requested as well. ***This matter will be brought to the attention of the local authority public health commissioners.***

In one case examined, we saw that a young father had been referred by social care as they had concerns regarding his possible use of cannabis. They were undertaking a parenting assessment and requested CGL to undertake a drug test to confirm if he was using cannabis as suspected.

When he attended his appointment, the CGL practitioner was concerned about his presentation and also tested him for the presence of other substances. The results of the drug test indicated that he was also using opiates. When asked about this, he admitted that he was in fact injecting heroin.

Due to the risks identified a decision was made that he should not have any further unsupervised access to his children and CGL engaged him with the service and continue to support him in relation to his disclosed substance misuse.

Following this incident, CGL have reviewed their policy and no longer drug test clients without the completion of a full assessment and further offering them a minimum of four follow up appointments to meet their need.

3.23 CGL adult substance misuse services have recently been involved in a community initiative to help reduce the amount of drug related paraphernalia that was being discarded on the streets of St Helens.

It was widely recognised that used needles that had not been disposed of safely posed a risk to children who may pick them up out of curiosity. If they then sustained a needle prick injury they may then be susceptible to contracting blood borne viruses that could be detrimental to their health.

In response to this issue, CGL have launched single use needle packs. Once the needle has been used, it is disposed of into a small bin which acts as a lock box. The needle also breaks when inserted into the bin as an extra safety measure. A promotional campaign was launched alongside this to educate the injecting service user population about the potential risks that incorrectly disposed of needles pose to the community and in particular, children.

This campaign and use of single use injecting packs has proven successful and the presence of drug litter has reportedly decreased across the borough.

3.24 GPs across St Helens make good use of safeguarding alerts in electronic patient records. Alerts include; where a child is the subject of child protection measures, is a looked after child and where domestic abuse is indicated within the family. Where a referral is made to children's social care via the MASH, we saw that GPs ensure a copy of the referral is maintained within patient records. Referrals made to inform the safeguarding decision making processes were seen to be detailed, clearly articulating risk and expected outcomes.

4. Looked after children

4.1 At the end of March 2017, the St Helens local authority reported that they were responsible for the care of 427 looked after children. The care of children and young people who are placed outside of St Helens is provided by the host community health organisation where they live. However, the responsibility for the care and well-being of these children remains with St Helens Local Authority and the coordination of health assessments remains the responsibility of Bridgewater Community Healthcare NHS Foundation Trust (BCHFT). The number of children in care has increased from 410 in 2016.

4.2 The health provision for looked after children in St Helens is fragmented. The looked after children's health service as provided by BCHFT, have responsibility for all looked after children in St Helens. However, the delivery of the Review Health Assessments and most direct work is provided by the 0–19 community children's nursing service, provided by NWBH. Commissioning of looked after children's services across two health providing organisations leads to challenge. It is difficult for the looked after children's team to have full oversight of staff in a different organisation, resulting in fragmentation. **(Recommendation 7.1)**

4.3 Looked after children who receive care from NWBH do not benefit from a helpful synopsis generated by their 0 to 19 health practitioner to support the Initial Health Assessment process. This means that community paediatricians have to spend additional time collating and preparing information for assessment which may delay the assessment process and further impact on their capacity to deliver other services. As a proactive approach to support the pathway for 0-19 colleagues, there is a plan for the specialist nurses from Bridgewater looked after children's health team to expand their practice to cover/complete a synopsis for children who are seen by NWBH. Ideally the case holder would complete this summary but at the time of inspection this had not been fully implemented. **(Recommendation 7.1 as at paragraph 4.2 above)**

4.4 Children who are looked after are not being fully supported to access services to meet their mental health needs. Evidence in records examined demonstrated that SDQs are routinely completed and are available to identify concern and inform health assessments, but there was an absence of referrals to emotional wellbeing services despite when need was clearly identified. This is in contradiction to local processes where SDQ scores of 13 and above should automatically trigger a referral to the Emotional Health and Wellbeing Panel as the referral route to appropriate support services. This means that not all looked after children are being considered for the correct support to address their emotional health needs. **(Recommendation 3.6)**

4.5 In St Helens, the BCHFT patient access policy states; *'In accordance with the guidance on promoting the health and wellbeing of Looked After Children, the organisation must ensure that when a child or young person moves placement or moves into an area from another area covered by a different organisation, necessitating moving from one NHS waiting list to another, he/she is not disadvantaged by being placed at the bottom of a new list. Every effort should always be made to ensure that looked after children are seen without delay or wait no longer than a child in a local area with an equivalent need who requires an equivalent service.'*

Practitioners we spoke with told us that they were unaware of dedicated health services or care pathways for children who are looked after who were already placed within the St Helens area. We were advised that looked after children are able to access generic services and that Looked After Children's health nurses can offer additional support in individual cases where a decision needs to be challenged, or access to a service expedited. However, this is not routine practice and policies in relation to increased priority being given to the additional vulnerabilities of looked after children are not well understood by those practitioners. This means that given the complex nature of children in care and potential for poorer engagement, their needs may not be met in a timely or effective way. **(Recommendation 7.3)**

4.6 The voice of the child was not evident in many of the health assessments examined within looked after children services. Children and young people should be given time and the opportunity to actively engage in the health assessment and planning process and this was not routinely evidenced in St Helens. Obtaining and recording the voice of the child or, where younger children are concerned their lived experience, ensures the health assessment is individualised and for young people encourages them to take responsibility for their own health care as they transition into adulthood. This was further evidenced in discussion with young people who participated in the children in care forum who told us that they did not feel engaged in the health review process.

BCHFT does provide flexibility in the location, time and date of health assessments and the option for young people to be seen alone, but again, young people we spoke with told us they were not always aware of these options. **(Recommendation 3.4)**

4.7 Systems used by the looked after children team to identify and address outstanding health assessments does not always also identify risk and where young people are difficult to engage in the Initial Health Assessment or Review Health Assessment process efforts to do so are not well recorded. BCHFT identifies risk for refusers via a refuser pathway, developed from audit. However, records examined did not indicate that, if all attempts to complete the assessment have been unsuccessful, then a health plan is completed with the available information. **(Recommendation 3.3)**

In one case examined we saw that an Initial Health Assessment had still not been completed over a year since the young person came into care. The young person was known to be at risk of CSE and of self-harm. Although efforts were made to engage the young person in the Initial Health Assessment once the delay had been noted, those efforts were not recorded and did not appear to be robust or persistent, even when the young person returned from incidents of being missing from care or further disclosed that they had been accessing healthcare in a different area.

To date the young person has not had an Initial Health Assessment. Despite social care records stating that the young person was declining the assessment this was not seen recorded in the health records. The young person also has unmet health needs over and above their episodes of self-harm. At the last recorded contact the young person asked for their height and weight to be recorded but even then there was no mention of discussion in relation to the Initial Health Assessment.

4.8 Plans generated following Initial and Review Health Assessments of older children lack focus in relation to expected outcomes and we saw that information was not always carried through from other records and systems. Action plans were not SMART with the repeated use of terms that include 'ongoing' or 'asap' without target dates set for example. There was little evidence to suggest that actions were being monitored or proactively completed. This means that young people may be left with outstanding concerns not being met and services not put in place to support their needs. **(Recommendation 3.5)**

4.9 Available screening tools are not always being used consistently or effectively by the looked after children's health team to inform decision making. In cases examined we saw that there was evidence of tools being present and completed in children's files, but these did not always reflect a full history of known information and there was a lack of actions recorded as a result of concerns being identified. This is a missed opportunity and means that need might not be identified and children may not receive referrals to appropriate services to meet their needs. **(Recommendation 3.1)**

4.10 The specialist nurse for looked after children attends children in care council meetings which supports joint discussion about the service provided. However, on the whole, obtaining feedback from children and young people is underdeveloped within the looked after children team. This is an area the service recognises as requiring strengthening. A new initiative 'Rate your Review Health Assessment' has recently been introduced but we were unable to test its effectiveness at the time of inspection. **(Recommendation 3.2)**

4.11 Health passports are routinely prepared for young people who are about to leave care. We examined completed health passports during our inspection and saw that they provided a range of background information including valuable personal detail that the care leaver might otherwise not have access to. This means that young people are benefiting from having a record of important health information for future reference and sensitive detail in relation to their early childhood.

4.12 Plans to develop the role of a community paediatric and looked after children advanced nurse practitioner is an innovative approach to driving improvement in the completion of Initial Health Assessment. Through assisting with the engagement and information sharing during the Initial Health Assessment, the community paediatric support worker will enhance the experience received by children and young people and their families.

4.13 The looked after children's health team ensure that looked after children have good access to GPs, dentists and opticians. In most cases examined it was evident that GPs are routinely consulted prior to the health assessment appointment taking place to ensure information from primary care is included as part of the health assessment process. This means that children who are looked after have appropriate access to services to meet their health needs.

4.14 Despite the current high numbers of looked after children in St Helens, there is currently no specialist CAMH offer to this vulnerable group of children and young people. Although CAMH practitioners we spoke with are aware of the additional vulnerabilities of this particular cohort of young people, looked after children are not, for example, always given prioritisation for service consideration.
(Recommendation 4.11)

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 Within STHK, the director of nursing, midwifery and governance is the executive lead responsible for safeguarding supported by the dedicated post, head of safeguarding and public protection, the named nurse, doctor and midwife, safeguarding children and specialist safeguarding staff for paediatrics and maternity.

The Trust's safeguarding children steering group, which reports to the patient experience council, has responsibility for ensuring the safeguarding children agenda is achieved. The well-established group includes representatives from all service areas within the Trust and review the overarching safeguarding children work plan which ensures that the Trust has a clear oversight of the agenda, the work it is undertaking and progress being made.

5.1.2 STHK maternity services now benefit from an identified named midwife, part of a senior community midwife role. A strong working relationship has already been established between the named midwife and named nurse for safeguarding with proactive leadership, oversight and assurance of safeguarding. As a consequence, safeguarding vulnerable children and young people has maintained a high priority within maternity services.

5.1.3 The health visiting and family nurse partnership teams are currently fully staffed and the workforce is stable and consistent. Although there are no specific specialist health visiting or family nurse posts across the 0–19 service, there are a number of 'practitioner champions' who have special interests including; breast feeding, infant feeding, perinatal mental health, special education needs and disabilities, sexual health, smoking and implementation of nicotine replacement therapy and National Institute for Health and Care Excellence (NICE) guidance. This ensures that health visitors and family nurses have ready access to share specialist knowledge to best support their practice.

5.1.4 The school nurse service aims to provide children and young people subject to child protection measures or who are looked after with access to timely health needs assessments and a named school nurse. However, achievement of this is hindered by insufficient staffing and managing other competing priorities. As a consequence, children experience delays in having their health needs assessed which may impact upon the timely achievement of improved health outcomes.

NWBH ongoing attempts to recruit and retain qualified school nurses has had limited success in St Helens. Whilst the use of bank staff is reported to provide some relief, this is not a sustainable solution to ensure school aged children benefit from responsive targeted support. This has reportedly been placed on the trust risk register. We are aware that work is ongoing in this matter with plans in place to fill vacant positions.

5.1.5 School nurse team leaders maintain an oversight of children and young people known to the service with additional needs and vulnerabilities through monthly management supervision. We saw the use of a colour coded spreadsheet that set out key pertinent information so the manager could keep a track of matters identified such as outstanding health assessments.

5.1.6 There are good quality assurance arrangements by the LAC health team for both St Helens looked after children and those who are placed into the area from other boroughs. All initial and Review Health Assessments are checked using a standardised template and a comprehensive database, capturing relevant information for all looked after children. This system is used effectively to monitor the timeliness of all health assessments.

5.1.7 The introduction of a new clinical manager within the LAC health and community paediatric service is a positive step in driving the improvement and development of the service. The need to improve working relationships and partnership working is high on their agenda as it is central to enhancing the service to children and young people who are looked after. However, it was too early to measure the impact of this role at the time of the review taking place.

5.1.8 There has been a recent significant decrease in looked after children receiving timely Review Health Assessments. Since the 0 to 19 service transfer to a different provider there has been a subsequent change in arrangements for the completion of Review Health Assessments. This means that not all children are having their needs addressed in a timely manner. Work is ongoing between partners to better ensure the timeliness of Review Health Assessments across the borough, and BCHFT ensures requests for Review Health Assessments are undertaken in a timely manner and an escalation process is in place, but work with partners needs to be expedited to ensure delays are kept to a minimum. **(Recommendation 7.4)**

5.1.9 The CASH service nurse lead maintains a database to track safeguarding referrals made by practitioners, enabling them clear oversight of safeguarding processes. In addition, every referral is copied to the named nurse for safeguarding children for quality assurance purposes. Routine feedback is received via the named nurse who will also follow up any high risk cases. This means that appropriate information is shared and oversight maintained to help keep young people safe.

5.1.10 CASH service user views are used well to drive forward service across multi-disciplinary teams in St Helens. For example, we heard how staff in the TAZ conducted a survey with young people to gain feedback and suggestions to further improve the service. As a consequence, the waiting room at the clinic was refurbished so it was better suited to the needs of young people and also to be separate from the adults waiting area. The reception desk was also moved into the waiting room to ensure safe supervision of the young people arriving at the centre.

5.1.11 In adult mental health, practitioners benefit from access to a safeguarding champion in each team to support them in non-complex safeguarding practice and also in relation to the dissemination of information and practice updates. Whilst it was expected that safeguarding discussions with the champion are recorded in client electronic records, this was not always evident in cases examined. This means that client records are not complete and in the absence of actions or plans there is limited assurance of the impact of this role. (**Recommendation 4.12**)

5.1.12 The profile of safeguarding practice within adult mental health is raised routinely as part of multi-disciplinary team meetings and management supervision. Such approaches support the exchange of information between disciplines and can contribute to safeguarding being embedded in practice.

5.1.13 CGL took over the existing adult alcohol and substance misuse contract from Addaction and have been the provider since February 2017. The service offer is broad, and service provision is equitable and accessible due to support being offered in a variety of locations across St Helens and via outreach support. Home visits are routinely carried out in cases where service users are unable to travel to groups and appointments and service managers maintain oversight of all aspects of service provision to ensure continuity and safety of service.

5.1.14 Managers and team leaders at CGL demonstrated that they have good knowledge and oversight of all safeguarding cases held by practitioners. High risk cases are discussed in a daily flash meeting. These meetings are recorded and actions are allocated to practitioners each time a case is discussed where required. These actions are also recorded in client records

Team leaders are dip-sampling cases on a monthly basis and safeguarding cases are also being discussed in regular peer safeguarding supervision. There is a Quality Audit and Governance lead in post that supports service managers with quality assurance and audits.

5.2 Governance

5.2.1 The NHS St Helens CCG Interim Accountable Clinical Officer is the deputy Chair of the LSCB board and, as well as the Designated Nurse for safeguarding children, is also a member of the LSCB executive group. As the group is responsible for setting priorities of action for the area and also for holding organisations to account in relation to their shared safeguarding children responsibilities, the Interim Clinical Accountable Officer and Designated Nurse for safeguarding children are well placed to ensure safeguarding roles and responsibilities are at the forefront of practice across the borough.

The Designated Nurse and named GP also represent the CCG on various LSCB sub-groups including the multi-agency audit group and the child exploitation group. The Designated Nurse also chairs the case review group and the serious case review panel when required to do so. Both the named GP and designated nurse for safeguarding children undertake work as identified in the board's priorities which involve all required partner agencies.

5.2.2 Quarterly meetings are held between safeguarding leads of provider organisations with the CCGs Designated Nurse for children. Quarterly supervision is also in place with these individuals to ensure all parties remain up-to-date in relation to local safeguarding issues.

