

Review of health services for Children Looked After and Safeguarding in Blackburn with Darwen

Children Looked After and Safeguarding

The role of health services in Blackburn with Darwen

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CCGs included:	Blackburn with Darwen CCG
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Contents

Summary of the review	3
About the review	3
How we carried out the review	4
Context of the review	4
The report	7
What people told us	8
The child's journey	9
Early help	9
Children in need	12
Child protection	14
Looked after children	17
Management	21
Leadership & management	21
Governance	24
Training and supervision	27
Recommendations	31
Next steps	34

Summary of the review

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

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

About the review

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

- The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.
- The focus was on the experiences of looked after children and children and their families who receive safeguarding services.
- We looked at:
 - the role of healthcare providers and commissioners.
 - the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
 - the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.
- We also checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, *Working Together to Safeguard Children 2018*.
- Where we found areas for improvement in services provided by NHS but commissioned by the local authority then we will bring these issues to the attention of the local public health team in a separate letter.

How we carried out the review

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

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

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

In total, we considered the experiences of 79 children and young people.

Context of the review

Blackburn with Darwen is a unitary authority to the east of Lancashire, in the north west of England. It comprises two parliamentary constituencies and 51 local authority wards.

The population of Blackburn with Darwen was 148,772 in 2017 (*JSNA, 2018*), 28.5% of which [42,400] were children and young people under 20-years-old. This is higher than the England average (*PHE Child Health Profile, 2019*).

Blackburn with Darwen comprises of a diverse population with 28.6% of the total population and 54% of school aged children [5-19-years] originating from black and minority ethnic (BME) groups. The most prevalent ethnic origin after white-British is South Asian–Indian and Pakistani. This is significantly higher than the England average (*JSNA, 2018*).

Blackburn with Darwen is one of the 20% most deprived unitary authorities in England, with 21% of children and young people living in low-income families (*PHE Local Authority Health Profile, 2018*). In a snapshot taken in September 2017 however, it was estimated that 39.5% of children and young people were living in poverty (*JSNA, 2018*).

Children in Blackburn with Darwen are generally less ready for school than their peers nationally, with 66% of children in 2017 achieving a good level of development by the end of the Early Years Foundation Stage (EYFS), which is lower than the England average. Children eligible for free school meals achieve less well than their peers, although the difference is slightly better than the England average (*JSNA, 2018*).

There has been an average of nine infant deaths (under 1-year-old) and nine child deaths (1-17-years-old) in Blackburn with Darwen each year since 2015. The rate of infant mortality between 2015-17 was 4.3 per 1,000 live births which is similar to the England rate. Child mortality however, was 24.0 per 100,000 for the same period, which is significantly worse than the England rate of 11.2 and is the fourth highest in the country (*PHE Child Health Profile, 2019; JSNA, 2018*). The pan-Lancashire child death overview panel (CDOP) is hosted by Lancashire LSCB on behalf of Blackburn with Darwen, