

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

Children Looked After and Safeguarding The role of health services in Sefton

Date of review:	23 rd July - 27 th July 2018
Date of publication:	28 th November 2018
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CCGs included:	NHS South Sefton CCG (SSCCG) NHS Southport and Formby CCG (SFCCG)
NHS England area:	North Region
CQC region:	North Region
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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 Sefton. 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 Sefton, 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 2018.
- 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.

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 considered the experiences of 140 children and young people.

Context of the review

The latest data published by Public Health England shows the population in Sefton as 273,790, with a small population of 59,300 children and young people 0-19 years old. Almost 95% of Sefton's population are white British compared to 78% nationally. 92.3% of children in Sefton are white British.

There are mixed levels of deprivation across Sefton with some areas experiencing significant poverty. There are 21% (9,500) of children living in low income families and 17.4% living in poverty. Life expectancy for both men and women is lower than the England average, and approximately 10 years lower for both men and women living in the most deprived areas of Sefton compared with the least deprived.

The rate of family homelessness and of homelessness in young people aged 16-24 years is significantly lower than the rest of England.

Attendances at emergency departments for injury in children and young people aged 19 years and under is higher than the England average. However, emergency hospital admissions in Sefton is similar to the England average. Alcohol and substance misuse related hospital admissions for those under 18 years old in 2017 was worse than the England average but better than the rest of the North West. Mental health and self-harm related hospital admissions for young people under 18 years old are both higher than the England average with admissions for self-harm continuing to rise since 2013/14.

Commissioning and planning of most health services for children are carried out by NHS South Sefton CCG (SSCCG), and NHS Southport and Formby CCG (SFCCG).

Liverpool CCG is the co-ordinating commissioner for Mersey Care NHS Foundation Trust, Alder Hey Children's NHS Foundation Trust and Liverpool Women's NHS Foundation Trust.

Acute hospital services, including emergency and maternity services, are commissioned by SSCCG and SFCCG. They are provided by Southport and Ormskirk Hospitals NHS Trust at Southport and Formby District General Hospital and Ormskirk District General Hospital; Alder Hey Children's NHS Foundation Trust and Liverpool Women's NHS Foundation Trust.

Community based health services for children and young people, including the 0-19 health visiting and school nursing services, are commissioned by Sefton Council's public health team, and provided by North West Boroughs Healthcare NHS Foundation Trust. The children in care nursing service is commissioned by SSCCG and SFCCG. It is provided by North West Boroughs Healthcare NHS Foundation Trust through sub-contracting arrangements from Mersey Care NHS Foundation Trust.

Child and Adolescent Mental Health Services (CAMHS) are commissioned by SSCCG and SFCCG, and provided by Alder Hey Children's NHS Foundation Trust.

Adult mental health services are commissioned by SSCCG and SFCCG, and provided by Mersey Care NHS Foundation Trust.

Adult substance misuse (Ambition Sefton) are commissioned by Sefton Council's public health team, and provided by Mersey Care NHS Foundation Trust.

Young people's substance misuse services known as 'Sefton Stars' are commissioned by Sefton Council's public health team, and provided by Addaction.

Contraception and sexual health services are commissioned by Sefton Council's public health team and provided by Southport and Ormskirk Hospitals NHS Trust.

The last inspection of health services for Sefton's children took place in 2011 as a joint inspection, with Ofsted, of safeguarding and looked after children's services. Recommendations from that inspection were considered as part of this review.

Ofsted carried out a single agency inspection of the local authority and the local safeguarding children board in 2016 and we have taken account of their findings during this review.

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

The report

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

What people told us

We heard from four parents accessing the 0-19 enhanced health visiting service, they told us:

One parent stated her named health visitor had taken time to get to know her, was 'really helpful' and always arranged to help 'as soon as'. They said:

"I've worked with four different health visitors and they've all been amazing, they listen to me."

A second parent reported that there was no waiting time to access the service. They said:

"They've really helped me with mental health problems, they sent me to a group which really helped, I met other people there and made friends."

Another parent reported that she finds it easy to contact her health visitor via a work mobile phone; her health visitor checked how she was feeling and she felt part of planning her own care. They said:

"I got lots of help from my health visitor, I felt clueless as a first-time mother, I'm grateful they've been there."

The fourth parent described the health visitor service as 'really good'. They told us the health visitor had referred her child to see a paediatrician when she was six weeks old although, she was six months old by the time of her appointment.

We also heard from two parents at Ormskirk and District General Hospital Children's Emergency Department (ED). One parent told us:

"I tried to book in to see my doctor this morning. I was told that I would have to wait ages so I came here as we always get seen quickly and we prefer it here. The staff are always good and there is more a personal touch coming here compared to [another hospital in the area]. This place is always nice and clean and we don't have to wait half as long."

Another parent said:

"I've brought her here a few times, whenever she has an accident. You get seen quicker here. We've never had any problems, everything runs smoothly."

We heard from a young person in care about their children in care nurse. They told us:

"I only see the LAC [Looked After Children] nurse once a year for my health assessment and I saw her recently for my health passport as I needed my last assessment as I'm nearly 18. She left me her contact details so that I can get in touch if I need to. I've never had them before."

We heard from a parent of a child in local authority care, but who was living at home with their birth family. They told us:

"My daughter has been seen by CAMHS [Child and Adolescent Mental Health Services] and they've been brilliant and dead supportive. They bared [persevered] with her because she didn't want to see them at first but now they have got through to her and she's starting to open up to them to talk about things."

"...they see her straight away because they know it's serious with her. I can call them and they will make space so that they can see her. She goes in to Alder Hey A&E and the staff have always been really good with her there too."

"Nurses in the LAC team have been good. When my daughter kept refusing her needles [immunisations] with the doctor I told the nurse at the LAC review and then they came out the next day to make sure she's up to date with everything."

We heard from a foster carer of children of different ages. They told us:

"Our older one, he doesn't see the point in his health reviews and says that if he wants to talk to someone it wouldn't be a stranger as he only sees the nurses once a year."

"One of our younger girls has them [health reviews] and always enjoys the attention and the time to talk about herself. The thing about the LAC nurses is that it is hard to get hold of them. There are a lot of numbers [contact details and information] but really the lists need updating."

“The health visitors are really good, she always comes out and sees our children when we take on a new foster child. We just give her a call and she comes straight out.”

“We have a good relationship with [the] Dr who is the community paediatrician for fostering. It’s quite easy to speak to them and we can talk to her openly.”

“If they [children in care] have been to the GP, then the [children in care] nurses don’t know about that and sometimes other professionals don’t know what’s going on either, so we have to update everyone which is frustrating.”

We also heard from a care leaver who told us:

“I wasn’t really offered anything as I was seen as a ‘straightforward case’ because my older sister was my carer.”

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 Expectant women attending Liverpool Women's Hospital and Ormskirk and District General Hospital for their maternity care benefit from effective risk assessment, including the assessment of social vulnerability. In all case records reviewed at both hospitals, where it had been possible to identify the father of the unborn child, this had been recorded on the maternity systems. The identification of additional vulnerabilities such as learning difficulties, physical or mental ill-health were also recorded at booking. This enables midwives and other clinicians providing care throughout pregnancy to be fully informed of identified risks as early as possible.

1.2 Despite risk assessment supporting the early identification of risks, records examined in Ormskirk and District General Hospital lacked analysis of the impact of risks such as parental mental ill-health or substance misuse on the unborn. This impedes effective, needs led care planning in order to reduce the risk of harm.

Recommendation 12.3

1.3 Midwives from Ormskirk and District General Hospital do not offer routine home visits to aid the assessment of the safety of the home environment before the baby is born. This limits the opportunity for the early identification of actual or potential risks that relate to the home environment and family circumstances, so they can be addressed prior to birth. ***Recommendation 2.1***

1.4 Effective information sharing processes are in place to safeguard children and young people who attend for emergency care across Sefton. Clinicians and safeguarding leads at Ormskirk and District General Hospital are attentive in ensuring that information is shared and safeguarding referrals are made to the appropriate neighbouring services as well as to services in Sefton. Children and young people from a number of areas are served by the ED, and effective information sharing means that they do not experience avoidable delays in accessing additional support. It also ensures that services are well informed of any emergency attendances.

1.5 Children, young people and families benefit from the early identification of safeguarding risks by the 0-19 public health nursing service provided by North West Boroughs Healthcare NHS Foundation Trust. The health visiting element of the service reports good performance on undertaking the five mandated contacts within the healthy child programme. The service managers acknowledge there is an area for development to increase the number of new birth visits completed within the revised national reporting timescales. This is being closely monitored through performance reporting to the trust board.

1.6 The school nursing element of the 0-19 service offers health reviews to children and young people during the reception year, year six and year nine, with plans in place to extend this to year 11. Practitioners also deliver sessions in schools on specific topics in response to requests by children, young people and staff, which include puberty and sexual health. This supports the early identification of need and the educational approach helps children and young people to recognise when they may be at risk.

1.7 Inspectors saw evidence of how skilled the specialist practitioners, from the newly launched enhanced element of the 0-19 service, are in adapting their approach. For example, enhanced school nurses work flexibly with parents who have mental ill-health or other vulnerabilities, to help them improve their parenting ability. It has not yet been possible to effectively evaluate the impact of the service due to the early stage of implementation.

1.8 The existing emotional health and well-being specialist role in the 0-19 service has been enhanced to better address and support those needs in school age children in Sefton. The specialist practitioner carries a small caseload of young people who require short-term intervention to support emotional well-being. A bespoke assessment tool helps to give a picture of the whole family, and the direct intervention involves one-to-one engagement with the child, with feedback and reflection with parents in an effective whole family approach.

1.9 The emotional health and well-being specialist has also developed a 'SATs Survival' programme incorporating a 'How to Manage Worries' programme for year six children, based on the Young Minds model of normalising worries rather than focus on anxiety. All school nurses are being trained to deliver the programme to be launched at the start of the next academic year. This will ensure that all year six children will access targeted prevention work to support their emotional wellbeing. This is a very positive development for Sefton where emotional health and well-being is a recognised local issue needing improved support. The pilot has evaluated well with children.

1.10 There is good liaison between CAMHS in Alder Hey Children's NHS Foundation Trust and the Emotional Health and Well-Being Service within the North West Boroughs Healthcare NHS Foundation Trust's enhanced 0-19 service. This close working relationship supports the ongoing care of children who do not meet the threshold to access CAMHS and reduces the risk of their needs escalating.

1.11 Young people in Sefton are able to access timely sexual health intervention, support and advice. This includes visitors to the area as there is an open access system in place. Young people under 18-years-old are prioritised.

1.12 Sexual health services within Southport and Ormskirk Hospitals NHS Trust provide a health promotion team who deliver training to a variety of multi-disciplinary and multi-agency professionals, as well as direct teaching to children and young people with special educational needs and/or disabilities who attend special schools, and those who attend the pupil referral unit. This increases awareness, knowledge and understanding to improve sexual health and well-being and helps to reduce unplanned pregnancies and sexually transmitted infections (STI).

1.13 Addaction are proactive in identifying, and responding to, the needs of the local population and incidence of substance misuse. For example, referral data has been used to identify schools where there is a prevalence of substance misuse among young people. This has led to the further development of a workshop based educational programme to examine risk taking behaviour, self-esteem and self-efficacy. The scheme is ready to launch at the start of the next academic year so could not be tested during the review.

1.14 A preventative programme known as 'Breaking the Cycle' has been developed by Addaction, the young person's substance misuse service, aimed at families with children affected by adult substance misuse. The programme is delivered at locations of the family's choice to facilitate stronger engagement. Documentation reviewed considered the risks and protective factors to the child, and described the child's lived experience. One case example examined, demonstrated that staff were supporting a young person effectively through early help processes. This work was considerate of risks and protective factors and the lived experience of the child. Appropriate child centred work regarding the child's lived experience was actioned to ensure the child's voice continued to be heard throughout their involvement and that their emotional needs were considered and met.

1.15 Ambition Sefton provides integrated adult substance misuse services to people aged 18 years and over living in Sefton. The service's access arrangements enable people to be seen in the clinic, a community setting, GP practices and sometimes in their own home. This flexible approach increases engagement with services, leads to better opportunities to identify risk to children and young people in the care of those adults and has a positive impact on parenting capacity.

1.16 Information sharing is under-developed in primary care. Most, but not all GP practices are reported to hold regular vulnerable families' meetings in line with recognised best safeguarding practice. Health practitioners including midwives, health visitors and school nurses attend these meetings when invited, facilitating information sharing and the early identification of vulnerabilities and opportunity for early help support. However, not all GP practices that hold such meetings are routinely inviting partners such as midwives, health visitors and school nurses. One practice reported that they were unclear on the current agreed method of communication with health visitors. This means that there are potential barriers to working together effectively to share risks and put support in place to safeguard children and work with families.

Recommendation 1.4

1.17 The arrangements in GP practices for identifying children in need of additional support or early help are variable. For example, one GP practice inspectors visited routinely sends out a birthday card to all 14-year-old patients advising them of the support available to them at the practice and further signposts them to other advice and support services. The birthday card invites the young person to make an appointment at the practice to discuss any issues of concern, such as their skin or their emotional wellbeing. This individualised, young person friendly approach helps increase awareness of primary care and other services in the community although at the time of the review, the uptake of appointments was reported to be low.

However, in another GP practice, recent training in thresholds has not had a demonstrable impact on the practice's ability to identify children who may need early help. During the visit, the practice could not identify any cases for review where a referral had been made by the practice to the multi-agency safeguarding hub (MASH) or Early Help Gateway for either preventative or protective services. This means that some children and families with additional needs may be overlooked.

Recommendation 1.2

2. Children in need

The consideration and assessment of risk; and level of professional curiosity and analysis in Sefton is too variable. Our findings below articulate the inconsistency across health services.

2.1 Pregnant women accessing maternity services from both Liverpool Women's Hospital and Ormskirk and District General Hospital, benefit from joint clinics run by specialist midwives and obstetricians when perinatal mental health concerns have been identified. Inspectors saw evidence that maternal mood is considered, individualised care plans are developed in conjunction with the woman which are flexible and woman centred, and where appropriate, result in a referral to Mersey Care NHS Foundation Trust's adult mental health service. This ensures that women receive early intervention and support to improve their mental health and well-being and increase their capacity to parent.

2.2 Maternity staff in Ormskirk and District General Hospital are expected to make a routine enquiry of domestic abuse only once during pregnancy. This approach limits further consideration of domestic abuse throughout the care episode. Case examples examined demonstrated that this single enquiry had been made, but there was no evidence of further proactive enquiries that could aid the tracking of changing risk to secure a robust safeguarding response. In one case reviewed where domestic abuse had been disclosed, the assessment made by the midwife was insufficient to determine risk. **Recommendation 2.2**

2.3 In Ambition Sefton the routine enquiry of domestic abuse was completed in all cases reviewed, as part of initial and ongoing risk assessment of adults that access the service. This supports the practitioner to explore the impact of domestic abuse on children and identify emerging or escalating risk.

2.4 When children and young people attend Ormskirk and District General Hospital's ED, clinicians routinely complete safeguarding triage questions in addition to a checklist to ensure due consideration of risks. Where risks were identified, inspectors saw evidence of appropriate referrals to children's social care.

The safeguarding questions in Alder Hey Children's Hospital's ED however, are not always fully completed to capture all necessary information, and the exploration of risk was not always evident. Case records seen in Alder Hey Children's Hospital's wards however, better demonstrated professional curiosity and the completion of safeguarding questions. **Recommendation 4.1**

2.5 Children and young people presenting at the ED at Alder Hey Children's Hospital and Ormskirk and District General Hospital with significant mental ill-health, benefit from good access to CAMHS assessment. The outcomes of assessments are shared with ward staff to support joint working and ongoing care planning.

In one case reviewed at Alder Hey Children's Hospital, the CAMHS worker identified heightened suicidal risk and shared a safety plan with parents and ward staff. The plan included the need for one to one care and for the ward staff to complete environmental checks for ligature points. This facilitates joint working not only between health disciplines, but also with families to help safeguard children and young people. It also ensures that needs are identified effectively in order to provide the most appropriate form of intervention.

Such consideration for environmental risks was not always demonstrated in records reviewed at Southport and Ormskirk NHS Trust. Records clearly documented that CAMHS made requests for ward staff to complete environmental assessments, yet in one case examined there was no evidence of ligature points being considered. This means that the safety of young people in mental health crisis could not be assured whilst on the ward. **Recommendation 8.1**

2.6 Children and young people with mental health concerns who access emergency care in Southport and Ormskirk NHS Trust, have access to a paediatric and CAMHS liaison practitioner. This practitioner facilitates appropriate sharing of information across health and social care services to ensure the best outcomes for the child. There is good monitoring of children and young people who attend requiring mental health support in addition to the oversight of referrals made.

2.7 The designated nurse for safeguarding children from South Sefton CCG and Southport and Formby CCG has carried out significant work around awareness raising and training on child sexual exploitation (CSE) for practitioners across Sefton's health services. Despite this, and with policies and guidance being in place, too many practitioners told inspectors they are unaware of CSE assessment tools; that they consider CSE to be a low risk in Sefton, and as a result the number of referrals in relation to CSE remain low. Not all assessment templates support staff to consider the risk. In the absence of embedded tools to aid assessment, greater reliance is placed on staff being professionally curious in order to identify those at risk from, or with a lived experience of CSE or female genital mutilation (FGM). **Recommendation 1.1**

2.8 Primary care staff lack professional curiosity in their enquires around domestic abuse, CSE and FGM. Nationally and locally recognised assessment tools and checklists are not being used to aid the early identification of child safeguarding risks. This leaves children and young people at risk of exploitation and emotional harm from exposure to domestic abuse. **Recommendation 1.3**

2.9 Practitioners within Southport and Formby District General Hospital ED make use of the Domestic Abuse, Stalking and Honour based violence (DASH) risk assessment form for people who are involved in suspected domestic abuse. However, there are no other supplementary risk assessments to assist in identifying other factors such as CSE or FGM. Furthermore, key safeguarding questions pertaining to children in the family, parental responsibility, mental capacity, social circumstances and alcohol use are frequently not completed. In some of the cases inspectors reviewed, there was exploration of these issues captured within the case notes but this important information was not recorded in a prominent place which would assist other practitioners in considering safeguarding factors at the earliest opportunity.

2.10 It was also identified that practitioners were more likely to capture details about children and the family composition when the patient was female. A number of male records showed little or no consideration about who they may be living with or children they may have frequent contact with despite presenting with risky behaviour. This practice does not support a 'Think Family' approach and does not provide assurance that risks to children are being considered and managed appropriately. **Recommendation 2.3**

2.11 Effective arrangements are in place at Southport and Formby District General Hospital to identify children and young people who may be at risk from adults who present at the emergency department. When clinicians in Southport and Formby District General Hospital identify children linked to patients presenting with risky behaviour, paediatric liaison forms are completed and shared appropriately. This ensures that practitioners in primary care and universal services are kept informed of parental behaviours and health needs that may have a negative impact on children.

2.12 The quality of assessments completed by practitioners in Addaction were variable with some lacking in professional curiosity. Assessments were not always completed in full and did not consistently reflect the changing needs and risks to children. In one case examined, a young person shared that they sometimes feel sad, but the template used to assess mental health in more detail was not completed. Risk assessments reviewed did not always reflect the changing risks to children and young people which limits their effectiveness. *This matter will be brought to the attention of the Public Health commissioners in Sefton Council.*

2.13 Good practice was demonstrated in Southport and Ormskirk NHS Trust's sexual health services with a detailed proforma for under 18-year-olds that incorporates child sexual and criminal exploitation, domestic abuse and safety. The template is reviewed on a regular basis and the most recent addition was the names of friends to be considered as contactable in the event of a missing episode. This enhanced screening helps to not only identify risk for that individual child but helps build a picture up of activity and potentially other children who may be at risk across Sefton.

2.14 Record keeping in Southport and Ormskirk NHS Trust's sexual health services is variable between disciplines. Records completed by nurses were done so in depth, in accordance with expected practice, and considered the impact of circumstances on the young person. A record documented by a doctor however, was seen to be incomplete and did not demonstrate professional curiosity or full consideration of risks. **Recommendation 12.2** *This matter will also be brought to the attention of the Public Health commissioners in Sefton Council.*

2.15 An additional prompt has been added to a proforma for adults accessing sexual health services, to aid the identification of FGM. This is intended to pick up those women who have been subject to historical FGM, but does not consider female children within the family who may be at risk. The risk of FGM has also not been extended to the under 18 pro-forma for young women who may be at risk. This is a missed opportunity to safeguard children and young women. **Recommendation 2.4** *This matter will be brought to the attention of the Public Health commissioners in Sefton Council.*

2.16 The receptionist in the sexual health service utilises her own professional curiosity and alerts the nurses when a service user needs to be seen quickly; for example, a young person attending with an older person who is not, or does not appear to be, a family member. This demonstrates a responsive service based on the prioritisation of need and was evident in records seen by inspectors.

2.17 Enhanced multi-agency arrangements are in place to meet the needs of a number of vulnerable families, including those with electively home educated children. The school nurses within the enhanced 0-19 service form part of the service and have an identified role in undertaking home visits, participating in early help, child in need and child protection arrangements. They also work closely with such children where they have identified health needs. This means that vulnerable children and young people can access an equitable school nursing service to meet their health needs.

2.18 Some children and young people who access CAMHS are not always having their safeguarding needs identified. The dedicated risk assessment template is not consistently completed to reflect known risks to children. Case records examined demonstrated that practitioners consider mental health risks that result in safety planning, but professional curiosity around possible CSE and broader safeguarding concerns is not embedded. This limits the opportunity to identify safeguarding risks sooner. In one case reviewed, actions taken by staff to safeguard a child were not highly visible in the child's health record. As a consequence, inspectors could not evaluate the quality of any intervention and whether risks to the child were articulated sufficiently to ensure the help needed was secured from children's social care. There was no evidence that this safeguarding risk was considered again by CAMHS staff in their ongoing work with the child and family. **Recommendation 4.2**

2.19 The consideration of 'Think Family' and hidden harm as a result of concerning parental behaviour is inconsistent in CAMHS. In one case reviewed, this resulted in delays in the identification that a family's circumstances met the threshold for a referral to children's social care. The psychiatrist considered that social care intervention may be required due to the child's living arrangements but there was no evidence that this was reviewed until a referral was made five months later when the mother could no longer cope. **Recommendation 15.4**

2.20 Mersey Care NHS Foundation Trust's adult mental health service, use a proforma at the initial assessment of an adults' mental health needs. The proforma prompts practitioners to ask about children in the care of service users. This is a mandatory field to ensure a 'Think Family' approach is incorporated into adult practice. In a case tracked by inspectors however, children's details were documented in the assessment completed by a psychiatrist, but consideration was not given to the potential impact of parental mental ill-health on the children's well-being. This lack of professional curiosity did not contribute to ensuring the children were effectively safeguarded.

Conversely, in a dip sampled case reviewed, there was very clear evidence of a 'Think Family' approach with a detailed plan for supporting the whole family's needs, rather than just the adult service user. Such variability indicates a lack of operational oversight and quality assurance which would strengthen the quality and consistency of practice. **Recommendation 15.4**

2.21 Children who are not brought to paediatric appointments at Ormskirk District General Hospital are subject to robust processes to ensure that their health needs are met. Inspectors saw evidence of close monitoring when a child missed more than one appointment, with processes in place to inform community health services and alert children's social care where necessary.

2.22 Oversight and follow up of clients who do not return to Ambition Sefton following initial assessment are not robust enough in their consideration of child safeguarding. In one case examined a pregnant woman sought help with her alcohol and drug use following her release from prison, and was invited to return for a comprehensive assessment. The initial assessment identified another child being cared for by a relative. This second appointment was not attended and there was no follow up, or efforts made to liaise with other health services. There was no evidence of consideration of risk, or the safeguarding of either the adult service user, the child, or the unborn. **Recommendation 6.1** *This matter will also be brought to the attention of the Public Health commissioners in Sefton Council.*

2.23 In Addaction, information sharing with other services is not well embedded. Whilst inspectors saw examples of liaison with children's social care and educational settings, this was not well established with health services. In one case, the young person was accessing CAMHS but there was no evidence of a collaborative approach to supporting improved mental health outcomes of the young person. Young people accessing Addaction would benefit from improved information sharing agreements between Addaction and other services. *This matter will be brought to the attention of the Public Health commissioners in Sefton Council.*

2.24 The most vulnerable people in Sefton, including children and young people, benefit from a sexual health outreach service to improve accessibility for those who otherwise may not access services. The outreach team work flexibly to meet the needs of the individual. For example, the team offer 'clinic-in-a-box' contacts at a variety of community locations to responsively meet the needs of service users. This ensures that vulnerable young people who find it the most difficult to engage, can receive timely intervention, support and advice in order to meet their sexual health needs.

2.25 Whilst young people are able to access any sexual health clinic in Sefton, there are also sessions available specifically for young people in some areas. This improves choice for some young people who may feel less confident and uncomfortable accessing a service with mainly adults. However, this is currently an inequitable service as it is not yet available in all localities.

2.26 Inspectors were told that there is a significant gap in service provision for adults with attention deficit hyperactivity disorder (ADHD). The service for Sefton borough is provided by one consultant psychiatrist and there is a lengthy wait to access an initial appointment. This means that parents with unstable ADHD do not have their conditioned effectively managed often leaving their needs unmet. **Recommendation 1.7**

2.27 Young people are not routinely benefitting from timely transition into adult mental health services. Good practice expects the transition process to begin 6-12 months before a young person's 18th birthday, but adult mental health practitioners report that transition begins much later in too many cases. This limits the opportunity for the young person and their family to be prepared for the differences in adult services, and delays appropriate support being put in place. CQUIN quarterly reporting confirms that young people benefit from a smooth transition process into adult mental health services, but further work is needed to improve and effectively monitor the timeliness of transition. It is encouraging that in order to improve transition for these vulnerable young people, a dedicated post has been developed to work with both the child and adult mental health services on a case by case basis. In one case reviewed, the practitioner proactively and sensitively planned the transfer of a young person to adult services and primary care in advance, so the needs of the young person could continue to be met. **Recommendation 9.1**

2.28 Adult mental health practitioners from Mersey Care NHS Foundation Trust routinely contribute to the child in need process through multi-agency liaison and attendance at child in need meetings. This was evident in a case where the family were subject to a child in need plan, through detailed documentation of the meeting by the practitioner. However, the child in need plan was not attached to the record and it was not possible to see how the practitioner was contributing to the effectiveness of the plan to safeguard the child.

2.29 Ambition Sefton's service users who receive take-home opiate substitution therapy to manage their substance misuse, are supplied with free lockable storage cabinets. Staff are expected to complete a home visit where there are children under the age of five years, and liaise with the health visitor. Whilst we saw this evidenced in one case seen, this was not seen in another example. No audit has been completed to provide managers with assurance that this expected practice is fully embedded and safeguards children effectively. It is also unclear why this robust approach is not extended to where there are school aged children or vulnerable adults in the household. *This matter will be brought to the attention of the Public Health commissioners in Sefton Council.*

Case Example

A maternity case at Ormskirk District General hospital highlighted a period of missed appointments that demonstrated weak ongoing oversight of identified vulnerabilities that contributed to delay and drift. Information sharing between the maternity service and the GP regarding safeguarding concerns to support joint working was found to be weak.

A woman was assessed and booked when she was 10 weeks pregnant and social issues were identified that resulted in a discussion with the social worker. This alerted the midwife to maternal mental health concerns, the fact that other children were placed in the care of other adults, and that the social worker had a lot of concerns. The entry lacked analysis of the social concerns and the impact on the unborn and as a result what ongoing maternity care and planning was required.

Liaison with the named midwife three days later and subsequent referral to children's social care, did not articulate or analyse the risk to the unborn and was largely descriptive in content. This impeded the effective identification of safeguarding concerns and the action maternity staff required of children's social care to aid a timely and effective response.

Records demonstrated a lack of professional curiosity and following two missed clinic appointments, the need for a home visit was identified but there was no evidence that the home visit took place.

The next entry related to a national alert reporting the woman had fled the country but analysis and action planning was lacking. Maternity staff at Ormskirk District General hospital appropriately resumed care three months later to support a possible home birth and became actively involved in multi-agency working to safeguard the unborn until delivery and the baby was placed into the care of the local authority.

3. Child protection

3.1 A team of enhanced specialist midwives from the Liverpool Women's Hospital hold a caseload of women where there are safeguarding concerns and effectively manage their care whilst protecting the unborn child. Although the patient record IT system is sometimes difficult to navigate and is not intuitive, this is recognised by the safeguarding team who have introduced systems and process to ensure the safe management of vulnerable women.

3.2 We saw evidence of clear planning to protect the unborn child, with a system of purple envelopes being available to midwives working on the Liverpool Women's Hospital delivery suite which contained all the necessary information relating to vulnerable women, including birth plans and plans for safe discharge. Effective systems are in place to ensure that referrals to children's social care are routinely followed up. However, the incorrect perception in Liverpool Women's Hospital's maternity service is that Sefton Local Authority will not progress safeguarding referrals before 20 weeks gestation, despite the LSCB website clearly stating that delays in referral should be avoided. **Recommendation 3.1**

3.3 Unborn and newborn babies are safeguarded through the sharing and recording of important information pertaining to risk, by all maternity units in the Mersey region. Tracking systems and information sharing forms to ensure that women who are mobile across Merseyside and who may present at any of the areas' maternity units are shared with neighbouring hospitals.

3.4 In order to protect the newly born infant from being taken from the Liverpool Women's Hospital; effective, regular abduction drills take place so that staff are aware of what to do if a baby is abducted. It is a feature of the building that the whole area can be locked down to prevent a baby being taken from the premises.

3.5 There are robust safeguarding arrangements in place for women who book late or arrive at Liverpool Women's Hospital in labour to ensure that checks are undertaken with the woman's home local authority children's social care teams. The Associate Director of Nursing for Safeguarding, who is also the named midwife, is working closely with Merseyside police on a project to identify expectant women who are unknown to local services and have come from abroad, to identify possible CSE and trafficking. This has resulted in a small increase in referrals to children's social care and has been evaluated well.

3.6 The children's safeguarding teams at Liverpool Women's NHS Foundation Trust and Southport and Ormskirk NHS Trust attend local safeguarding children board (LSCB) sub-groups, multi-agency risk assessment conferences (MARAC) in relation to domestic violence and abuse, and Prevent meetings which work to identify and reduce the risk of individuals becoming involved with, or supporting terrorist activity. One safeguarding practitioner at Liverpool Women's Hospital has a joint role as an independent domestic abuse advocate (IDVA) to support women who experience, or are at risk of domestic violence and abuse. This supports a strong multi-agency approach to safeguarding children.

3.7 In the absence of a clear understanding of the LSCB agreed pre-birth assessment protocol, the named midwife at Southport and Ormskirk NHS Trust proactively facilitates the creation of a birth plan to safeguard the newborn infant. The template is shared with the social worker so they can complete the plan and specify what actions to take when the baby is born. Inspectors saw examples of these templates completed in records to support the ongoing care of women when they present in labour and postnatally. The CCGs acknowledge that further work is needed to increase understanding of the existing multi-agency processes in place regarding pre-birth assessment. **Recommendation 3.1**

3.8 Attendance at child protection conferences by health practitioners across Sefton is good. Midwives from Liverpool Women's Hospital and Ormskirk and District General Hospital, and health visitors, school nurses and specialist nurses from North West Boroughs Healthcare NHS Trust 0-19 service, routinely attend child protection conferences, core groups and contribute to child protection arrangements. Practitioners from Mersey Care NHS Foundation Trust's adult services attend where possible when the parent is an open case to the service. CAMHS staff reported that they have had difficulty attending some child protection meetings due to competing priorities.

3.9 Reports are submitted on a template in line with agreed local expectations and inspectors saw this practice evidenced in cases examined with the exception of CAMHS staff who were unable to identify any reports for inspectors to review. Practitioners take their own notes at child protection conferences which are promptly converted into a post-conference report setting out attendees, key risk factors identified and discussed, outcomes and decisions and practitioner actions to be taken. This is good practice and cases reviewed evidenced that the practice is routine and embedded.

3.10 Inspectors did not however, see minutes of child protection conferences or child protection plans routinely secured in health records across services. While children's social care has an obligation to ensure these are sent out promptly to relevant partners, it is the responsibility of health practitioners to be proactive in ensuring they receive minutes and secure them as part of the child's case record in order to inform day to day practice. Managers in frontline services recognised a level of passivity in not pursuing minutes and plans from social services and acknowledged this area for improvement. **Recommendation 12.1**

3.11 In GP practices, inspectors saw evidence that GPs make appropriate referrals to children's social care. Although not routinely asked to contribute to the child protection process from MASH enquiries through to child protection proceedings, when asked to do so inspectors saw evidence that information submitted was not always timely, the format of the templates used does not prompt the GP to articulate risk or consider the voice of the child and are often limited to a list of contact dates and 'no concerns' documented. Furthermore, the outcomes of referrals are not routinely shared by children's social care, nor are they followed up by primary care staff. This episodic approach does not support effective multi-agency decision making and is a missed opportunity to use important health information to complete the risk assessment and care planning of vulnerable children. **Recommendation 1.5**

3.12 GPs are not well sighted on risk and vulnerability factors such as domestic violence and abuse, which have been reported to the police. GP practices reported that they are not notified of MARAC, multi-agency public protection arrangements (MAPPA) or any lower level domestic violence incidents. This means that primary care are not alerted to the fact there may be risk factors within families which may need additional intervention or monitoring. **Recommendation 1.4**

3.13 Mersey Care NHS Foundation Trust are represented at MARAC and MAPPA and contribute information to aid consideration of risks and multi-agency decision making. Information is shared into these meetings and then any actions for Ambition Sefton and the adult substance misuse service are shared with frontline staff which can then go on to inform their interactions with service users.

3.14 Practitioners in Southport and Formby Hospital's ED complete referrals to children's social care where a safeguarding concern has been identified, although the quality of such referrals require strengthening. The referrals contained a good level of detail regarding the presenting risk factors of the adult. However, more could be done to consider and articulate the risk to the child or young person. This was particularly evident in referrals for children with exposure to one or more of the toxic trio of domestic violence and abuse, substance misuse and mental ill-health, where the adult's ability to parent the child may have been compromised. **Recommendation 12.3**

3.15 In reviewing one referral made to children's social care by the Addaction young people's substance misuse service, inspectors saw that there can be delays in making referrals to children's social care where safeguarding concerns were identified. The referral was delayed by five days from the point the practitioner identified risk, which obstructed timely access to services. Furthermore, the practitioner was not informed of the outcome of this referral until the young person reported she had seen a social worker. There is no evidence that the practitioner proactively followed this up before discharging the young person. *This matter will be brought to the attention of the Public Health commissioners in Sefton Council.*

3.16 The family team in Ambition Sefton provide care to adults and children who have complex vulnerabilities and where there are child protection concerns. Cases examined demonstrated proactive oversight, effective identification of changing risks and good multi-agency working to safeguard children. Inspectors could also see practitioners' attendance at child protection conferences, core groups and strategy discussions as well as involvement with looked after children's planning and review of care. This ensures that risks to children as a result of concerning adult behaviours inform decision making and planning to keep children safe.

3.17 Single Point of Contact (SPOC) nurses within the sexual health service attend the monthly multi-agency child exploitation (MACE) meetings. This demonstrates a multi-agency commitment to safeguarding the needs of young people at risk of exploitation.

3.18 Conversely, sexual health nurses are not routinely invited to contribute to child protection assessments or attend child protection conferences, do not receive copies of child protection plans, and often are not informed when young people are subject to a child protection plan. This is a missed opportunity for a service who may hold relevant safeguarding information to contribute to joint working or receive information that may be relevant to inform practice. *This matter will be brought to the attention of the Public Health commissioners in Sefton Council.*

Case example

A 16-year old female was taken by ambulance to Southport and Ormskirk NHS Trust ED due to recently diagnosed, unmanaged health issues. She did not speak much English however, practitioners were alerted to the fact she had been presented at MARAC six months previously regarding concerns about honour based violence from her brothers who were in a neighbouring area.

The ED practitioners contacted the trust safeguarding team for additional support. It was established that the case had recently been stepped down from child in need but the trust safeguarding team advocated for her needs and re-referred to children's social care.

The hospital also recognised her deteriorating presentation as her condition was not being managed effectively and linked her in with the specialist paediatric nurse, as opposed to the adult team, to ensure that her needs were met.

4. Looked after children

4.1 Children and young people entering the care system in Sefton may experience delays in having their health needs assessed promptly. Performance on the completion of initial health assessments (IHA) within expected timescales has been, and continues to be challenging with many contributory factors. These include slow notifications from children's social care on occasion, a two-step process to arrange the IHA, and high numbers of children not brought to appointments, resulting in IHAs having to be rescheduled, sometimes several times. **Recommendation 1.6**

4.2 Alder Hey Children's NHS Foundation Trust looked after children's (LAC) service closely monitors the expected completion of typed IHAs within three days of the child's clinic assessment, yet these are not always included on case records held by health partners, including children in care nurses in North West Boroughs Healthcare NHS Foundation Trust, in a timely manner. This means that the children in care nurses may not be aware of identified health needs of children and young people on their caseload in a timely manner.

4.3 At Alder Hey Children's Hospital, inspectors saw that IHAs are undertaken by appropriately qualified community paediatricians, with the support of the Alder Hey specialist LAC nurse. These clinicians also formulate the initial health plan for the child. The quality assurance of IHAs is undertaken retrospectively within a month by the specialist LAC nurse in Alder Hey with the additional quality assurance of a random selection by the designated doctor for looked after children. This ensures that those IHAs are of the required quality and contain appropriate information to provide care and support to the child or young person.

4.4 The database used to capture data on children in care in the North West Boroughs Healthcare NHS Foundation Trust 0-19 public health nursing service, includes the date the young person came into care. This information is then utilised to plan the timing of the completion of the IHA. However, it does not currently include the number of review health assessments (RHA) or episodes of care there have been for children in care placed from other local authority areas. Neither is it currently possible for the service to identify different groups of children in care such as unaccompanied asylum-seeking children (UASC). This restricts the opportunity for the service and the commissioners to track and monitor population changes or use information effectively to inform service development and training needs. **Recommendation 5.3**

4.5 The recent introduction of quality assurance of health assessments by North West Boroughs Healthcare NHS Foundation Trust 0-19 team managers is positive. Quality assurance for all health assessments would ensure a clear managerial oversight of frontline practice across the service. There were some examples of good practice in relation to health assessments and health plans in the cases chosen by the children in care practitioners to be reviewed by inspectors. However, cases randomly dip sampled by inspectors demonstrated a variation in quality in both initial and review health assessments. Some health plans were task focused, generic and not child-centred. They were often not specific, measurable, achievable, realistic and time limited (SMART), and in some cases, did not adequately meet the needs of the child as identified in the assessment. Furthermore, it was not clear from the children's case records what, if any, quality assurance process had been applied. **Recommendation 5.2**

4.6 Although the number of unaccompanied asylum-seeking children in Sefton is low compared to national averages, the quality of assessments reviewed for those children was variable and it was not clear that all clinicians are fully cognisant of the asylum-seeking experience and the impact of the young person's journey into the UK on their emotional health and wellbeing. One case record examined demonstrated the clinician having some understanding of the potential future mental health needs of the young person and a referral was made for counselling, but an assessment completed by a locum clinician did not demonstrate the same level of consideration. The use of locums at Alder Hey for Initial Health Assessments is reportedly rare, however it is essential that all clinicians undertake the specific training relating to asylum seeking young people offered by the trust and that understanding of the lived experience of the child is demonstrated consistently in assessments. **Recommendation 10.1**

4.7 The quality assurance template used for initial health assessments in Alder Hey Children's NHS Foundation Trust includes the consideration of strengths and difficulties questionnaires (SDQ) as part of initial assessments undertaken if a child has been in care for three months. Inspectors were told that children's social care undertake the SDQs and that the results are not routinely shared with health partners and are not used to inform relevant initial assessments or subsequent routine health reviews. This had previously been identified as an area for development in the 2016 special educational needs and/or disabilities (SEND) inspection and continues to be an outstanding action. **Recommendation 10.2**

4.8 In some IHAs sampled by inspectors, there was little or no information from children's social care on the family or parental health history, or the reasons for the child coming into care; this is an area for development for health and social care partners working with children in care. Where this important information is captured at the point the child or young person enters the care system, it is not clear that this information is fully utilised to inform the care leavers final health review and development of their health passport. Young people frequently state that this information is important to them as they enter adulthood, to enable them to manage their own health needs. **Recommendation 10.6**

4.9 Statutory health assessments do not routinely benefit from information held within Primary Care. Despite the staff in North West Boroughs Healthcare NHS Foundation Trust and GPs using the same electronic patient record system, electronic access restrictions in place prevent the children in care health team from using valuable information to inform their assessment and planning of children in care. **Recommendation 1.4**

4.10 The North West Boroughs Healthcare NHS Foundation Trust children in care' nurses do not have access to the information held in the initial health assessments in a timely manner. Due to a fragmented process, with system challenges impacting on effective and timely information sharing, it was evident in records reviewed that there are delays in completed assessments being uploaded to the children in care electronic patient record system. This means that practitioners actively supporting this group of vulnerable children and young people may not be aware of important information obtained during medical examinations undertaken by Alder Hey Children's NHS Foundation Trust looked after children's colleagues. **Recommendation 5.3**

4.11 North West Boroughs Healthcare NHS Foundation Trust children in care team are not always informed when children have been placed for adoption despite Alder Hey Children's NHS Foundation Trust looked after children's colleagues completing the required adoption medical. There is currently no system in place to ensure the inclusion of the children in care health team in the process. This is an area for development for both trusts. **Recommendation 10.3**

4.12 The allocation of children in care aged under five years to a named health visitor facilitates effective follow-up to identify, monitor and address health needs and further helps the child to develop trust and rapport with the practitioner.