5.2.3 The CCG safeguarding leads have established a GP safeguarding leads network which meets on a quarterly basis. The meetings aim to explore safeguarding and related issues and to share initiatives, best practice and offer advice and support. The meetings also identify themes, trends and training needs within primary care. This is important work in an area that provides its own challenges to the borough, including the fact that many currently practicing GPs are due to retire in the near future and recruitment to the service continues to be difficult.

5.2.4 The STHK maternity service has robust arrangements in place to identify and record risk as identified to service users. Staff routinely collect and record details of a range of risks as standard and the electronic patient record includes prompts for practitioners to make further enquiries, particularly at the pregnancy booking stage. We saw examples of this used effectively to identify and manage those identified risks.

5.2.5 The maternity service at STHK currently uses paper records alongside an electronic patient record system. In one case examined, we saw that there was a mismatch between the information in the two sets of records examined. In the paper record the need for a referral to children social care was identified but in the electronic patient record the midwife had only recorded that contact had been made with a social worker. There appeared to be a disparity between the records with neither record demonstrating the action taken in respect of a referral and the outcome. Both records were therefore incomplete.

The maternity service has a number of actions planned to make improvements to the record keeping arrangements. These include, for example, redesigning the cause of concern form, amalgamating it with other liaison forms and moving to this being wholly electronic. In addition, there is a regular audit process in place. We heard that work is ongoing across STHK to move to a full electronic patient records system. However, record keeping remains an area of risk in maternity services and one where further work is needed to ensure there is consistency and one complete record in place at all times. **(Recommendation 2.4)**

5.2.6 The trust's safeguarding team quality assure the majority of safeguarding referrals and contribution to child protection meetings and LAC Review Health Assessments carried out by health visitors. Evidence of robust quality assurance was evident in every case examined during our review and we saw reports and assessments that contained a good level detail, analysis and generally SMART objectives. This helps to result in the delivery of relevant and meaningful outcomes for children and families across St Helens.

5.2.7 The existing record keeping arrangements in school nursing do not support practitioners to have efficient access to complete records containing highly visible child safeguarding information. Whilst information such as minutes, reports and safeguarding outcome plans were part of children's records examined, it was difficult to navigate the volume of information held in different sections and folders. When children attend ad-hoc at drop-in session held at a school the very nature of this contact means their health records are unlikely to be available to practitioners and thus immediately aid and inform that assessment.

In the absence of robust chronologies, particularly in complex cases, to aid swift oversight of risks to children, there is a reliance on practitioners having to search for information to support ongoing care to children and young people.

(Recommendation 4.3 as at paragraph 1.17 above). This matter will also be brought to the attention of the local authority public health commissioners.

5.2.8 We are not confident in the robustness and quality of oversight and audit of safeguarding practice within the school nurse service. For example, in one case examined the school nurse identifies domestic abuse and appropriately makes a referral to children's social care. However, this is not underpinned by the use of a domestic abuse risk assessment tool to help illustrate the level of risk to the child. The use of the tool and inclusion of the result might help strengthen the referral. **(Recommendation 4.9)**

5.2.9 NWBH have established forums and reporting processes in place pertaining to the monitoring of quality and safety from operational level to board level. The matron for quality and safety for children's services is working to increase their visibility having seen how 'safety huddles' held in other areas have enhanced practice. However, assurance of the effectiveness of operational safeguarding practice is limited as there is currently no monitoring, audit or spot checks undertaken on the quality of practice within the service. **(Recommendation 4.13)**

5.2.10 Currently, there are complex record keeping arrangements in place for children who are looked after in St Helens. At present the 0 to 19 service, provided by NWBH, use a paper record keeping system with limited content being loaded onto the shared electronic patient record system. However, this service is moving to a different electronic patient record system meaning that access information by the LAC health team will be reduced. We were assured that discussions are underway to mitigate the risk through read only access and training but in the meantime record keeping and information sharing remain an area of risk. (**Recommendation 7.5**)

5.2.11 Consent to complete looked after children health reviews was not evident in school nurse records sampled. As a result, it was evident that health assessments were completed without formal consent being obtained and recorded. It is important that, where age appropriate, consent is given by the young person or their carer as a record that they understand the potential implications of providing that consent, including where information sharing might need to take place. (**Recommendation 7.2**)

5.3 Training and supervision

5.3.1 Across STHK level three safeguarding children training is delivered internally by the Named Nurse safeguarding children as one full day course every three years. Level three specialist training is accessed via the LSCB every three years. This is a two day 'Working Together to Safeguard Children' Course provided as part of their multi-agency training programme and is accessed only by practitioners who are involved in care planning and case management of children subject to child protection procedures.

Evidence of compliance with the policy and Trust Safeguarding procedures was provided by quarterly audits of health records in paediatrics and the ED to review compliance with safeguarding processes, in particular the Laming documentation standards. An annual audit report was completed and overall the general standard of documentation was very good with some areas consistently achieving 100% compliance.

STHK management of Female Genital Mutilation (FGM) has been ratified and is now available on the trust Intranet, accessible by all practitioners and staff. A communications plan to raise awareness has been added to the trust safeguarding children work plan. FGM training is available to staff, including those practitioners in the paediatric ED, through the Local Safeguarding Children's Board (LSCB), as well as being included in all levels of internal safeguarding children training. The STHK safeguarding children policy also has a specific section relating to CSE, informing staff of action to be taken if they have concerns. There is a single point of contact identified to deal with internal and external queries. CSE has been added to all three levels of safeguarding children training in order to raise awareness and respond to both local and national areas of learning.

5.3.2 Practitioners within the ED at Whiston hospital told us that they received protected time for supervision which allows them time for reflection on cases in which they have been involved and learning from a supportive and structured environment. Both local and national serious case reviews form part of the supervision process and this was highlighted across all services in St Helens.

5.3.3 St Helens midwifery practitioners have received additional training around Child Sexual Exploitation (CSE), FGM, and Domestic Violence and Abuse (DVA). The training has been effective in developing midwives understanding and identification of safeguarding issues. We saw that following FGM training, more cases of identifiable Female Genital Mutilation (FGM) have been reported by midwives. There is a clear policy in place regarding FGM which supports midwives to act promptly and appropriately when they identify that a woman has been or may be subject to FGM.

5.3.4 Within midwifery services there is a clinical educator in post who supports newly qualified midwives to develop their clinical practice and understanding of safeguarding vulnerable children and young people. The clinical educator is based on the delivery suite and is available to support less experienced midwives with more complex cases and decision making.

We heard that whilst support, guidance and advice is readily available to all staff, non-case holding midwives are not accessing one to one safeguarding supervision on a regular basis. Despite not holding cases, midwives may still encounter complex cases and vulnerable women, and therefore it is imperative that all practitioners obtain supervision that is supportive and facilitates their ongoing professional development as they may not individually recognise risk outside of such supervision. **(Recommendation 2.3)**

5.3.5 Both health visitors and the FNP benefit from good safeguarding supervision arrangements with the safeguarding team as would be expected of the FNP programme nationally and this is recorded accordingly. Children who are the subject of child protection proceedings are discussed at least every three months and those known to be looked after or open to FAM are discussed at least every six months with the additional opportunity for any ad-hoc supervision available should concerns arise.

Plans generated from safeguarding supervision were seen to be both clear and SMART and were documented in the patient record.

5.3.6 In school nursing, child safeguarding and looked after children supervision was evident in those records examined although in some circumstances it was difficult to find due to the size and complexity of the records. This supports practitioners to access dedicated time to review and analyse the impact of their role in safeguarding children and young people. Plans arising from supervision were seen to go on to inform and support their ongoing practice and care of children and young people.

5.3.7 All practitioners in the St Helens CAMH service have received dual diagnosis training. This is an important process for practitioners to be able to recognise how some young people not only struggle with mental health issues but also alcohol or substance misuse at the same time. Dual diagnosis training better prepares practitioners to meet the needs of those young people in St Helens.

5.3.8 Practitioners from the CAMH service have provided joint training with the adult site liaison team based in the ED at Whiston Hospital to paediatric ward staff. The training informs those staff how best to manage children and young people who present on the wards with difficult behaviours. The training also further ensures those young people remain safe whilst waiting for an acute mental health placement.

The training also informs practitioners on paediatric wards about the services available from the CART to allow them to utilise the team more effectively. This training was provided predominantly to nursing staff in the ED and ward areas. The training has reportedly also improved the relationship between the ED and CAMHS which in turn has also improved communication between both departments.

5.3.9 There are good arrangements in place for safeguarding supervision within the St Helens CASH service. This includes ad-hoc one-to-one sessions based on case discussion and quarterly scheduled group supervision of which staff must attend at least two per year. These are currently managed by the named nurse for safeguarding children. The plan for the health improvement lead to receive safeguarding supervision training and taken on a supervisor role within the CASH service will further strengthen the current offer.

Cases are presented and discussed at the twice yearly service training 'away days' which always include safeguarding content such as domestic abuse awareness. These arrangements mean staff are well supported and helped to make improvements in their safeguarding work.

5.3.10 From January 2017 all GP practices across St Helens were informed that they would each be responsible for recording their own compliance against safeguarding training. A meeting with all practice managers took place to explain the new approach and templates, training needs documentation and a training calendar were shared with all practices. The training calendar and underpinning training needs analysis ensures that GPs are empowered to plan, attend and record their own safeguarding training practice compliance and it further offers freedom and flexibility to access training according to their own needs and schedules.

During 2017/18 further exploration will take place to further consider how primary care will verify their practice training compliance using this new model.

5.3.11 GPs are kept up-to-date on both local and national safeguarding children issues by way of newsletters as provided by the CCG. This ensures that GPs have access to information that might better inform their interactions with vulnerable children and young people.

5.3.12 GP practices provide locum packs for temporary staff who are new to the practice. These packs include information in relation to the practice layout, health and safety and other services to refer patients to such as social services and mental health. However, on examination we found they did not contain specific information in relation to safeguarding in relation to children and young people. This means that locum staff may not have access to the correct details and pathways for following safeguarding procedures. We are advised of routine use of locums across the borough. (**Recommendation 1.2**)

Recommendations

1. St Helens CCG should:

- 1.1 Ensure the transition of CAMH services to those of the proposed THRIVE model are closely monitored so that current waiting times are not extended and are soon improved.
- 1.2 Ensure GP locum packs include important and relevant safeguarding children and young people information so that those locums are aware how to protect vulnerable children and young people.

2. St Helens and Knowsley Teaching Hospitals NHS Trust should:

- 2.1 Ensure that, particularly where more complex family structure or risk is indicated, that practitioners within midwifery services use chronologies to assist them identify and record risk.
- 2.2 Ensure prompts on CAS cards are used to their fullest extent to provide a more holistic approach to safeguarding vulnerable children and young people and further that that all those children and young people who attend the ED benefit from comprehensive screening of their vulnerability to identify safeguarding or child protection needs.
- 2.3 Oversee the quality of work and safeguarding responsibilities of non-case holding midwives by way of improved supervision so that all have access to that safeguarding supervision.
- 2.4 Strengthen processes and quality assurance methods within midwifery services to assure themselves that record keeping and patient records are compliant with NMC guidance and are complete at all times.

3. Bridgewater Community Healthcare NHS Foundation Trust should:

- 3.1 Ensure screening tools available for practitioners to use in their work with looked after children are used to identify additional needs and that managerial oversight of the process is in place.
- 3.2 Strengthen the collection and use of feedback from looked after children so that they continue to play a positive part in ongoing service development.
- 3.3 Improve the use of systems currently in place to identify the timeliness of Initial Health Assessments and Review Health Assessments to further identify risk in those who are difficult to engage in the health assessment process.

