

Review of Health Services for Children Looked After and Safeguarding in Wirral

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

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Provider services included:	Wirral Community Health and Care NHS Foundation Trust (WCHC) Wirral University Teaching Hospital NHS Foundation Trust (WUFT) Cheshire and Wirral Partnership NHS Foundation Trust (CWP) Wirral Ways to Recovery- CGL
CCGs included:	NHS Wirral Clinical Commissioning Group
NHS England area:	North region
CQC region:	North
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Summary of the review

This report records the findings of the review of health services in safeguarding and looked after children services in Wirral. 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 the Clinical Commissioning Group (CCG) and Local Area Team (NHS England).

Where the findings relate to children and families in local authority areas other than Wirral, 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 before and during the visit. This included document reviews, interviews 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 individual cases where there had been safeguarding concerns about children. This included some cases where children were recently referred to social care and others where children and families had not been referred but were assessed as needing early help from health services. We also sampled a spread of other such cases spanning universal and specialist health provision.

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

In total, we considered the experiences of 90 children and young people including 8 cases that we tracked involving the work of a wide range of health practitioners and partner agencies.

Context of the review

Wirral Council has a population of 321,328 people including approximately 74,440 children and young people (0-19 years). The population's ethnicity is predominantly white British (90%). Minority groups include those of Irish, Chinese and Polish heritage.

Wirral overall is one of the 20% most deprived districts in England. The rate of children under 16 years living in poverty is higher than regional and national averages. The child mortality rate is also higher than the England average. Levels of women who smoke whilst pregnant and breastfeeding rates are comparatively high. Attendance of children 0-4 years at emergency and urgent care settings is high.

The reported incidence of school pupils with social, emotional and mental health needs is higher than regional and national levels. The rate of child inpatient admissions for mental health conditions or self-harming behaviours is also higher than the rest of England. Wirral Council has a relatively high rate of conceptions under 18 years and has higher teenage pregnancy rates. The level of alcohol misuse in children and young people leading to hospital admission is comparatively high.

Wirral has better performance in relation to young people 16-17 years of age not in education, employment or training. The rate of first-time entrants to the youth justice system is much better than the average for England.

Commissioning and planning of most health services for children is carried out by Wirral Health and Care Commissioning. This new joint commissioning structure, established on 1st April 2018 brings together the leadership, expertise and resources of the CCG and the Council.

Commissioning arrangements for looked-after children's health are the responsibility of Wirral Health and Care Commissioning. Designated leadership roles are provided by NHS Wirral CCG. Named professionals are provided by Wirral University Teaching Hospital NHS Foundation Trust (WUTH) and Wirral Community Health and Care NHS Foundation Trust (WCHC).

Acute hospital services, including the Emergency Department (ED) and midwifery services are provided by WUTH. WCHC operates 3 nurse-led walk-in centres providing assessment, treatment and advice for minor injuries and illnesses.

Health visitor and school nursing services, the 0-19 team, are commissioned by Wirral Council Public Health Team and provided by WCHC.

Contraception and sexual health services are also commissioned by Wirral Council Public Health Team and provided by WCHC. Local arrangements for young people include a sub-contacting arrangement between WCHC and Brook.

Child substance misuse services are commissioned by Wirral Council Public Health Team and provided by Wirral Council, Cheshire and Wirral Partnership NHS Foundation Trust (CWP) and WCHC who sub-contract some aspects of prevention work to Barnardo's.

Adult substance misuse services are commissioned by Wirral Council Public Health Team and provided by Change, Grow, Live known locally as Wirral Ways to Recovery.

Child and Adolescent Mental Health Services (CAMHS) are commissioned by Wirral Health and Care Commissioning and provided by Cheshire and Wirral Partnership NHS Foundation Trust (CWP). Specialist facilities are provided by CWP and Liverpool Children's Hospital. Adult mental health services are also commissioned by Wirral Health and Care Commissioning and provided by CWP.

A total of fifty-one GP practices operate in the local area.

At the time of this review, 2,542 children and young people were on a child in need plan. A total of 370 children were on a child protection plan. Wirral had 841 children looked after, 171 of whom were between 0 and 4 years. A total of 172 children and young people had been placed in other areas outside Wirral, and 226 children looked after had been placed in Wirral by other councils. A total of 9 young unaccompanied people seeking asylum were accommodated.

Strengths and Difficulties Questionnaire (SDQ) scores of the emotional and behavioural needs of children looked after are generally better than reported for the rest of England.

This report takes into consideration the findings of previous inspections by CQC and areas where Ofsted inspections have identified risk on a multi-agency basis. Attention is also given to assessing organisational learning from recent serious case and learning reviews and how this is supporting improvement in safeguarding practice.

The report

This report follows the child's journey and reflects the experiences of children and young people, parents and carers to whom we spoke; or whose experiences we tracked. Recommendations for improvement are made at the end of the report.

What people told us

Some staff are great, they can be very helpful and accommodating, but this is not always the case. Reasonable adjustments are not always made for me when I attend hospital which makes it difficult for me to be independent in managing my health care.
Young disabled person

The initial health assessment helped in unlocking a lot of doors for my foster child. We could not have asked for more help. We have not had a problem getting access to CAMHS. The support from the physio, OT and school nurse has been great; and we continue to have the support we need from hospital specialists.
Foster carer

The school nurse sees the children regularly which means they don't worry about their review health assessments. Gaps in the handover of health information when one child moved placement however, resulted in their missing an appointment.
Foster carer

Support provided by CAMHS and the school nurse has been good and has helped our foster child to return to school. This is a considerable achievement given they had experienced significant trauma and were not able to attend school for many months. Review health assessments have been completed on time. We were fully involved and received copies of the health action plan.
Foster 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 Access to the Children's Emergency Department (ED) at Arrowe Park hospital was not available 24 hours a day. Children and young people under the age of 16 who attended overnight were seen in the adult ED. Medical and nursing staff with relevant paediatric training were not available on all ED shifts. Children and young people did not always have staff caring for them with the appropriate paediatric knowledge and competencies. This risk was highlighted in previous CQC inspections at Arrowe Park hospital. **(Recommendation 16.1).**

1.2 Young people aged between 16-18 years were seen in the adult ED. They were assessed using adults' rather than children's documentation. This meant they did not have the same recognition of their legal status and vulnerability as a child in the level of safeguarding checks undertaken. In these circumstances, their additional vulnerabilities to harm or exploitation may not be effectively identified. **(Recommendation 16.2).**

1.3 We found strong multi-disciplinary liaison and information-sharing between Wirral University Teaching Hospital (WUTH) and Wirral Community Health and Care Trust (WCHC) in monitoring ED attendance of children and young people. The children's liaison nurse, part of the trust's safeguarding team, was notified and reviewed all children and young people who attended up to their 18th birthday. Information on every attendance was routinely shared with the 0-19 public health nursing team. This ensured universal health services were kept informed of children's health needs and of any changes or escalating risks.

1.4 Good links and joint working arrangements had been established out of hours between ED staff and the young person's substance misuse services. The referral pathway had been reviewed and refined to support ease of use by ED practitioners. This helped promote early identification and follow up of young people who were intoxicated or under the influence of drugs; including those at risk of exploitation. Work undertaken by the team had a positive impact in reducing re-attendance rates. However, given local arrangements that children (out of hours) and young people 16 years and older were seen in adult ED, further work was needed to ensure consistent responses to identification and referral across the age range. **(Recommendation 2.1).** *This was also brought to the attention of the Director of Public Health as commissioner of substance misuse service.*

1.5 WUTH and Wirral Ways to Recovery had established a programme of joint working to address the 20 most frequent attenders at ED. This had led to a 60% reduction in re-presentations of adults with a high level of alcohol or substance misuse. However, information sharing about hospital discharges via the secure email system was not always timely. Late notification was reported by managers as impacting on timely follow up and support for individuals and their families. **(Recommendation 15.1)**. *This was also brought to the attention of the Director of Public Health as commissioner of substance misuse service.*

1.6 WUTH and CWP had also engaged in a similar programme to help reduce ED attendance rates of the 20 most frequent attenders with mental health needs. This too was reported to have led to a reduction of 60% in the initial stages of the project and helped strengthen support for those with parental responsibilities.

1.7 The need for joint working between Walk-in Centres and the young person's and adult substance misuse teams had not been clearly mapped. There was no agreed protocol or care pathway for alerting substance misuse teams to concerns about people presenting with minor injuries under the influence of alcohol or drugs. This may be leading to an under-identification of some people and missed opportunities for working with families to promote greater awareness of potential harms children may be exposed to. **(Recommendation 2.1)**. *This was also brought to the attention of the Director of Public Health as commissioner of substance misuse service.*

1.8 Substance misuse awareness-raising training delivered for parents and schools was helping to provide an increased focus on risk to children from misuse of drugs and alcohol. Attention was paid to preventing such harms, including recognition and management of concerns via social media.

1.9 Wirral Ways to Recovery offered a short 'Family Focus' parenting programme to help strengthen awareness of risk factors associated with parental substance misuse. The effectiveness of the programme in engaging parents and evidencing improvement in outcomes had yet to be evaluated.

1.10 Pregnant women booked to receive maternity care from the midwifery teams at Arrowe Park hospital benefited from detailed assessments of their history, health and social circumstances. Routine enquiries about domestic abuse were undertaken as part of good clinical practice in line with NICE guidance. Checks for female genital mutilation (FGM) and mental health were embedded within assessment and review activity and appropriately recorded. Detailed assessment templates, including screening for maternal drug and alcohol use, were consistently completed. Positive responses to these concerns triggered more detailed assessments, including referral to specialist midwives.

1.11 Young pregnant women accessing midwifery care however, did not routinely benefit from the early identification of risks of child sexual or criminal exploitation. Although child exploitation risk assessments were available for midwives to use, and they had all received training in their use; such assessments were rarely completed. Gaps in practice meant that pregnant women at risk of exploitation could remain unknown and without intervention or support until concerns escalated. **(Recommendation 16.5).**

1.12 Midwifery documentation included relevant details of fathers, partners and other household members. Details of other children; including whether they lived with their mother, were well-recorded. Less consistent however, was the recording of adults with whom children lived, if not with their mother, despite the prompts being on the templates. Whilst risks to the woman's wellbeing from family composition were explored, the impact for the unborn or new born was not explicitly assessed or recorded. **(Recommendation 16.6).**

1.13 Caseload management within the 0-19 public health nursing team was effectively aligned to address levels of need within families and communities. WCHC managers ensured health visitors had capacity to offer the majority of the Healthy Child Programme (HCP) mandatory visits within the home. Home visits provided essential opportunities to observe parent-child interactions in a familiar environment and identify any environmental risks. The service had recently introduced a Saturday morning clinic which parents had evaluated positively as it allowed working parents to actively participate in their children's health checks. Such approaches encouraged early identification and open discussion of their needs and concerns.

1.14 Children and their families however, did not have a consistent caseworker to deliver HCP developmental checks over the first years of the child's life. Whilst each family had a named health visitor, they were not able to routinely conduct every contact with the family. Strengthening continuity of care would help to further enhance relationships and support for families in promoting their children's health and development.

1.15 Wirral had a well-established Family Nurse Partnership which provided consistent care to young pregnant women and their partners. The local team had adapted its eligibility criteria to provide a flexible response to local need. The impact of this approach was in the process of being evaluated. Casework seen evidenced positive outcomes in building parental capacity to enable them to safely care for their babies.

1.16 Health visitors effectively identified and responded to concerns about maternal mental health. Some team members were skilled in delivering the *Improving Access to Psychological Therapies* (IAPT) and *'Incredible Years'* parenting programme. This helped ensure good access to support for parents who were struggling to meet their children's needs. Positive outcomes from this work included improved parental mental health, attachment and confidence in managing their children's behaviour and sleep patterns. Such initiatives promoted a holistic and effective response in strengthening parental capacity.

1.17 Health visitors routinely screened for domestic abuse at each contact where it was safe to do so. They used a range of assessment tools to help them assess the severity of the situation. They promptly shared information with partner agencies where concerns about the safety, development and wellbeing of children were escalating.

1.18 There was no specific prompt on the assessment documentation however for health visitors to ask parents about drug misuse. Whilst practitioners were confident they screened parents for this, there was no evidence in the records reviewed that this had been explored or acted on. Leaders reviewed this immediately and contacted their IT department to ensure a question about substance misuse was more visible to practitioners. **(Recommendation 17.1)**. *This was also brought to the attention of the Director of Public Health as commissioner of the 0-19 and substance misuse service.*

1.19 Families who were not well-informed about or reluctant to access health visitor support were appropriately targeted. Outreach work included health visitors offering a drop-in clinic in Wirral's Multicultural Organisation. This helped to strengthen oversight of and support for children with emerging concerns about their growth and development. Good use was made of interpreting and translation support to secure parental involvement.

1.20 In one locality where there was significant social need, health visitors and midwives offered joint home visits and worked closely with children's centre staff. This led to improved communication between professionals and promoted parental engagement with early years services. Such joint approaches not only made access to and the management of appointments easier for parents with young children; but helped promote better health outcomes and 'school readiness'.

1.21 The school nursing service was innovative in its approach to recognising and meeting children's needs. Managers effectively used feedback from children and young people to shape the local offer.

1.22 The school nursing model was responsive to areas of concern highlighted in public health data. This had resulted in strengthening support for children with emotional and mental health needs. We saw that school nurses routinely considered the emotional wellbeing and mental health needs of young people as part of the health needs assessment and offered a range of interventions to address identified needs.

New Ways of Working in Wirral School Nursing Service

An inter-generational project had improved young people's confidence and emotional wellbeing. Young people taught older people how to use IT. The older generation in turn taught young people how to play bingo. Both age groups reported improved emotional wellbeing, with younger people reporting improved confidence.

A pilot scheme was about to be implemented which involved the use of therapy dogs for young people accessing support for their weight, anxiety or attention deficit hyperactivity disorder (ADHD) issues.

These examples demonstrated the vision and commitment of school nurses to developing more creative ways of engaging and improving young people's health holistically.

1.23 School nurses worked effectively with other agencies to help improve wellbeing and educational outcomes for children. A panel had recently been developed where school health, educational psychologists and child and adolescent mental health (CAMHS) practitioners came together to identify and target additional support for children at risk of exclusion from primary school. This new joint approach was helping to strengthen local capacity to reach children and their families before they were at crisis point.

1.24 Home-educated children were appropriately supported to access the school nursing service. The service was aware of all home-educated children and contact was encouraged. The school nurse was available to visit the child at home on request. Older young people could also access the community drop in-clinics for school nursing support. This helped ensure this vulnerable group of children had good access to public health nursing interventions.

1.25 Joint working and information exchange between the 0-19 public health nursing team and GPs was inconsistent across the local area. Whilst each GP surgery had a named health visitor and had been offered face to face contact, some GP's declined this or requested less regular contact. School-aged children were not routinely discussed in these forums and GPs reported they were not consistently notified when a school aged child's case was stepped down or closed. This was a missed opportunity to review the experiences of all children within the family and did not promote a strong 'Think Family' response. **(Recommendation 7.1)**. *This was also brought to the attention of the Director of Public Health as commissioner of the 0-19 public health nursing service.*

1.26 The processes within primary care for following up adults who did not bring children to appointments were variable. In one GP surgery every child or young person for whom there were safeguarding concerns or who were looked after, who had not been brought to a booked appointment, were routinely followed up. However, this was not common practice in the other practice we visited. **(Recommendation 11.1)**.

1.27 Children and young people accessing generic sexual health clinics were prioritised at the point of contact. In the all age clinics, young people aged 16 years met 'urgent criteria' and were triaged before adults also waiting. This ensured the needs of young people were promptly identified and responded to.

1.28 Young people in Wirral from LGBTQ+ communities benefited from tailored support that recognised the diversity of their sexual identities and individual experiences. Brook facilitated a weekly group for young people struggling to understand and accept their sexuality and sexual identity; and were offered advice, guidance, and education in a safe space.

1.29 Young people under 18-years attending sexual health clinics had an additional assessment using a template that was introduced following CQC's last inspection in 2018. The template however did not adequately identify or support analysis of risk in line with '*Spotting the Signs*' or other CSE specific assessment frameworks. The expectation of operational managers was that all young people would have the safeguarding template completed at every contact. Audit of practice indicated significant improvement in the use of the new template. However, whilst enquiry about previous sexual partners was prompted; key detail such as names and ages of partners was reliant on professional curiosity and was not always documented. This limited the opportunity for a thorough assessment of risk from partners, and of exploitation and sexually harmful behaviours. **(Recommendation 20.1)**. *This was also brought to the attention of the Director of Public Health as commissioner of sexual health services.*

1.30 Wirral CAMHS service clearly recognised the need to strengthen access to out of hours support for young people, their families and partner agencies and established a consultation and advice line in 2017. Since its inception, there has been a steady and sustained reduction in the rates of young people admitted to the paediatric ward overnight (estimated at 44%) and a reduction in the numbers of young people requiring onward referral to specialist CAMHS teams (23%). A record of the concerns and actions agreed with the out of hours team was uploaded onto the child's school record. This ensured partner agencies were promptly informed of any emerging emotional or mental health needs.

2. Children in Need

2.1 The 'Think Family' approach was not effectively embedded in safeguarding practice when adults present at the ED at Arrowe Park Hospital. There were no templates within triage or assessment documentation to prompt the practitioner to ask whether the adult had parental or caring responsibility for a child, or whether they had regular contact with children. Parents of children and young people attending the ED were not asked whether their child was known to children's social care. This restricted the opportunity for practitioners to explore concerns for children who fell below the Child Protection Information Sharing (CP-IS) alert threshold. [CP-IS identifies children on child protection plans and children looked after by the local authority]. **(Recommendation 16.3).**

2.2 The identification of safeguarding risks to children and young people was under-developed in the Walk-in Centre in Wallasey. There was no separate children's triage or assessment documentation to include safeguarding prompts including risks associated with domestic abuse, child exploitation or mental health. Whilst there were care pathways for managing children and young people in mental health crisis; systems for identification and referral for wider safeguarding issues were not in place. Non-mobile babies and children attending the walk-in centre were not sufficiently protected. There was no policy or pathway to guide staff to the appropriate action to take when presented with bruising in a non-mobile baby or child. **(Recommendation 10.1).**

2.3 Children and young people attending the ED and admitted to the children's ward at Arrowe Park Hospital in mental health crisis, did not always have their immediate safety risks well-managed or benefit from timely access to a CAMHS practitioner. Children and young people were often only assessed by CAMHS practitioners following admission to the ward, and rarely seen out of hours. WUTH had relevant policies and guidance for environmental risk assessments, ligature cutting and safety planning for children admitted to the ward. On the day of our visit, however, individual case records of risks the young person posed to themselves or others were not available for those who had been admitted pending mental health assessment. This meant that inspectors were not assured that safety planning was embedded in care practice or appropriately reviewed. **(Recommendation 14.1).**

Case example

A young person attended ED following an intentional overdose of their prescribed medication and analgesics. Although an internal referral was made to the safeguarding team, it contained limited information and lacked analysis of risk.

The young person was appropriately admitted to the children's ward and received a CAMHS assessment the following day due to their deteriorating and chaotic behaviour. A ward environmental risk assessment however was not stored in the child's records, yet it was documented that it had been completed by the ward staff.

We found the environmental risk assessment was also missing on another young person's record who had been admitted onto the ward pending transfer to a specialist placement.

2.4 Specialist midwives provided strong leadership and oversight of pregnant women's care as the pregnancy progressed; with effective use made of monthly pre-birth liaison meetings to promote the involvement and contribution of wider partner agencies. Safety plans were regularly reviewed and updated and recognised the diversity of women's needs and their social circumstances. Good performance in this area was helping to strengthen shared understanding of parental capacity and of work required to support birth families to safely care for their own children.

2.5 The work of the pre-birth liaison group was underpinned by an effective multi-agency pre-birth pathway; although named group members did not include Wirral Ways to Recovery. Case tracking evidenced that children's social workers did not always adhere to pathway timescales. This resulted in appropriate escalation by the named midwife. Such challenge helped prevent drift in care co-ordination and reflected urgency in ensuring that future safeguarding arrangements were effectively planned for during and following the birth.

2.6 The most vulnerable pregnant women were visited at home during pregnancy. This helped improve their engagement and provided the opportunity for a comprehensive assessment of their home circumstances. Home visits were not routinely offered to all women as the expectation was that they would attend hospital and community antenatal clinics for their care. Midwives were working to strengthen their approaches to earlier identification of neglect. The management of concealed pregnancies and post-natal home safety checks were key areas of learning from recent incidents.

2.7 Health visitors clearly understood the local area's safeguarding threshold document. Case records seen indicated good leadership and challenge by health visitors in 'team around the family' cases. In one record reviewed we saw the family was 'stepped up' to social care appropriately when family circumstances had changed resulting in increased risk of harm to children. This approach recognised the dynamic nature of safeguarding children work, including the need for vigilance and escalation when early help plans were not effective.

2.8 Health visitors made effective use of safeguarding and clinical assessment tools to inform their identification and response to domestic abuse and child neglect. We saw examples of family nurse partnership tools being used alongside neglect assessment tools in assessing risks to children's growth and development. The approaches used helped practitioners to objectively measure risk, monitor situations for change and enabled timely sharing of concerns with other agencies.

2.9 We found a lack of professional curiosity about men however, within health visitor records. Too often specific details about fathers were scant. Fathers were not being screened for vulnerabilities such as mental health, substance misuse and previous social care involvement. Former children of the father were not recorded if they reported they had no contact with them. In one record we saw the details about a mother's new partner had not been recorded. This led to a lack of exploration of any risks they may pose to children within the new relationship. Being curious about new adults joining the household was highlighted as an area for learning within local learning reviews. **(Recommendation 17.2)**. *This was also brought to the attention of the Director of Public Health as commissioner of the 0-19 public health nursing team.*

2.10 Health visitor referrals to MASH contained good analysis of risk to the child and suggested a clear course of action to help address concerns. The voice of the child however, was not sufficiently strong in some referrals seen. The agreed multi-agency referral form developed in the local authority electronic system did not include specific prompts to support an explicit focus on the lived experience and voice of children across the age range. **(Recommendation 5.2)**. *This was also brought to the attention of the Director of Public Health as commissioner of the 0-19 public health nursing service.*

2.11 Chronologies or significant event lists were used effectively to help the 0-19 public health nursing team identify disguised compliance or case drift. Health visitors and family nurses used multi-agency escalation arrangements appropriately to safeguard children. They reported feeling well-supported by their managers and safeguarding leaders in challenging partner agencies and reflecting on their practice.

2.12 Multi-agency safeguarding meetings were well attended by the 0-19 public health nursing team. Each family receiving the partnership plus level of service had a named health visitor who prioritised attendance at team around the family, child in need and child protection meetings. This meant that the practitioner who knew the family and their history best was appropriately involved in the safeguarding process.

2.13 The 0-19 team actively engaged with a range children's social care teams and voluntary agencies working in local neighbourhoods. This included joint problem solving in supporting the work of the local area's 'stuck case' meetings. These forums enabled sharing of expertise and resources in leveraging additional capacity where parents were not making necessary changes in line with agreed plans. This approach helped build shared understanding of the experiences and impact for children.

2.14 The quality of sexual health safeguarding practice was not secured by a shared culture of professional confidence, curiosity and vigilance to risk. We found poor practice in one case where child sexual exploitation (CSE) had not been effectively considered within assessment or provision of care. Checks to their safety were not followed up with relevant other agencies.

Case example

The sexual health record of a young person indicated that they had previously been raped and had been medically examined at local sexual assault referral centre. Other alerts included additional vulnerabilities arising from their disabilities, with evidence of escalating concerns about their safety including discussion in the multi-agency child sexual exploitation (MACSE) meeting.

The young person's sexual health records however did not show that the practitioner had adequately considered these risks. There was limited exploration of the young person's emotional or mental health or of the impact of their specific conditions on their understanding and capacity to recognise unsafe situations. There was no evidence of information being shared about further clinic attendances with wider partner agencies to help inform shared understanding of current levels of risk.

2.15 Young people accessing sexual health services in WCHC and Brook did not routinely have their needs holistically assessed or considered. Assessments and consultations focused primarily on sexual health needs with limited exploration of wider circumstances and vulnerabilities. Young people did not benefit from a collaborative approach to care and intervention. There was no evidence in records of joint working with other services such as CAMHS or the young person's substance misuse service. **(Recommendation 20.1)**. *This was also brought to the attention of the Director of Public Health as commissioner of sexual health services.*

2.16 The 'Think Family' approach was not embedded in the sexual health service provided to adults. Whilst adult females were asked about their obstetric history, they were not asked for details of children or whether they had parental or caring responsibilities. Adult males were not asked about children at all. Sexual health practitioners did not consider the 'hidden child' or the impact that behaviours and risks of adults may have on children. **(Recommendation 17.3)**. *This was also brought to the attention of the Director of Public Health as commissioner of sexual health services.*

2.17 Young people with mental health needs rated as 'routine/non-urgent', did not have timely access to CAMHS assessment and treatment. Children waited approximately 5 months to access support from the 0-13 service. Older young people were waiting for up to 9 months for intervention from the 14–18 service. Overall, 688 young people were waiting for help. Of these, 450 were waiting for initial assessment. Gaps in CAMHS workforce capacity risked some young people only being seen when their needs escalated or when they presented in crisis. **(Recommendation 12.1)**.

2.18 Risk assessments undertaken by CAMHS practitioners using 'Care and Risk to Self and Others' (CARSO) forms were comprehensive. Case examples demonstrated succinct and clear identification and evaluation of risks, with regular updating of assessments to inform young person-centred care plans. Children were routinely offered the opportunity to see CAMHS practitioners alone for their initial assessment and subsequent interventions. This was clearly recorded on the child's record. The 'Emotional Dysregulation' group programme was effective in helping young people develop practical coping strategies for building resilience. In one case record seen this helped reduce missing from home episodes.

2.19 Some CAMHS practitioners were tenacious in their efforts in contacting other professionals. This helped ensure effective liaison and information-sharing about identified or emerging risks. Frontline practitioners were clear in both their liaison with other professionals and in their case recording about the status of a child's case, including informing others about case closure. This helped ensure shared understanding of children's emotional and mental wellbeing within wider safeguarding discussions and denotes learning from local serious case reviews.

2.20 We saw case examples where children and young people benefited from the therapeutic child-centred approaches of the CAMHS service. Home visits were undertaken where this was in the best interests of the child. High priority was given to promoting the safety of children and young people where their complex mental health needs and behaviours indicated a high risk to their own personal safety or that of others.

2.21 Wirral Ways to Recovery substance misuse service had developed a 'Think Family' team comprising 3 recovery co-ordinators and a team leader. Team members were familiar with local safeguarding thresholds and carried a reduced caseload of approximately 40 adults. They prioritised work with families with children under the age of 5 years. We saw positive practice in addressing a mother's substance misuse issues which helped reduce risks of harm to an older child at risk of exploitation. The work of the team has not been evaluated since it was established. Our findings suggest the profile of the team and its contribution to child safeguarding practice would benefit from further review. **(Recommendation 19.1)**. *This was also brought to the attention of the Director of Public Health as commissioner of the adult substance misuse service.*

2.22 Wirral Ways to Recovery also employed a young person's specialist substance misuse worker who supported young people up to 25 years of age to engage with treatment. Improved outcomes included a 60% successful treatment completion rate for its non-opiate users. The service was working to strengthen its focus on the impact of adverse childhood experiences on adults' misuse of drugs and alcohol. It had appointed staff with additional expertise to help inform increased understanding of people's earlier experiences and its implications on their substance misuse.

2.23 Child safeguarding work within adult mental health services was of a good standard and maintained a clear focus on the experiences and outcomes for children. Recording of parental capacity in areas such as being emotionally available and establishing safe care routines and supervision of children was well-evidenced in records seen. Mental health and wellbeing plans provided a holistic overview of parental needs and risks to their safety. The impact for children from a deterioration in parental mental health was clearly identified, with appropriate contingency plans agreed for the management of their care.

2.24 The perinatal mental health service, although still relatively new and not yet at full capacity, provided effective support alongside midwifery and the 0-19 team including Family Nurses. Mental health practitioners provided regular and structured support to mothers who had experienced trauma in their childhoods or were diagnosed with emotionally unstable personality disorders. It is positive to note enhanced practice in this area as people presenting with these needs may not have easily 'fitted into' traditional models of mental health provision. Case records indicated open and positive communication with good use of joint visits to help align professional accountabilities and safeguarding actions. The approach encouraged creative and practical solutions to families with a wide range of health and social need.

3. Child Protection

3.1 Joint working and information exchange between the safeguarding nurses in the multi-agency safeguarding hub (MASH) and wider health teams was good. We found an open mutually supportive team culture underpinning partnership working. The contribution of health to multi-agency safeguarding arrangements denoted significant improvements in practice since the Ofsted inspection in 2016.

3.2 Local information-sharing agreements enabled easy access to relevant NHS case recording systems and to the children's social care recording system. This ensured efficient and timely communication with other safeguarding leaders and frontline teams in addressing high priority safeguarding work. Further work was planned to strengthen information-sharing with maternity services in WUTH, building on the effective ED liaison arrangements in place.

3.3 MASH nurses made effective use of chronologies to inform their analysis of risk and of protective factors. This helped build a clear picture of the needs and experiences of children and their families and of their current involvement with health services. Analysis of risks included reporting of 'no access' visits, children who were not brought to appointments, and of parents who had a history of dis-engaging with services.

3.4 MASH nurses were routinely involved in strategy discussions. The relevant named health practitioner for active cases also attended where possible. Sharing of views and challenge was encouraged to help promote joint decision-making and a consistent standard of practice. Engagement of MASH nurses in weekly sampling of re-referrals helped promote reflection and challenge of decisions about previous case closure. Any gaps found in children's health or development were promptly actioned.

3.5 MASH nurses actively contributed to the weekly multi-agency child exploitation meetings. They also received and shared information about families discussed at multi-agency risk assessment conferences (MARAC). This supported ongoing vigilance of missing children, those at risk of exploitation or exposed to domestic abuse. Their leadership and co-ordination of safeguarding activity effectively informed frontline practitioners about changes in children's needs or personal circumstances.

3.6 ED practitioners at Arrowe Park Hospital had received training on the thresholds for referral to children's social care. A single page referral pathway had been developed which increased practitioner confidence in making MASH referrals. However, the quality of recording within referrals overall was of poor quality and often did not clearly articulate risk. Failure to provide relevant information specifying concerns meant further checks had to be made or clarity sought regarding thresholds of harm. Gaps in performance standards had been recognised by trust safeguarding leaders who were working with ED team members to reduce the number of inappropriate referrals to children's social care. (**Recommendation 16.4**).

3.7 The 0-19 public health nursing team reviewed each ED attendance and used significant events forms to monitor for patterns of attendance or incidents that would indicate a concern. However, professional curiosity following attendance at ED was not evident in two children's records we tracked. This included lack of follow up of an injury to a child on a child protection plan. This was a missed opportunity to further explore issues surrounding their presentation. (**Recommendation 17.4**). *This was also brought to the attention of the Director of Public Health as commissioner of the 0-19 nursing team.*

3.8 The Wallasey Walk-in Centre practitioners did not make use of information held by the public health nursing team about previous ED attendances to inform a holistic review of children's health needs or safeguarding risks. Furthermore, children's care records did not demonstrate that CP-IS had been checked or the outcome documented. This was a significant gap in compliance with expected standards of practice in informing better care and earlier interventions for children at risk of abuse or neglect. (**Recommendation 10.2**).

3.9 Babies born to women at Arrowe Park Hospital were protected by comprehensive safeguarding guidance including the management of concealed pregnancies. In cases where the pregnant woman had not accessed any ante-natal care, there was a clear expectation for an immediate referral to MASH to safeguard the baby. Midwives routinely attended relevant child safeguarding meetings and conferences and actively contributed to decision making, planning and interventions. Outcomes and actions of meetings were clearly and consistently documented in their records.

3.10 The 0-19 public health nursing team had strengthened its safeguarding systems and practice in response to learning from serious case reviews. Training had been recently provided in the use of genograms and eco maps (a graphic representation of the social and personal relationships of an individual with his or her environment). All children on child protection plans had a completed genogram on their records. This was helping strengthen professional curiosity of adults within the household where significant concerns had been identified.

3.11 Relevant details about the legal status and vulnerability of children were flagged on the 0-19 caseworker's records. This included risk of exploitation and whether they had any special educational needs or disabilities. Every case record we reviewed was correctly flagged with an alert. This meant that any practitioner accessing the record was immediately aware of concerns.

3.12 Frontline health practitioners reported they were generally informed of the outcome of the MASH referrals within 48 hours which helped ensure they were well-informed about the plan of care for the family. We saw health practitioners effectively challenged any decisions about referral outcomes they did not agree with.

3.13 The role and accountabilities of health visitors alongside midwifery services for safeguarding babies in the antenatal period was unclear. In 3 cases we tracked where safeguarding issues have been identified by the midwifery service, health visitors did not become actively involved until the baby was ten to fourteen days old, to coincide with the new baby review as no targeted notification was received by the 0-19 service from WUTH. Reports to initial conference were not routinely submitted by health visitors for unborn babies even though they may have had key information about the family. This practice restricted opportunities for joint working with midwives and other partners and did not make best use of the expertise of health visitors at a sufficiently early point in the baby's life. **(Recommendation 3.1)**. *This was also brought to the attention of the Director of Public Health as commissioner of the 0-19 public health nursing service.*

3.14 The quality of child protection reports written by health visitors was of a variable standard. Reports were written using the local area's report template, but this did not prompt practitioners to explore the lived experience of the child. Whilst we saw examples of reports that contained clear analysis of risks and protective factors with specific recommendations to help inform protection plans; the standard of practice was not consistently good. The voice of the child was not strongly promoted to help build shared understanding of their experience of parental care. **(Recommendation 17.5)**. *This was also brought to the attention of the Director of Public Health as commissioner of the 0-19 public health nursing service.*

3.15 Vulnerable children and young people with health needs benefited from having a named school nurse. When school nurse casework was deemed 'active' they attended all children looked after reviews, core groups, initial and review child protection conferences. Children and young people who met the threshold for a child protection conference were supported by an effective health needs assessment pathway. School nurses offered a face to face health assessment prior to the child protection meeting taking place and children's views and wishes effectively informed their reports to child protection conferences. The assessment sensitively considered their emotional wellbeing and mental health, alongside any concerns about a child's physical health or development. This denoted good practice and helped ensure a strong focus on the holistic needs and experiences of children.

3.16 The school nursing service worked effectively to build relationships with young people and identified those at risk of child exploitation. Safeguarding practice reflected good recognition of all forms of exploitation, including criminal exploitation. School nurses appropriately used CSE screening tools to inform multi-agency referrals. This included good practice by the school nurse within Wirral's local 'Teen Team' in identifying risk to a young person on a child protection plan.

Case Example

The school nurse identified a young person appeared to have undiagnosed additional health needs. Their home life was chaotic, and they had attended several different schools. They had not been brought to clinic appointments so work in relation to assessment and care interventions had not been progressed.

When the young person went missing from home the school nurse promptly identified they were at risk of criminal exploitation. A multi-agency meeting was convened to provide additional support and enhanced monitoring of safety risks.

3.17 Children under 13 accessing sexual health services in WCHC and Brook were effectively safeguarded in line with sexual offences legislation. All sexual activity relating to a child aged 13 or younger was immediately referred to the MASH. Referrals were copied to the trust's safeguarding team to ensure oversight and for quality assurance. We were unable to review the quality of these referrals however, as they had not been saved on young people's records in line with expected standards of practice. **(Recommendation 20.2)**. *This was also brought to the attention of the Director of Public Health as commissioner of sexual health services.*

3.18 WCHC and Brook did not routinely have representation at child protection meetings to help develop joint strategies for children and young people. Sexual health practitioners did not submit reports or attend child protection conferences or receive minutes or plans. School nurses gathered sexual health information and shared this on behalf of sexual health practitioners. Further review of these arrangements was needed to ensure all relevant information was consistently well-understood and used by sexual health practitioners and the multi-agency partnership to inform their assessment of risk. **(Recommendation 20.1)**. *This was also brought to the attention of the Director of Public Health as commissioner of sexual health services.*

3.19 CAMHS practitioners adhered to the children's social care threshold document when making referrals to MASH. In some cases, referral content was succinct, with well-articulated risks of harm to the child. However, there were inconsistencies in the quality of referrals completed. Some referrals were overly descriptive leading to the key concerns being lost within a lengthy narrative. **(Recommendation 18.1).**

3.20 CAMHS effectively identified and responded to child protection concerns including where the care arrangements were at risk of breaking down. CAMHS records evidenced good support for parents in helping them to safely manage children's complex and challenging behaviours. In one case record seen, this had also resulted in a joint review of children's education, health and care plans to provide better understanding of their complex needs and additional support. Joint action in this case enabled the level of concerns to be stepped down to 'child in need' with ongoing involvement of all relevant partners.

3.21 CWP operational managers and safeguarding leads were working to strengthen transition arrangements in supporting families where there were concerns about both adults' and children's mental health. New approaches aimed to promote shared vigilance to risks of harm spanning child and adult safeguarding agendas and incorporated learning from recent serious case reviews.

3.22 Assessment documentation used within Wirral Ways to Recovery adult substance misuse service prompted completion of family demographics including children, their names, ages and where they were living. The case records of relevant adults using the service could be linked which provided good oversight of household members and parental caring responsibilities. Records flagged adults using the service about whom there were safeguarding concerns including those who had children under 5 years of age. Risks of domestic abuse within parental relationships were clearly highlighted. Last year, the service provided 683 safe storage boxes to local people which reflected the high level of identified risk in the local area.

3.23 We found Wirral Ways to Recovery practitioners were not involved in multi-agency child protection work at a sufficiently early point. Adult substance misuse practitioners were not always invited to multi-agency child protection meetings. Child protection plans were not available on records to help guide the work of adult substance misuse practitioners. The safeguarding lead reported this had been escalated to children's social care managers but remained an area to be effectively addressed. **(Recommendation 13.1).** *This was also brought to the attention of the Director of Public Health as commissioners of adult substance misuse services.*

Case example

The pre-birth referral highlighted a lengthy history of parental alcohol and substance misuse. Older children were not living with their parents. The threshold for significant harm was met and the unborn baby was placed on a child protection plan under the category of neglect. Mother denied mis-using alcohol during pregnancy; but tests later evidenced high levels of alcohol misuse. Parents were informed by children's social care only after the birth, that the baby would be removed.

Wirral Ways to Recovery had not been involved in the initial child protection conference or core group. Parent records did not include a copy of the child protection plan.

Parents self-referred to Wirral Ways to Recovery saying they were motivated to change and make a fresh start. They enrolled on the Family Focus parenting group and had signed up for alcohol and drugs abstinence courses.

3.24 Wirral Ways to Recovery frontline practitioners told inspectors that if they attended a child protection conference, verbal feedback was satisfactory. They were not using the multi-agency reporting template used by other partner agencies as they said children's social care had asked for verbal or email feedback rather than a written report. This meant practice in relation to sharing of reports with parents was not well-established. **(Recommendation 19.2)**. *This was also brought to the attention of the Director of Public Health as commissioners of adult substance misuse services.*

3.25 Adult mental health practitioners recognised their accountabilities for safeguarding children including those at risk of domestic abuse. They were effectively engaged in MARAC and MAPPA-related activity and used relevant assessment tools to help inform a shared understanding of risk. Frontline practitioners escalated concerns and proactively checked progress in relation to casework undertaken by partner agencies.

3.26 All GPs in Wirral had a lead GP for safeguarding children and adults. In one practice, children looked after and those on a child protection plan were always be seen by a senior GP, rather than a locum or trainee GP. This ensured continuity of care and good oversight of their health needs and social circumstances. This approach however, was not consistently offered in other GP practices.

3.27 Where concerns had been raised about the safety of a child or adult in the household, all GP records were flagged with an alert. However, individuals were not routinely asked if they lived with or had contact with children when they registered at the practice. This meant there was an over-reliance on primary care staff to demonstrate professional curiosity regarding parental responsibilities. **(Recommendation 11.2)**.

3.28 GPs reported positive feedback on the additional training they had received from Brook in helping them build shared understanding of CSE risk, including signs and indicators; and of their accountabilities for safeguarding young people.

3.29 We reviewed one MASH referral made by a GP. This contained no analysis of risks and protective factors, and there was no clear expected outcome from the referral. Annual training and support for GP's included provision of guidance about safeguarding thresholds and the expected standards of referral practice. Practice oversight of the quality of referrals and reports to child protection conferences however was under-developed and would benefit from further challenge and feedback. **(Recommendation 11.3).**

4. Children Looked After

4.1 The recent co-location of children looked after nurses with social workers and personal advisors generated new opportunities for improving outcomes for children. Co-location was helping to progress skill sharing and understanding of each other's roles and accountabilities. Positive emerging practice for example, included the supervision of personal advisers by the children looked after specialist nurse. Children looked after nurses regularly attended children's statutory reviews which enabled good oversight of their experiences and needs. This helped ensure their specific health and development needs were clearly recognised within individual health care plans.

4.2 All children looked after in Wirral had a named health professional in line with national guidance. Analysis of initial health assessment (IHA) indicated the need to embed timely arrangements for notification and management of consent. IHAs were undertaken by appropriately qualified paediatricians who ensured additional health needs were screened for and appropriately followed up. WUTH's capacity to meet the continued high level of local demand remained a significant challenge. The timeliness of IHA's was poor. The most recent performance data indicated only 23% of IHA's requested within timescale were completed and returned to the local authority within 28 days of the child becoming looked after. This was recognised as a significant risk and identified as a priority area for improvement in the new joint Health Outcomes Task and Finish Group. **(Recommendation 9.1).**

4.3 The quality of initial health assessments of younger children was variable. Better practice was seen in relation to older children, including their engagement. Some records of younger children contained entries that were illegible, with incomplete demographics and gaps in information about parental health history. Some records described adults present as 'mother and father' which did not support clear identification of their caring roles and responsibilities. This variability in quality meant that the local area could not be assured that the child's social and family health history was fully considered as part of the health assessment. **(Recommendation 16.8).**

4.4 Operational managers clearly understood the challenges they faced in maintaining good oversight of children placed by Wirral out of area and those placed by other local authorities in Wirral. The recent appointment of a half-time specialist nurse was helping to strengthen support and tracking of outcomes for Wirral's children placed out of area, including ensuring a timely response to those who moved placements or were leaving care. This new approach recognised the additional vulnerability and impact on young people's emotional and mental health at key points in transition when they may be feeling anxious or concerned about change.

4.5 Other local authorities did not routinely share IHAs or review health assessments (RHAs) with Wirral's nurse specialist team when they placed children and young people in Wirral. Wirral's team appropriately challenged gaps in practice with placing authorities to promote a comprehensive picture of the child's health history and progress.

4.6 RHA's undertaken by Wirral's 0-19 public health nursing team indicated strong comparative performance in the coverage of assessments and care plans. Recent performance data showed that 95% of RHAs undertaken by health visitors and 96% of RHAs by school nurses were completed within statutory timescales. All records seen denoted appropriate follow up and checks of progress against priorities identified in the previous health care plan. This was an important achievement given the high numbers of looked after children in Wirral.

4.7 WCHC had made significant improvements in the quality of RHAs and health care plans over the past year with the introduction the Coram BAAF documentation. This, combined with the introduction of regular quality review, provided a clear structure and challenge to support continuous improvement in assessment practice. Health care plans were appropriate, and clearly attributed relevant actions to identified professionals or foster carers. Timescales and measurable health outcomes within the plan however, were less well-developed. This was being addressed within the developing quality assurance arrangements.

4.8 Positive practice included health visitors and school nurses undertaking an introductory visit to the child and their carers before the RHA took place. This approach helped build shared understanding about what was required and ensured the assessment was child-centred and promoted sensitive care delivery. Foster carers spoke highly of the support they received from the 0-19 public health nursing team. The child and carers were seen in their preferred location, usually at home. Health practitioners engaged well with the child and gave the necessary time required to complete the assessment. They recognised the diversity and complexity of children's needs and encouraged them to talk about themselves and their wellbeing.

4.9 Children's own words and perspectives were rarely directly recorded in health assessments though. There was also limited recording of how younger children presented, including their non-verbal communication or interactions with adults. Practitioners recognised that this is an area for further development both in their routine practice and within their quality assurance guidance. **(Recommendation 17.6).** *This was also brought to the attention of the Director of Public Health as commissioner of the 0-19 public health team.*

4.10 Children looked after with additional health needs or disabilities living in Wirral benefitted from regular school nursing support. In one case, we saw that the school nurse assessed the child every 3 months as the child had described feelings of anxiety. The school nurse liaised closely with the child's social worker to address concerns about their emotional wellbeing. Regular review helped prevent escalation of concerns and supported good corporate parenting practice. Evidence of alignment of statutory health assessment activity with education, health and care plans for children with special educational needs or disabilities, however, was relatively limited.

4.11 Health practitioners undertaking review health assessments were not consistently informed about emotional health and wellbeing 'Strengths and Difficulties' (SDQ) scores. This did not enable them to promote holistic care and tracking of changes to children's wellbeing and behaviour. Social workers did not routinely share copies of the SDQ assessment with them. When a child looked after accessed the CAMHS service, practitioners undertaking RHAs did not routinely request information to inform the child's assessment or care plan. **(Recommendation 8.1).**

4.12 Some children looked after were having to wait too long to receive help for their emotional, mental health and behavioural needs. Whilst children and young people in care were 'fast tracked' and assessed within two weeks of referral into CAMHS; some children were waiting a long time before they could access specialist therapeutic interventions. This meant they were not able to access the right help at the time they most needed it. Recognising the need to develop a specialist offer, CWP recently introduced a dedicated 1:1 psychotherapy service operating half a day a week on a pilot basis. Outcomes and impact of the pilot were being evaluated and used to inform future commissioning. **(Recommendation 8.2).**

4.13 Information-sharing between the 0-19 public health team and GPs in assessing risk and tracking outcomes for children looked after was not sufficiently embedded. Practitioners undertaking RHAs were not routinely seeking information from the child's GP to inform their assessment. Records did not show that the completed assessment and health care plans had been shared with GPs. Strengthening communication and the focus on children looked after, particularly school-aged children, would help ensure relevant information about children's health between annual reviews was not missed. **(Recommendation 6.1).** *This was also brought to the attention of the Director of Public Health as commissioner of the 0-19 public health team.*

4.14 Support arrangements for unaccompanied young people seeking asylum were acknowledged as an area of practice to strengthen to promote wider understanding of the needs and risks to this group of young people looked after. Numbers being supported in Wirral were relatively low. The 0-19 team had recently received training on the needs and experiences of young asylum-seekers; but specialist nurses had not yet undertaken relevant training in this area. **(Recommendation 17.7).**

4.15 Safeguarding children practice, including those missing from home, education or care was well-embedded with effective follow up of health risks to children. Local arrangements would benefit from a more explicit focus on PREVENT (the national strategy to help prevent people from being drawn into terrorism). In one case reviewed possible radicalisation had been identified, however, records did not show that risks had been fully explored by the multi-agency team. WCHC managers followed this up immediately with the local authority when inspectors brought it to their attention. **(Recommendation 17.8)**. *This was also brought to the attention of the Director of Public health as commissioner of the 0-19 public health nursing team.*

4.16 The health offer to young people leaving care was good and denoted significant improvements in practice since Ofsted's last inspection visits. Joint health and social care passports co-produced with young people were introduced in January 2019. These acted as a central place to record all relevant health information, including family history and birth records. This meant care leavers did not have to repeat themselves to new health professionals and ensured relevant information about their own health history was readily available. The new passports were well received by young people and were being rolled-out to everyone aged 14 years and older. This approach was helping young people prepare for taking responsibility for managing their future health needs including promotion of healthy lifestyles.

4.17 It is positive to note, that although the children looked after health service was commissioned to support young people up to 19 years of age, the specialist nurses were able to provide on-going support to some young people, on a case by case basis, to ensure their smooth transition into adulthood. This approach recognised the need for additional time to co-ordinate and review handover arrangements for young people with long term conditions or specific health needs.

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 The Independent Chair of the Local Safeguarding Children Board (LSCB), together with Board Members, provided effective challenge and support to the health sector and wider partnership in tackling local priorities. This included shared work to strengthen the early help offer, with increased use of assessment tools to promote wider understanding of risks. Strong promotion of the 'Threshold' tool provided a clear structure and reinforced recognition of safeguarding children accountabilities. Thresholds were increasingly well-understood by frontline health practitioners and helped support timely information sharing about risks to children.

5.1.2 Senior leaders together with designated and named safeguarding professionals had a strong shared vision and strategic direction focused on securing continuous improvement in safeguarding practice. Priorities for improvement included embedding '*Think Family*' approaches; making effective use of relevant screening and assessment tools, with improved reporting of risks and service impact in delivering improved outcomes. Appropriate use of escalation and challenge was evident within the practice of most frontline health practitioners and managers.

5.1.3 NHS Wirral CCG's safeguarding leadership capacity had been very stretched in recent months. This was due to reduced designated workforce availability, combined with increases in complex safeguarding activity and numbers of children looked after. The designated nurse for looked after children carried significant additional workload responsibilities as acting designated nurse for safeguarding children. Further assurance was needed of the capacity of all safeguarding lead roles to ensure the timely delivery of job plans and service development priorities. This would help ensure leadership arrangements were sustainable and delivered in line with intercollegiate guidance '*Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff*' (2019). (**Recommendation 1.1**).

5.1.4 Named safeguarding professionals were visible within their organisations and supported frontline staff and managers with appropriate guidance and tools. For example, action taken by CWP's safeguarding team led to significant improvements in practice in enquiring about the whereabouts and safety of children of parents admitted onto psychiatric wards. Routine use of the safeguarding screening tool enabled ward staff to be more aware of the needs of the whole family. They were working closely with social workers from the point of admission to discharge to promote contact with children in line with their best interests and wishes.

5.1.5 All NHS provider trusts were working to address areas for improvement identified within CQC's regulatory inspections. They had strengthened their internal leadership and were working to continuously raise workforce morale. It was positive to note the progress made by WUTH and WCHC in staff retention and stability in both the adults' and children's ED and the Walk-in Centres. However, as earlier sections of this report identify, there remained gaps in embedding safeguarding systems and information sharing to achieve a consistently high standard of safeguarding practice.

5.1.6 Local area leaders sought to make best use of partnerships to achieve required changes in areas where the quality and availability of local provision was not adequately meeting children's needs. We found leaders were open to learning and were building a culture of collaboration and innovation. The Wirral Health and Care Commission established in April 2018, provided new opportunities to strengthen models of integrated care delivery, share resources and expertise, and progress joined-up service delivery to better meet the diverse needs of its local neighbourhoods. The earlier sections of this report evidence the need for stronger joint working between Walk-in Centres, sexual health, substance misuse and children looked after teams.

5.1.7 Wirral's elected members encouraged and challenged partner agencies in developing a whole-system approach to the delivery of corporate parenting arrangements. The recently established Health Outcomes Task and Finish Group provided new impetus to address some long-standing performance issues in the timeliness and quality of health assessments. Poor performance in the timely completion of initial health assessments remained an area of high risk for Wirral.

5.1.8 Local leaders were actively encouraging creative operational responses to strengthen support to children with complex needs, including those 'on the edge of care'.

Meeting the Needs of Teens- Improving Outcomes

This multi-agency, multi-disciplinary team worked with young people not in education, employment or training. The service provided a 'one stop' approach enabling young people to build their relationship with the most relevant health or care practitioner.

We saw positive examples of nurses working to address unmet physical and mental health needs which in turn helped improve their life chances through being able to sustain tenancies and access work. One young person who had been supported by the teen team stated his life had 'been turned around' due to the support he received from his nurse.

5.1.9 Changes recently made such as the integration of child and adult disability services within CWP aimed to provide simpler and quicker access to support for children and their families. CWP had reviewed and streamlined its care pathways for children and young people awaiting a diagnosis of autism. This had led to a steady reduction in waiting times from initial screening to completion of assessments; with the process now taking on average 8 months compared to 12 previously.

5.1.10 The numbers and waiting times experienced by young people and their families who required help from specialist CAMHS however remained a concern and indicated poor performance against expected waiting times. It was recognised by local leaders that team capacity was inadequate to meet current demand, including for children looked after. Although the new out of hours consultation line had delivered measurable improvements in the early help offer, there remained some critical gaps in meeting local need that commissioners were working to address.

5.2 Governance

5.2.1 Wirral leaders had effective systems to promote the engagement of children looked after in shaping the design and delivery of local services. Good practice was seen in the listening and feedback events for children looked after, 'Involve' work, CAMHS and the 0-19 public health nursing team. Young people said they wanted to access school nurse drop-ins outside of the school environment. In response, the service offered 4 evening clinics in community settings across Wirral.

5.2.2 Governance and reporting of child safeguarding activity was well-established within the CCG and provider trusts. Quarterly assurance visits by the designated nurse combined with performance reporting to the LSCB provided good oversight of themes, trends and service capacity. Self-assessments encouraged challenge and reflection on strengths and areas for improvement. However, there had been limited scrutiny of the activity and performance of GPs and Wirral Ways to Recovery within performance reporting. This meant that the local area had gaps in its understanding of their contribution to safeguarding across the whole system. (**Recommendation 4.1**).

5.2.3 Safeguarding leaders demonstrated a strong drive to strengthening safeguarding practice, ensuring shared ownership and recognition of the root causes of previous failures to safeguard children. Good progress was being made in addressing areas of risk highlighted in local serious case and learning reviews; with appropriate use of audits to check compliance and progress.

5.2.4 Named safeguarding leaders were clear about their agency accountabilities and ensured frontline practitioners were actively contributed to relevant safeguarding meetings. The support provided by CWP to adult mental health practitioners recognised the episodic nature of their involvement and encouraged engagement with children's social care and child health practitioners. The levels of participation and attendance by Wirral Ways to Recovery adult substance misuse practitioners at safeguarding meetings would benefit from stronger management oversight.

5.2.5 The appointment of suitably experienced health practitioners in the MASH ensured strong operational oversight and co-ordination of safeguarding activity within and between diverse organisations and teams. Information-sharing and governance was underpinned by effective partnership agreements and systems; with trusted access to relevant child health and social care records. This denoted open and mature governance arrangements.

5.2.6 Services we visited had appropriate alert systems to flag records where there were child safeguarding concerns or children were looked after. In some cases, additional flags were used that provided a comprehensive picture of the additional vulnerabilities of children or their parents.

5.2.7 Joint working between WCHC and Brook sexual health services was effectively supported through use of a shared electronic record keeping system. This ensured good oversight of young people accessing either sexual health service and provided an overview of previous needs, risks and care interventions to guide ongoing care and treatment.

5.2.8 In sexual health services, there was greater potential to use alerts to inform future service planning and evaluation of outcomes for children. For example, children looked after were flagged on the sexual health service record keeping system if they were known. There was, however, no strategic oversight or review of their access to sexual health services, including the cohort of children in care not accessing such services. **(Recommendation 5.1).**

5.2.9 The use and updating of alerts and coding within GP records also warranted review given issues raised by GPs about not being routinely informed of the changing legal status of children. Although GPs were involved in LSCB-led multi-agency audits; there was limited evidence that audits were used to promote shared understanding of the effectiveness of safeguarding practice and scrutiny of health outcomes for children looked after. Annual audits within primary care was suggested practice within the Royal College of General Practitioners/NSPCC's '*Safeguarding Children Toolkit for General Practice.*' **(Recommendation 11.4).**

5.2.10 The Council's Public Health team recognised the need to strengthen its focus on safeguarding children within contract monitoring arrangements with Wirral Ways to Recovery. A shared action plan had been developed to help strengthen governance, support for and assurance of workforce competencies. This aimed to strengthen opportunities for more integrated working between Wirral Ways to Recovery and the wider safeguarding system.

5.2.11 Wirral Ways to Recovery held daily 'Flash' meetings which included safeguarding issues as a general agenda item. Any issues of concern were also discussed in the weekly internal 'Complex Needs' meeting. These issues in turn were shared as appropriate in multi-agency Complex Needs meetings.

5.2.12 WCHC had recently strengthened its safeguarding governance operational model to provide enhanced support to its Walk-in Centre frontline teams. Daily 'safety huddle' meetings had been implemented. They were used to discuss practice improvements as well as offering advice and guidance on casework.

5.2.13 WCHC and WUTH had significantly strengthened quality assurance of health assessments and care plans for children looked after; with evidence of measurable improvement in the standard of practice of school nurses. It is positive to note that 100% of RHAs were quality assured by either a specialist safeguarding practitioner or by a panel dedicated to this task. Learning was promptly fed back to individual practitioners and proactively supported continuous professional development. Recent performance indicates 81% of RHAs completed by the school nurses and 70% completed by HVs had 'passed.' A similar approach is being taken to check the quality of IHA's undertaken by paediatricians. Performance in the period April 2018 to March 2019 indicated approximately 69% of those reviewed met the required standard.

5.2.14 Quality measures for children looked after however, did not include reference to the specific issues for children with special educational needs or disabilities (SEND) including alignment of practice with priorities outlined in education, health and care plans. This would help to provide a more holistic, co-ordinated approach to meeting need and reviewing outcomes.

5.3 Training and supervision

5.3.1 Overall, most providers achieved the required standards for safeguarding children training in line with intercollegiate guidance *'Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff'* (2019). This was closely monitored and regularly reported on to ensure coverage targets were consistently met.

5.3.2 WUTH's compliance with the level 3 safeguarding children training target of 90% had been consistently exceeded for the last six months. Compliance within children's and adult ED's exceeded 92%. Midwives demonstrated a high level of knowledge and competencies in safeguarding children. Their compliance rate at the time of our review was approximately 97%.

5.3.3 The midwifery preceptorship programme however did not include safeguarding children competencies, including those for unborn babies. This was a gap in current arrangements in helping prepare newly qualified midwives for the high level of knowledge and skill needed to protect unborn and new born babies. **(Recommendation 16.7).**

5.3.4 Over 90% of WCHC's 0-19 public health nursing team workforce had achieved level 3 safeguarding children training. The trust had also invested in regular action learning sets to promote the continuous professional development of its workforce. This helped ensure teams had the range of knowledge and skills needed to effectively discharge their professional accountabilities for safeguarding children.

5.3.5 Coverage of safeguarding children training in the Walk-in Centre workforce was below the trust target. This was reported at 78% at the time of this review. This was due to recent staff turnover. The trust had plans to address this as a priority by offering bespoke training to individual staff whilst they were waiting to access the formal programme of training.

5.3.6 All sexual health staff in Brook received level 3 safeguarding children training including receptionists. WCHC nurses and health care assistants received level 3 and their receptionists received level 2. Both services exceeded the trust target of 90%.

5.3.7 CWP's safeguarding children training compliance for its child and adult mental health practitioners was reported at 92%.

5.3.8 Level 3 training coverage of local GPs was reported at 90%.

5.3.9 Wirral Ways to Recovery staff had attended LSCB training in areas such as domestic abuse and neglect. However, its workforce would benefit from additional safeguarding children training as the current service offer was set at level 2 and was heavily weighted to e-learning. (**Recommendation 19.3**). *This was also brought to the attention of the Director of Public Health as commissioner of adult substance misuse services.*

5.3.10 Supervision, including advice and support was generally easily available to most frontline teams and managers, with strong practice evident in the work of some agencies. Most safeguarding leaders and practitioners responsible for delivering safeguarding children supervision within NHS trusts had undertaken additional externally accredited training to assure their competence and promote a consistent standard of practice in this area.

5.3.11 Staff working within the adults' and children's ED at Arrowe Park hospital had good access to advice and guidance from the trust safeguarding team, including the children's liaison nurse. Group and one-to-one supervision however, was dependent upon the practitioners requesting supervision. When supervision did occur, it was not documented in children's records. (**Recommendation 16.9**).

5.3.12 The midwifery supervision offer was strong. Community midwives and specialist midwives received safeguarding supervision on a one-to-one basis by an NSPCC trained supervisor, every six weeks. Supervision was recorded in detail by the supervisor and shared with the supervisee. The supervision discussion was routinely cross-referenced in the client's records. This supervision supported reflective practice and effective safeguarding responses as demonstrated in cases reviewed.

5.3.13 Safeguarding supervision arrangements for the 0-19 public health nursing team were also well developed and supported effective consideration of risk. Every looked after child, child in need and child protection case was reviewed by a safeguarding nurse supervisor every 3 months. Children's records demonstrated supervision was consistently conducted and actions were clearly documented and promoted strong ongoing oversight of practice.

5.3.14 Sexual health practitioners in WCHC and Brook were provided with group safeguarding supervision monthly as part of the team training days. One-to-one supervision was provided upon request of the individual practitioners following referral to MASH due to safeguarding concerns. Inspectors were told actions were clearly identified on the child's case record but, this was not evident within the sample of cases we reviewed. Stronger supervision of the quality of practice was needed to help build practitioner confidence and competencies as outlined in earlier sections of this report. **(Recommendation 17.9)**. *This was also brought to the attention of the Director of public health as commissioner of sexual health services*

Recommendations

- 1. NHS England together with NHS Wirral CCG should**
 - 1.1 Ensure designated safeguarding leaders have enough capacity to address local priorities.

- 2. NHS Wirral CCG together with the Council's Public Health team, WUTH, WCHC and local substance misuse services should**
 - 2.1 Ensure all children and young people presenting at ED and Walk-in Centres under the influence of alcohol or drugs are appropriately identified and helped.

- 3. NHS Wirral CCG together with the Council's Public Health team, WUTH and WCHC should**
 - 3.1 Ensure health visitors and midwives are clear about joint accountabilities for safeguarding in the ante-natal period.

- 4. NHS Wirral together with the Council's Public Health team should**
 - 4.1 Support GPs and Wirral Ways to Recovery to evidence and provide assurance on their safeguarding children practice.

- 5. NHS Wirral CCG together with the Council's Public Health team and WCHC should**
 - 5.1 Monitor usage and the experiences of children looked after to inform future sexual health planning and evaluation of outcomes.
 - 5.2 Ensure the voice and lived experience of children and young people actively informs analysis of risk within health visitor referrals to children's social care.

- 6. NHS Wirral CCG together with NHS England, WCHC and GP's should**
 - 6.1 Ensure the health needs of children looked after are holistically met through good joint working and information sharing.

7. NHS Wirral CCG together with GPs and WCHC should

- 7.1 Ensure timely identification and support for children and families who would benefit from joint review and early help.

8. NHS Wirral CCG together with the Council, WCHC and CWP should

- 8.1 Ensure information about the emotional, mental health and behavioural needs of children looked after is embedded within health assessments and plans.
- 8.2 Ensure children looked after experiencing emotional and mental health difficulties have timely access to therapeutic support.

9. NHS Wirral CCG together with WUTH should

- 9.1 Ensure children's health and development needs are promptly identified within initial health assessments.

10. NHS Wirral CCG together WCHC should

- 10.1 Ensure frontline practitioners in Walk-in Centres have appropriate guidance, tools and systems for safeguarding children and young people.
- 10.2 Ensure children and young people have a review of risks to their safety and wellbeing when they attend Walk-in Centres.

11. NHS Wirral CCG together with GPs should

- 11.1 Ensure children and young people who are not brought to GP appointments are promptly followed up.
- 11.2 Ensure local GP registration arrangements support a '*Think Family*' approach.
- 11.3 Ensure multi-agency referrals and child protection reports provide clear analysis of risks to children.
- 11.4 Ensure GP safeguarding children records are up to date and appropriately coded.

12. NHS Wirral together with CWP should

- 12.1 Urgently address CAMHS waiting lists and ensure the provision of a timely response to all children and young people requiring emotional and mental health support.

13. The Council's Public Health team together Wirral Ways to Recovery should

- 13.1 Ensure adult substance misuse practitioners are appropriately involved in and contribute child protection planning arrangements.

14. WUTH together with CWP should

- 14.1 Ensure safety risks and environmental safeguards are appropriately identified and available for review to help keep children and young people safe during their stay in hospital.

15. WUTH and Wirral Ways to Recovery should

- 15.1 Ensure information about hospital discharge arrangements for adults who misuse drugs or alcohol is promptly shared to enable timely follow up.

16. WUTH should

- 16.1 Ensure children and young people receive care and treatment from suitably trained medical and nursing staff in line with national guidance for emergency paediatric care.
- 16.2 Ensure young people aged 16-17 years attending ED have their status in law as children fully recognised and that appropriate safeguarding children documentation is used to inform analysis of risks.
- 16.3 Ensure ED practitioners check whether adults have caring responsibilities for children or previous contact with children's social care to strengthen their awareness of risks to children.
- 16.4 Ensure ED referrals to MASH clearly articulate risks in line with local threshold guidance.
- 16.5 Ensure midwives routinely use screening tools with young pregnant women to strengthen vigilance to risk of harms associated with child sexual or criminal exploitation.

- 16.6 Ensure midwifery records clearly articulate the voice and experiences of unborn and new born babies within analysis of wider family roles and relationships.
- 16.7 Ensure its midwifery preceptorship programme recognises the skills required for safeguarding children.
- 16.8 Ensure all initial health assessments for children looked after contains clear information about the children's social and family health history.
- 16.9 Ensure frontline staff in ED can access safeguarding supervision to help embed the required standards of safeguarding children practice.

17. WCHC should

- 17.1 Ensure assessment of parental misuse of drugs forms an integral part of the 0-19 team's safeguarding arrangements and that the impact for children is clearly identified and recorded.
- 17.2 Ensure health visitor records include clear identification and exploration of risks posed by fathers or other adults to the safety and wellbeing of children.
- 17.3 Ensure adult women and men presenting for sexual health support are routinely asked about their parenting history or caring responsibilities to strengthen awareness of any impact for children.
- 17.4 Ensure all injuries to children including those on child protection plans are promptly identified and followed up by the 0-19 public health nursing team.
- 17.5 Ensure child protection reports written by health visitors are of a consistently high standard and provide clear analysis of the voice of the child and their experience of parental care.
- 17.6 Ensure the voice of children and their perspectives are woven into health care assessments of children looked after to provide a holistic picture of their wishes and experiences.
- 17.7 Ensure all relevant practitioners have suitable training in assessing and responding to the health needs of young people seeking asylum.
- 17.8 Ensure all frontline staff are knowledgeable about their professional accountabilities for identifying and recording risks to children and young people who may be at risk of exploitation through radicalisation.
- 17.9 Ensure sexual health staff and managers have access to safeguarding supervision to provide challenge and support in driving improvements in the quality of practice.

18. CWP should

- 18.1 Ensure all referrals to MASH are of a consistently high quality to enable prompt decision-making in response to clearly articulated concerns.

19. Wirral Ways to Recovery should

- 19.1 Review the effectiveness of its *'Think Family'* team to provide a clear picture of its impact in supporting improved outcomes for children.
- 19.2 Ensure frontline teams are familiar with and achieve the standards of practice required in submitting reports to child protection conferences.
- 19.3 Ensure its safeguarding children training offer effectively equips its workforce for complex safeguarding children work.

20. WCHC together with Brook should

- 20.1 Ensure all young people under 18 years have their vulnerability and risk of exploitation clearly assessed with prompt sharing of concerns and engagement in child protection activity alongside other relevant agencies.
- 20.2 Ensure all MASH referrals are clearly recorded on young people's records to enable ongoing tracking of risk and of multi-agency actions.

Next steps

An action plan addressing the recommendations above is required from NHS Wirral CCG within **20 working days** of receipt of the final 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.