4.13 The children in care nurse in North West Boroughs Healthcare NHS Foundation Trust has been diligent in ensuring that unaccompanied asylum-seeking children are allocated an NHS Number, and access primary care services such as GP, immunisations and dental care.

4.14 Sexual health nurses are not routinely informed of children who are in care, therefore they do not contribute to statutory health assessments. Whilst it is not appropriate to share sexual health information arbitrarily, this lack of information sharing increases the risk for some young people who may require additional intervention or support to keep them safe in terms of their sexual health. This matter will be brought to the attention of the Public Health commissioners within Sefton Council.

4.15 There is no dedicated CAMHS offer to children in care. However, the local authority reportedly provides a therapeutic service for children in care but this could not be tested at the time of the review. Case records of children in care accessing CAMHS demonstrated good liaison with social workers, but there was no evidence that the North West Boroughs Healthcare NHS Foundation Trust children in care nurses are well sighted on this work to help inform the annual review health assessment. **Recommendation 10.5**

Management

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

5.1 Leadership and management

5.1.1 NHS South Sefton CCG and NHS Southport and Formby CCG share a senior leadership team who work well together to provide assurance on the improvement of the quality of safeguarding practice across Sefton. Accountability frameworks, the joint quality meeting and the audit committee are effective in ensuring that local providers are meeting their contractual requirements and in improving compliance with safeguarding practice. The CCGs carry out 'walk-about' across all providers, which provides opportunities to speak to children, young people and families as well as front line practitioners.

However, in some areas of key activity such as compliance to level three safeguarding training, the reliance on the provider's reporting is overly optimistic and lacks challenge for demonstrable impact. **Recommendation 1.8**

5.1.2 Multi-agency working is strong at a senior leadership level. Good cross sector senior leadership representation at the LSCB helps to ensure that the local area work collaboratively to address any inter agency concerns. The fact that the chief nurse and the designated nurse for children in care attend the corporate parenting board to ensure that the health needs of children in care are a priority is an example of good multi-agency links. A further feature of the integrated working across the local area is the cross representation of agencies involved in local commissioning decisions.

5.1.3 NHS South Sefton CCG and NHS Southport and Formby CCG are making limited progress in the implementation of their local transformation plan for emotional health and wellbeing. Inspectors saw evidence of recent initiatives to reach out and work with children, young people and families who require additional support. The CCGs recognise that additional investment is needed to address the increase in waiting times for children and young people to access the local CAMHS services. Plans are at an early stage to move the CAMHS service from the established choice and partnership approach (CAPA) to the 'Thrive' model and there is evidence of early commissioning to reflect this. **Recommendation 1.9**

Although the area's local transformation plan identifies vulnerable groups that should be the focus of the plan, such as children in care, children placed out of the local area and children suffering from exploitation, there is little evidence at operational level of any significant impact. **Recommendation 1.9**

5.1.4 It is a more positive story for those children with a diagnosed eating disorder where good progress has been made and are able to access urgent appointments quickly. Furthermore, the perinatal mental health pilot project being driven by NHS England is well regarded by midwives working out of the Liverpool Women's Hospital and inspectors saw good examples of a proactive and personalised approach to supporting women. To support this at a more local level, Sefton's CCGs are exploring how to support perinatal mental health within communities through their children's centres.

5.1.5 The voice of children and young people in Sefton is inconsistently captured. The most recent public health annual report has had a focus on children and young people's mental health services and is supported by a video of young people talking about their experiences of mental health and in accessing local support. It is a powerful video that the young people should be proud of. Furthermore, young people regularly take part in the recruitment process for key posts, such as the newly appointed designated nurse for children in care, yet the lived experience of children and young people is not always reliably captured in health records examined. **Recommendation 12.2**

5.1.6 SSSCCG and SFCCG are responsive to external reviews and recommendations to improve the experience of vulnerable children and young people. The designated safeguarding team including the designated nurse for children in care are now directly employed by the CCG and have a significant challenge ahead. Although this is a very recent development, it has already shown benefits to local information sharing and improved relationships across the local area.

5.1.7 SSSCCG and SFCCG recognise the importance of a continuity in approach over the coming months following a series of serious case reviews. Arrangements to support a newly appointed designated doctor for safeguarding are considered and robust to ensure a consistent approach in the way that the role will be developed in practice.

5.1.8 Inspectors were told that the Child Death Overview Panel (CDOP) process which is Merseyside-wide, has been leading on safe sleeping and set compliance targets for local providers. Practitioners inspectors spoke with articulated an awareness on the initiative and its use in practice.

5.1.9 SSCCG and SFCCG are working closely with North West Boroughs Healthcare NHS Foundation Trust on improving the health offer to children in care. An improvement plan is in place and progress is closely monitored through the LSCB, corporate parenting board and the CCG commissioning process. The planned new children in care health service model has been developed as a result of a recent review and will significantly increase capacity in the children in care nursing team, this has yet to be implemented so has not been tested during this review. The new model is intended to strengthen leadership, oversight and governance arrangements as well as facilitate and drive the development of cohesive multi-agency arrangements in a service for children in care that is currently fragmented.

5.1.10 A whole systems approach across the multi-agency partnership working has not yet been developed and there is a lack of an operationally focused, multi-agency children in care health group in place. Such a group would drive and oversee operational improvements particularly if it comprised of the four partner agencies: Sefton Council, SSCCG and SFCCG, North West Boroughs NHS Foundation Trust and Alder Hey Children's NHS Foundation Trust. **Recommendation 11.1**

5.1.11 SSCCG and SFCCG have maintained an effective oversight of Southport and Ormskirk NHS Trust's child safeguarding activity through contract monitoring. The CCGs imposed contract requirements on Southport and Ormskirk NHS Trust to improve child safeguarding performance. This resulted in the named midwife developing additional training to maternity staff to support improvement. This has increased the attendance of maternity staff to initial child protection conferences which aids multi-agency decision making and has improved the quality of referrals made to children's social care.

5.1.12 Southport and Ormskirk NHS Trust have increased capacity within the safeguarding children team through the recruitment of specialist safeguarding nurses to support named professionals in improving trust access to safeguarding specialist expertise and training. The team are further strengthened by a network of safeguarding link practitioners. This has enabled a more proactive approach to safeguarding across the trust to ensure that practitioners are supported when faced with safeguarding concerns.

5.1.13 Leaders and managers in CAMHS do not have effective oversight of the safeguarding practice of their frontline staff. Monitoring and audit of safeguarding practice is under developed. This prevents the identification of good practice so it can be sustained, and weak practice that requires improvement. As a consequence, we could not review any reports written for child protection conference or identify minutes from multi-agency safeguarding meetings or plans. Furthermore, there are no CAMHS practitioners with an enhanced child safeguarding role such as a safeguarding champion. This hinders opportunity to link more with the trust safeguarding team and provide an accessible resource for frontline staff. **Recommendation 4.2**

5.1.14 Children with mental health difficulties can experience long waiting times to access CAMHS, with the longest wait recently being 52 weeks for a partnership appointment. This wait was reportedly as a result of an administration error and inspectors were advised an incident had been logged. The average waiting time from referral to treatment at the point of the inspection was 22 weeks. Both CAMHS and the CCGs are working to improve children's access by recruiting four additional staff and through more flexible service delivery. This is being monitored by the trust and is also on their risk register. In one case examined, inspectors saw that a child had been on an internal waiting list for six months and was only seen when escalated to an urgent partnership appointment. This then resulted in an assessment and safety plan being developed. In this particular case, whilst there was some interim oversight by the eating disorders team, this was having little impact around this child and family's presenting needs. **Recommendation 1.9**

5.1.15 Safeguarding children in primary care is under-developed and the local area face significant challenges in embedding good local understanding of what the responsibilities of primary care are, and in introducing consistency of practice across Sefton. There is an under-developed relationship between the named GP and the North West Boroughs Healthcare NHS Foundation Trust 0-19 service leaders, which could facilitate the forging of effective working relationships under the new 0-19 service model. Senior operational managers in North West Boroughs Healthcare NHS Foundation Trust acknowledge that there is scope to strengthen connectivity with the named GP. **Recommendation 1.3 and 1.4**

5.1.16 North West Boroughs Healthcare NHS Foundation Trust school nurses are making progress in their public health function by developing individual school health profiles. Through the pilot phase, profiles have been developed in more than 70% of Sefton's schools. The full roll-out of the model is planned from the start of the next academic year and the service is confident that all schools will have a health profile within the next 12 months. Emerging themes are being used to tailor school nurse support to individual schools to meet the priorities as identified by pupils, but also to inform wider service development. Most notably, this includes the significant work being led by the emotional health and well-being specialist 0-19 practitioner on strengthening the provision of emotional health support to school age children across Sefton and the wider North West Boroughs Healthcare NHS Foundation Trust footprint.

5.1.17 In recognition of the fact that more young people in Sefton self-harm compared with the rate in England during the period 2016 to 2017, North West Boroughs Healthcare NHS Foundation Trust is implementing a range of actions to increase the level of frontline awareness and skills in supporting emotional health from an acknowledged low baseline. The vision for the 0-19 service is clear, with an improvement plan in place.

5.1.18 There is a need in North West Boroughs Healthcare NHS Foundation Trust to ensure that all team managers in the 0-19 service, through appropriate training and supervision, are well equipped to support the change of service model. The development of governance and service delivery at the frontline, particularly in relation to the introduction of clinical supervision, oversight and monitoring of practice, along with an increased focus on supporting the emotional health and well-being of children and young people, are essential to drive improvements in this area. The interim head of 0-19 service has a good understanding of how the service is performing and where areas for development but has more to do to ensure improvement. **Recommendation 5.4**

5.2 Governance

5.2.1 Good progress has been made in implementing the Child Protection Information System (CPIS) across Sefton with all urgent care providers now operational. Social workers in the Multi Agency Safeguarding Hub MASH proactively monitor health practitioners' access to the system to identify any involvement with a child which has not been brought to the attention of a social worker. Appropriate use is also made of the CPIS system when women arrive unbooked at Liverpool Women's Hospital in labour. This has also resulted in referrals to children's social care with plans being put in place to protect the unborn child.

Practitioners in the ED at Southport and Formby Hospital however, do not routinely check CPIS as it has been recently implemented and is not yet embedded in practice.

5.2.2 Inspectors reviewed two referral forms for children and young people that had been referred to children's social care by Alder Hey Children's Hospital ED staff due to safeguarding concerns. The forms were completed fully and contained all the required information. The safeguarding team followed up the outcomes and feedback was received from the children's social care after referral. However, inspectors saw that a system in place to record and monitor safeguarding referrals was not kept up to date and the time of the inspection. This means that the safeguarding team cannot be assured that they are fully informed of all referrals or have oversight of the outcomes. **Recommendation 4.5**

5.2.3 People accessing Southport and Ormskirk NHS Trust adult ED in mental health distress have improved access to the mental health crisis team. The team are available 24 hours per day, seven days per week and screen all referrals on both adult and child mental health electronic patient record systems and further complete risk assessments for those who are acutely unwell. ED staff do not have access to the completed assessments, but mental health practitioners give a verbal handover in addition to writing a summary in the patient's notes. At present there are no assurance measures in place about the quality of the information written into the patients notes and the trust safeguarding team and mental health crisis team recognise that this is an area which could be improved to ensure valuable information is not lost between the services. **Recommendation 14.1**

5.2.4 MASH arrangements in Sefton work well. A dedicated health professional is an integrated member of the team and arrangements are in place to ensure cover is provided to the MASH for planned and unplanned leave. Processes that are in place to obtain health information which then contributes to robust decision making and action planning are good with most health services, although professionals report that feedback from the MASH processes are inconsistent.

5.2.5 The Southport and Ormskirk NHS Trust safeguarding team are diligent in responding to all requests from MASH. Referrals are checked and if a child is known then checks are undertaken by a safeguarding nurse and responded to appropriately. This ensures that multiagency decision making is informed by relevant health information.

5.2.6 Cases referred to the MASH are graded red, amber, green and blue, which reflect the level of risk and timeliness that partner agencies are required to respond back to the MASH. This was reported by multi-agency professionals in the MASH to work well. However, inspectors saw in case records examined that CAMHS do not routinely respond to requests graded green. This is because the process in CAMHS for sharing information to the MASH is not robust and is in effect an administrative task. Whilst two examples reviewed demonstrated a timely response by CAMHS, the information shared was of little value to inform effective multi-agency decision making for children potentially at their most vulnerable. Managers took swift action to improve the robustness of CAMHS' responses to the MASH, but this is in the early stages of development.

5.2.7 At the time of the review there was no established clinical, managerial or safeguarding team oversight of this arrangement to monitor its effectiveness. In one case, this lack of oversight was significant as there were ongoing concerns about the child's mental health. This was acknowledged by leaders as an area for development.

Recommendation 4.3

5.2.8 Information sharing and joint working is inconsistent across the Sefton local area. Liaison between GPs and health visitors was evident in records, but staff could not demonstrate similar liaison with school nurses. Inspectors saw evidence that family workers within Ambition Sefton liaised with schools to support joint working but school nurses are not well sighted unless they are part of the child in need or child protection processes. The North West Boroughs Healthcare NHS Foundation Trust 0-19 service use the same electronic case recording system as the GP practices in Sefton, facilitating the sharing of information about vulnerable children and families, however, it does not work effectively. This limits the opportunity for health practitioners working with children, young people and families to access all relevant information in order to plan care and intervention effectively. ***Recommendation 1.4***

5.2.9 GPs do not always share information effectively when children and young people in Sefton are at their most vulnerable, as they are brought to the attention of the MASH. Information is not routinely shared with the MASH, unless it is part of Section 47 enquiries. For some other children, this means that the MASH practitioners must make decisions about assessments and planning without valuable and pertinent information held in primary care, which could hinder effective safeguarding practice.

Recommendation 1.4

5.2.10 The quality assurance arrangements of health referrals to the MASH and children's social care are inconsistent, which impedes the assurance that referrals are of good quality to secure the help and intervention that children and families need. Case examples inspectors saw across health services demonstrated that practice is too variable. Some referrals were delayed, failed to capture the voice of the child, did not always clearly articulate the risk of harm to the child or lacked clear analysis and evaluation of risk. Other referrals however, were of good quality with an analysis of risk and reference to the impact on the child which is positive. Arrangements in provider services to oversee referrals made by frontline staff would benefit from further development. **Recommendation 15.1**

5.2.11 Southport and Ormskirk NHS Foundation Trust have appropriate governance arrangements in place, with clear lines of accountability from the safeguarding steering group through to the trust board. They have very recently merged the children and adult steering group to improve attendance and to further develop a 'Think Family' approach across the organisation. The Safeguarding Assurance Group is chaired by the Head of Safeguarding and is attended by commissioners, including representation from Sefton. The Safeguarding Assurance Group formally reports to the Quality Group which is a formal sub-committee of the trust board.

5.2.12 Southport and Ormskirk NHS Trust have a maternity standard operating procedure to aid the follow up of non-attendance at appointments and no access visits in the antenatal and postnatal period. Compliance with this guidance was not evident in one case tracked at Ormskirk District General Hospital which resulted in poor ongoing oversight of known safeguarding risks. In the absence of ongoing monitoring or audit of compliance with this guidance, assurance that this expected practice is embedded and safeguards those in their care is limited. **Recommendation 2.5**

5.2.13 When a child attached to a GP practice has been discussed at the MASH or child protection conferences, the outcomes are not routinely conveyed back to primary care. This is a missed opportunity to ensure that the primary record holder has a complete and informed picture of a child's needs and support in place. It was also often unclear on GP records examined as to the legal status of a child or whether the child was in receipt of any statutory intervention. **Recommendation 1.5**

5.2.14 Records management is a challenge for health staff across all providers in Sefton, often due to different systems used to store records and information. There is a significant risk however, around fragmented record keeping arrangements in Southport and Ormskirk Hospitals NHS Trust.

For example, the enhanced midwife works with the most vulnerable pregnant women and families, but uses a different record keeping system that is stored off site. Similarly, the sexual health nurses working with the most vulnerable young people use a paper based recording system stored separately. Furthermore, the quality of completed documentation is too variable. There is a significant gap in the consistency of record keeping quality, particularly for the most vulnerable families.

Leaders are aware of challenges with these systems and IT improvements are expected, but evidence of robust plans to mitigate risk from split records in the interim have not been effectively demonstrated. Leaders are also aware of weaknesses in record-keeping in some areas and have prioritised training, but at the time of the review it was noted that this has not been timely enough. **Recommendation 15.2**

5.2.15 The use of alerts on electronic records is too variable. In some services such as sexual health, they are used well to, for example, 'alert SPOC of attendance'. Alerts are also well used in CAMHS and health visiting, yet the use of alerts in all EDs visited, and Mersey Care Foundation Trust's adult services is inconsistent. The existing coding and alert arrangements seen on GP electronic patient recording systems do not provide staff with accurate, up to date and highly visible information about vulnerable children registered at the practice. Whilst some efforts are being made to address this, the progress is too slow. When used well, the presence of an accurate alert can increase staff vigilance in safeguarding and prevent a focus on their presenting condition. This reduces the visibility and reliability of important safeguarding information about changing risk to health practitioners accessing records, which if seen could inform their ongoing care. **Recommendation 15.3**

5.2.16 Family composition is not consistently documented in health records across services in Sefton, including primary care, which can hinder a 'Think Family' approach. For example, the electronic systems are not all conducive to recording the details of fathers or other adults living in the family home. The quality of maternity record keeping regarding linked children and adults was good in Liverpool Women's Hospital but poor in Southport and Ormskirk NHS Trust. Here, the dedicated field that records the details of linked children and birth history only contained forenames of the children and their dates of birth.

5.2.17 Record keeping within Ormskirk District General Hospital's children's ED however, is of a good standard. Demographic details were captured well in addition to who accompanied the child and the number of previous attendances. This enables practitioners to have a clear picture of the child's episode of care and provides relevant information which may be needed to share with other services.

5.2.18 Referrals from health services made to children's social care did not always include the details of linked children or clarify the childcare or parental responsibility status of the children. The EMIS electronic patient records system is a particular challenge when adults move out of the family home, as the adults' and children's records can no longer be electronically linked. Genograms, particularly in the cases of complex family make-up, were not present in records seen and the demographics section does not prompt practitioners to complete this important information in many of the services visited. Whilst inspectors could find some family details in the case notes, it was not easy to retrieve and not always accurate. This information would help practitioners, managers and supervisors to easily understand often highly complex family relationships and support effective risk assessment. **Recommendation 15.4**

5.2.19 Case recording in all health services across Sefton is not robust. Key significant events in the life of a child, such as being taken into care or stepping up or down from child protection processes were not consistently easy to identify in records examined. Chronologies were not routinely used to build a picture of concerns such as missed appointments. The problem was exacerbated by the variation in the naming of uploaded documents and disparities in filing arrangements making it challenging to easily access key information about a child. A further example is the lack of a field on the change of school notification template for the reason for the move to be entered onto the 0-19 case record. This prevents the reason for the move being known by school nurses to inform their assessment of risks to the child. **Recommendation 15.5**

5.2.20 Some practitioners in the North West Boroughs Healthcare NHS Foundation Trust 0-19 public health nursing service are task focused and process driven rather than fully considering the lived experience of the child. Whilst observational recording in case records by health visitors and school nurses was good, there was a lack of analysis and routine evaluation of risk which would support effective safeguarding practice and enable the practitioner to identify any changes in risk over time. Furthermore, the voice of the child was not consistently captured. Operational management oversight is not being well facilitated by this absence of regular analysis and risk evaluation. *This matter will be brought to the attention of the Public Health commissioners in Sefton Council.*

5.2.21 North West Boroughs Healthcare NHS Foundation Trust have identified a challenge in scanning and uploading documents onto children's case records. Documents are prioritised according to identified risks; with child protection, children in care and children in need being uploaded as the priority. This is resulting in some significant delays to the uploading of lower priority documents which impacts on the ease of understanding the child's journey and experiences as reflected in the running record. There is good understanding of the problem by the trust and inspectors acknowledge that work is underway to find an electronic solution to this issue. **Recommendation 5.5**

5.2.22 A daily safety 'huddle' takes place in the 0-19 service where a range of key issues may be discussed. This is a good forum for teams to address any identified capacity pressures, share caseload and key emerging issues and deploy cover to minimise risk of non-attendance at child protection and other key meetings. Practitioners are expected to attend or dial in to those meetings whenever possible. This helps to support prompt actions and is supported through agendas and minutes to support reflection on practice.

5.2.23 Ormskirk District General Hospital's children's ED and paediatric ward take a multi-agency approach to safeguarding children. They engage a number of professionals, including social care, in meetings such as the weekly 'safety huddle' meetings and 'regular attenders' meetings. This means that children receive a holistic approach to safeguarding to ensure they are kept safe.

5.2.24 In an attempt to consider safeguarding measures pertaining to children, a process has been established for all admissions of 16-18-year old young people to the Southport and Formby Hospital's adult ED to be checked by the paediatric liaison the following day. The files are reviewed for safeguarding considerations and shared with the paediatric liaison nurse. This provides some level of oversight of children receiving treatment, albeit retrospectively. However, the young people are triaged using adult documentation and the paperwork lacks any distinguishing characteristics which would draw clinicians' attention to the fact that they are treating a child especially within a busy ED environment. The assessment documentation does not prompt the practitioner to consider additional information regarding parental responsibility, social history and safeguarding vulnerabilities linked to age. This means that practitioners may not be aware that the patient needs to be assessed as a child and key safeguarding risk factors may not be fully considered. **Recommendation 2.6**

5.2.25 Managers in some health services have too much confidence that their existing processes and oversight of frontline staff's child safeguarding and clinical practice are robust. Practitioners are expected to escalate cases of concern to managers. Oversight relies on the individual practitioner following expected processes and that management oversight through supervision makes a difference to practice and children in their care. One case examined in Addaction exposed weaknesses in safeguarding practice, and management oversight that had not previously been identified. **Recommendation 15.6**

5.2.26 Sefton CCGs have strengthened governance arrangements to drive improvement in ensuring the health needs of children in care are identified promptly and addressed. This has been achieved through the implementation of an improvement plan and close oversight of North West Boroughs NHS Trust's performance by the designated leads.

5.3 Training and supervision

5.3.1 Liverpool Women's Hospital training recording system does not enable the trust to assure itself that midwives are accessing the appropriate number of hours to comply with the extended level three safeguarding training as outlined in 'Safeguarding children and young people: roles and competences for health care staff. Intercollegiate Document. March 2014.' There is an over reliance on individual discussion as part of the appraisal process between a manager and an individual practitioner. **Recommendation 13.1**

5.3.2 Maternity staff in Southport and Ormskirk Hospitals NHS Trust have access to four hours of safeguarding training per year but this is single agency reducing opportunities for additional learning through multi-agency discussion and reflection. Maternity staff's uptake of LSCB multi-agency training is reported to be low. This limits the opportunity for midwives to ensure their safeguarding needs are met in accordance with intercollegiate guidance. **Recommendation 13.1**

5.3.3 Multi-agency level three compliance within Southport and Ormskirk Hospitals NHS Trust and Alder Hey Children's NHS Foundation Trust EDs are above the trusts' targets.

5.3.4 The named midwife in Southport and Ormskirk Hospitals NHS Trust prioritises safeguarding training for frontline maternity staff to improve the quality of referrals and report writing to children's social care. An audit completed by the named midwife is reported to have identified improvements in practitioner safeguarding activity. The named midwife also has oversight of referrals to children's social care and conference reports. However, inspectors reviewed case examples of referrals made to children's social care that did not analyse or articulate the safeguarding risks to the unborn clearly enough. In one case reviewed, the referring midwife was unclear about the level of need and recorded 'level three/four' which suggests the training has not had the intended impact on practice. [Recommendation 12.3](#)

5.3.5 Leaders within the Southport and Ormskirk Hospitals NHS Trust's paediatric ward have responded to an increase in the number of children and young people presenting with mental health concerns by improving the training provided to staff working in the ward. Clinicians now have access to a full day's training each year specifically around mental health to support their interactions with this vulnerable client group.

5.3.6 Furthermore, Southport and Ormskirk Hospitals NHS Trust's safeguarding team recognise the need to develop safeguarding skills and awareness within the adult ED. Work has been undertaken to improve staff knowledge through training and four safeguarding link nurses have been identified to drive this agenda forward. It is anticipated that these roles will help to strengthen safeguarding practice and promote a 'Think Family' approach across the service.

5.3.7 The preceptorship programme in the North West Boroughs Healthcare NHS Foundation Trust 0-19 service is competency based with requirements for observed practice and demonstrated knowledge and competency to be signed off during the programme. Although inspectors were not able to test the strength of the preceptorship programme, we were verbally assured that safeguarding competencies are explicitly included for each banding of staff.

5.3.8 All health visitors in the 0-19 service have the Specialist Community Public Health Nursing (SCPHN) qualification. However, not all the school nurse practitioners have this qualification. North West Boroughs Healthcare NHS Foundation Trust has established this as a requirement and are working to increase the proportion of school nurses to gain the SCPHN qualification.

5.3.9 There is no rolling programme of training and standard setting to support 0-19 practitioners in undertaking RHAs to ensure consistent and effective practice. A one-off half-day training to health visitors was provided by the team manager while she was seconded into the children in care team as additional resource. The training included how to undertake an RHA with some case examples. However, despite this the quality of RHAs remains variable, although they are generally of better quality in health visiting compared with school nursing. [Recommendation 5.2](#)

5.3.10 The CCGs' designated doctor for looked after children has provided training for the Alder Hey Children's NHS Foundation Trust's consultant community paediatricians and paediatric registrars on how to undertake health assessments for children in care. Specific guidance sheets have been created to outline the expectations when completing an assessment and this has helped to drive improvement. Feedback is provided via the quality assurance process and the number of assessments returned due to not meeting the required standard has reduced significantly. Some training on the experience of the UASC or young person has been delivered for paediatricians, but the looked after children's nurse has not undertaken any UASC training despite working closely with practitioners undertaking the review assessments for this cohort. **Recommendation 10.1**

5.3.11 The Alder Hey Children's NHS Trust looked after children's nurse has undertaken training on CSE but not criminal exploitation including county lines, where vulnerable young people are groomed to distribute illegal substances across large geographical distances. She also receives periodic supervision from the named nurse, but this is purely caseload focused and does not include any reflective practice or personal development. **Recommendation 15.7**

5.3.12 Southport and Ormskirk NHS Trust's sexual health nurses and most CAMHS practitioners from Alder Hey Children's NHS Foundation Trust have received level three child safeguarding training as set out by national guidance. LSCB briefings are disseminated which can aid learning and inform practice. The most recent topics covered have included child sexual abuse in the familial environment and criminal exploitation, although this did not incorporate county lines.

5.3.13 Practitioners in the MASH operate a model of continuous learning through action learning sets, reflective discussion, supervision and benchmarking practice against national audits and findings such as the recent Joint Targeted Area Inspection (JTAI) in Liverpool. This supports the continual improvement of safeguarding practice.

5.3.14 Midwives working for the Liverpool Women's Hospital access quarterly supervision. Inspectors saw evidence of supervision records for the enhanced midwifery team which were reflective and not limited to those expectant women where there was an unborn child protection plan, or where it was indicated that child in need arrangements would be needed.

5.3.15 The Southport and Ormskirk NHS Trust supervision policy and safeguarding supervision model described by the named midwife is weak. The model does not support regular scrutiny or professional challenge of safeguarding practice. Records of safeguarding supervision are not routinely made and were not identifiable to be reviewed. Therefore, we could not see what difference this makes to women, unborn and newborn infants. The trust recognises the need to improve their arrangements and discussions regarding how to make improvements are at an early stage. **Recommendation 15.7**

5.3.16 Supervision discussions are not routinely documented in the child or young person's clinical records in most services visited during the review. It is acknowledged by safeguarding teams in most provider organisations that the recording of supervision needs to be strengthened to ensure a complete record, including safeguarding risks and actions, is maintained. **Recommendation 15.7**

5.3.17 In North West Boroughs Healthcare NHS Foundation Trust however, where individual children are discussed in supervision, this is clearly and routinely recorded on the child's case record in the 0-19 service. Inspectors saw this consistently in all cases reviewed. A separate template is completed for each child in the supervision session, documenting details of the discussion and the decisions made and uploaded onto the case record. This is in line with best practice.

5.3.18 Supervision is not currently offered to the sexual health nursing team apart from the SPOC nurses. This has been identified by the service as an area for development as the new contract is embedded. However, there is not a SMART action plan in place to ensure it is implemented. **Recommendation 15.6 and 15.7** *This matter will be brought to the attention of the Public Health commissioners in Sefton Council.*

5.3.19 Nursing staff in Alder Hey Children's Hospital told inspectors they do not always have protected time for supervision to allow them to reflect and learn in a safe, supportive and structured environment.