- 3.4 Improve process to ensure the lived experience or voice of the child is better captured in both Initial Health Assessments and Review Health Assessments ensuring those children and young people are better involved and take ownership of the process.
 - 3.5 Ensure plans following Initial Health Assessments and Review Health Assessments are more robust and further that there is more quality assurance and oversight of progress made to meet those needs and goals identified.
 - 3.6 Ensure that assessment scoring mechanisms are used to support and meet mental health needs of children and young people.
- 4. North West Boroughs Healthcare NHS Foundation Trust should:**
- 4.1 Ensure that, where there is a noticed decline in targets not being met for health visitor mandatory contacts, then the reasons are investigated and recorded so that a plan can be formulated (where appropriate) to meet those set targets and that this information is understood by all those responsible for delivery of the programme.
 - 4.2 Ensure enquiries regarding domestic abuse are made and recorded at every opportunity and further that practitioners are reminded to do so in assessment documentation provided.
 - 4.3 Ensure that, particularly where more complex family structure or risk is indicated, that practitioners in school nurse services use chronologies to assist them identify and record risk.
 - 4.4 Ensure procedures are in place to assist adult mental health practitioners in identifying children and young people in the care of adult service users and those details are recorded accordingly in client records, and further that, where templates are provided to assist practitioners in identifying and recording risk, then these are used appropriately.
 - 4.5 Expedite methods to secure the quality and accessibility of important safeguarding information within client records in the health visiting service and further that those records are more easily accessible and complete.
 - 4.6 Ensure the 'voice of the child' is captured and recorded within client records to further ensure those young people's views form a meaningful part of the Public Health/young person relationship.
 - 4.7 Develop closer working relationships between school nurse teams and GPs (as primary record holders) to ensure information can be shared in a timely and effective manner.

- 4.8 Develop robust, formal methods for the transition of children from health visiting services to school nursing, especially where additional needs and risks are identified and that the process is recorded in the child's record.
 - 4.9 Ensure tools available to measure risk of domestic violence and abuse are used and further that there is managerial oversight of this process.
 - 4.10 Ensure more robust quality assurance processes are in place to assure themselves of the quality and strength of referrals made to children's social care from both CAMH practitioners and adult mental health practitioners.
 - 4.11 Ensure that as part of the THRIVE model, CAMH provide more directed mental health services to recognise and meet the additional vulnerabilities of looked after children.
 - 4.12 Ensure safeguarding discussions, either held informally or during managed safeguarding supervision, are recorded appropriately in client records including expected outcomes and timescales.
 - 4.13 Ensure more robust processes are in place across both health visiting and school nurse services to oversee the quality of operational safeguarding practice.
- 5. NHS St Helens CCG and North West Boroughs Healthcare NHS Foundation Trust should:**
- 5.1 Consult with multi-agency partners within in the One Front Door process as part of the MASH restructuring to ensure better and more effective health representation at the earliest stage of assessment following referral into the MASH.
 - 5.2 As part of the THRIVE model, ensure that CAMH practitioners better engage with the YOS in St Helens to meet the needs of young people within the criminal justice system.
- 6. St Helens CCG, North West Boroughs Healthcare NHS Foundation Trust, Bridgewater Community Health Trust and St Helens and Knowsley Teaching Hospitals NHS Trust should:**
- 6.1 Ensure that practitioners using templates to refer into adult mental health services complete all of the required fields to assist the assessment and decision making process.
- 7. NHS St Helens CCG, North West Boroughs Healthcare NHS Foundation Trust and Bridgewater Community Healthcare NHS Foundation Trust should:**

- 7.1 Expedite methods across multi-agency partners to ensure the needs of looked after children are met and further that those multi-agency partners work together to better share information and ensure the timeliness and quality of both Initial Health Assessments and Review Health Assessments
- 7.2 Ensure consent is sought, obtained and recorded at every stage of the health assessment process and further that those providing consent are aware of how important and personal information might be shared.
- 7.3 Ensure dedicated service pathways for looked after children across St Helens are better understood by practitioners so that they better recognise Looked After Children's additional vulnerabilities and so meet their needs.
- 7.4 Expedite methods and procedures already underway to ensure the timeliness of Review Health Assessments across St Helens.
- 7.5 Ensure robust procedures are in place to ensure looked after children health records are both complete and readily accessible to practitioners when moving from paper records to electronic.

Next steps

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