5.3.20 Furthermore, ward managers and matrons are not routinely notified of the safeguarding referrals raised in their areas. This means, at a higher level, that leaders are unable to analyse trends and themes in safeguarding reporting and whether any departments are over or under reporting. Staff who work in the wards are also not aware of safeguarding concerns their colleagues report and therefore are not alert to, or aware of specific safeguarding themes. **Recommendation 4.4 and 15.7**

5.3.21 Access to regular child safeguarding supervision that facilitates effective and sensitive professional challenge of practice is not embedded in CAMHS. Staff have access to ad-hoc advice from the trust safeguarding team, but the uptake of this is not currently monitored. Staff also have access to regular monthly clinical supervision where safeguarding cases can be discussed, but this is not routinely documented in children's records. Furthermore, safeguarding is not always fully considered or recorded when children are discussed as part of multi-disciplinary team meetings. Inspectors did not see any evidence of the impact of this supervision approach and what difference it makes to the lives of children and safeguarding practice of staff contained within records examined. **Recommendation 15.7**

5.3.22 Regular clinical supervision to include safeguarding is available to staff in Ambition Sefton, which includes supervisors auditing five adult cases to review risks and action plans. Practitioners and service users within adult substance misuse services also benefit from this approach. The family team within Ambition Sefton receive quarterly safeguarding supervision from the named nurse for safeguarding children and there are plans to extend this arrangement to other frontline staff. However, records of supervision discussions are held separately and no actions or supervision plans were recorded in the client records reviewed by inspectors. Therefore, the impact of this safeguarding supervision process for children and young people is unclear. *This matter will be brought to the attention of the Public Health commissioners in Sefton Council.*

Recommendations

- 1. NHS South Sefton CCG and NHS Southport and Formby CCG should:**
 - 1.1 Ensure that a rolling programme of training is implemented for practitioners in all services on child sexual exploitation, to include identification and assessment; and seek assurance of an ongoing evaluation of its impact on practice.
 - 1.2 Work with the named GP and GP practices to develop systems and processes to improve the identification of children, young people and families who may benefit from early help.
 - 1.3 Work with the named GP to ensure that all partners in Primary Care are fully cognisant in the assessment of risks to children and young people relating to child sexual exploitation, female genital mutilation and domestic abuse, including the use of locally and nationally recognised tools.
 - 1.4 Work with the named GP to establish an information sharing agreement which ensures that all partners in Primary Care are in receipt of all relevant information pertaining to vulnerable patients, and fully participate in effective multi-agency working to safeguard children and young people.
 - 1.5 Work with the named GP to implement a system of support to Primary Care partners to ensure effective and timely contribution to multi-agency child safeguarding processes including referrals and reports for child protection conferences. This should also include building professional relationships to ensure minutes and plans are also shared with Primary Care.
 - 1.6 Implement a process to identify and address challenges affecting the timely completion of initial health assessments for children who become looked after.
 - 1.7 Review the service provision for adults with unmanaged ADHD. This should include establishing an initiative to reduce waiting times and improve access to appropriate intervention for adults awaiting assessment.
 - 1.8 Embed robust processes that ensure a culture of challenge to providers. This should include the requirement of providers to evidence their reporting and demonstrate impact.
 - 1.9 Drive forward the implementation of their local transformation plan for emotional health and wellbeing to improve timely access to an effective range of mental health services for children and young people. This should include prioritising Sefton's most vulnerable young people at an operational as well as strategic level, with demonstrable impact.

2. Southport and Ormskirk NHS Trust should:

- 2.1 Implement a process that allows community midwives the flexibility to offer a home visit to women at least once during pregnancy to aid the assessment and identification of risk.
- 2.2 Implement a process in the maternity service to ensure that a routine enquiry about domestic abuse is made more than once during pregnancy to facilitate the identification of developing risk.
- 2.3 Implement a system of monitoring and audit, to ensure that practitioners in the adult emergency department consider child safeguarding when adults present, regardless of gender.
- 2.4 Ensure that consideration of the risks of female genital mutilation are given to young people accessing sexual health services and the female children of adults as well as the adult service users themselves.
- 2.5 Implement a programme of audit and monitoring to ensure midwives' compliance with the Trust's standard operating procedure for non-attendance at maternity appointments and no access visits, including evidence of risk assessment in records.
- 2.6 Develop a system to quickly identify young people under 18 years attending the adult emergency department, to ensure additional vulnerabilities and risks are assessed.

3. NHS South Sefton CCG and NHS Sefton and Formby CCG, Southport and Ormskirk NHS Trust, Liverpool Women's NHS Foundation Trust and North West Boroughs Healthcare NHS Foundation Trust should:

- 3.1 Work together to ensure that all practitioners working with pregnant women are fully cognisant in current LSCB processes for pre-birth assessments.

4. Alder Hey Children's NHS Foundation Trust should:

- 4.1 Establish a system of training, monitoring and assurance to ensure safeguarding risks are considered, assessed, analysed and recorded in the emergency department.
- 4.2 Implement a process to ensure that CAMHS practitioners fully assess all safeguarding risks such as child exploitation and 'hidden harm', to children and young people, in addition to their mental health needs; that is monitored by leaders to ensure appropriate managerial oversight.
- 4.3 Standardise the process to ensure a robust response to requests for information from the MASH, regardless of the RAG rating.

4.4 Establish a system of governance and a culture of learning. Referrals to the MASH should be copied to managers and utilised for case discussion with staff to facilitate learning in practice.

4.5 Implement an effective system for ensuring operational oversight of referrals made by health practitioners to the MASH, and monitor how this is maintained.

5. North West Boroughs Healthcare NHS Foundation Trust should:

5.1 Develop an effective and robust system to ensure full oversight and monitoring of the population of children in care.

5.2 Implement a thorough process for the training and quality assurance of review health assessments completed by all practitioners in order to improve and standardise the quality and benefit for children and young people.

5.3 Develop a timely and robust process to ensure practitioners working with children in care, and managers requiring oversight, have timely access to pertinent information held in initial health assessments.

5.4 Establish a programme of training and supervision for team managers to ensure they are equipped to support the incorporation of strong governance and supervision at the frontline.

5.5 Strengthen processes to ensure the timely uploading of all documents to children's case records whilst awaiting the implementation of an electronic solution.

6. Mersey Care NHS Foundation Trust should:

6.1 Establish a robust process to ensure that effective consideration is given to the exploration of risks to the unborn, to children and young people, when adults do not engage with substance misuse services.

7. Addaction should:

7.1 Implement a robust information sharing process to ensure effective liaison with the other health services that young people access.

8. Southport and Ormskirk NHS Trust, and Alder Hey Children's NHS Foundation Trust should:

8.1 Ensure that environmental risk assessments are completed in all ward areas where young people may be admitted experiencing a mental health crisis.

9. Alder Hey Children’s NHS Foundation Trust and Mersey Care NHS Foundation Trust should:

- 9.1 Work together to improve and develop the transition process for young people who are likely to require intervention from adult mental health services, to ensure their needs are appropriately assessed in a timely manner to avoid delays in accessing treatment.

10. Alder Hey Children’s NHS Foundation Trust and North West Boroughs NHS Foundation Trust should:

- 10.1 Ensure that all clinicians and practitioners working with unaccompanied asylum-seeking children and young people undertake appropriate training and demonstrate awareness and understanding of the lived experiences of this vulnerable cohort.
- 10.2 Establish a process of follow-up to ensure that responses from strengths and difficulties questionnaires are available to health practitioners to inform health assessments and plans.
- 10.3 Work together to ensure all practitioners working with children are alerted to children on their caseloads who are placed for adoption.
- 10.4 Ensure that all health practitioners working with children and young people across the health economy are notified of their looked after status allow for appropriate information sharing to better inform care planning.
- 10.5 Implement a system to ensure appropriate liaison between CAMHS and children in care health services takes place to prioritise and better meet the needs of children in care.
- 10.6 Work with Sefton Council to establish an effective process which ensures that information pertaining to a looked after child’s family health history is available to inform the completion of the initial health assessment.

11. NHS South Sefton CCG and NHS Southport and Formby CCG, Alder Hey Children’s NHS Foundation Trust and North West Boroughs NHS Foundation Trust should:

- 11.1 Work together with Sefton Council to develop a multi-agency whole systems approach to drive continual operational improvements to services for children in care.

12. Southport and Ormskirk NHS Trust, Liverpool Women’s NHS Foundation Trust, Alder Hey Children’s NHS Foundation Trust, North West Boroughs Healthcare NHS Foundation Trust, Mersey Care NHS Foundation Trust and Addaction should:

- 12.1 Implement a proactive process of follow-up to ensure that child protection conference minutes are shared with health practitioners and routinely stored securely on service users' records.
 - 12.2 Work together to implement a rolling programme of training and audit which will embed and regularly evaluate, the effective capture of the voice of the child in daily practice, including the unborn child, through improved record-keeping.
 - 12.3 Work together to implement a rolling programme of training for practitioners on the analysis and articulation of risk and its impact on children and young people. This should include clear evaluation of the impact of the training on practice through regular audit.
- 13. Liverpool Women's NHS Foundation Trust and Southport and Ormskirk NHS Trust should:**
- 13.1 Implement a process to effectively monitor midwives' compliance with level three child safeguarding training as per RCPCH Intercollegiate Document (2014).
- 14. Mersey Care NHS Foundation Trust and Southport and Ormskirk NHS Trust should:**
- 14.1 Establish a robust quality assurance process to ensure that accurate information regarding mental health crisis assessments and the associated risks to children is clearly documented and shared between the ED and adult mental health services.
- 15. Southport and Ormskirk NHS Trust, Alder Hey Children's NHS Foundation Trust, North West Boroughs Healthcare NHS Foundation Trust, Mersey Care NHS Foundation Trust and Addaction should:**
- 15.1 Develop and embed consistent, effective and proactive quality assurance for referrals into the MASH. This should include staff development from examples of poor quality as well as good quality referrals.
 - 15.2 Develop processes to mitigate risks from inconsistent record-keeping systems and split or duplicate records.
 - 15.3 Work together to develop a consistent and robust approach for the use of alerts on electronic case records to better identify children and young people at risk.
 - 15.4 Ensure greater consistency across the health economy to fully embed a 'Think Family' approach to record-keeping and practice in all services.

- 15.5 Establish, embed and monitor the recording of significant life events using chronologies that are fit for purpose to highlight risks to practitioners quickly.
- 15.6 Implement a process to ensure strong governance and robust managerial oversight of practice through effective reflection, supervision and challenge.
- 15.7 Ensure that practitioners are able to access and prioritise appropriate and reflective safeguarding supervision in accordance with their role. All discussions and action plans should be clearly documented and stored securely in the service user's records.

Next steps

An action plan addressing the recommendations above is required from NHS South Sefton CCG and NHS Sefton and Formby 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.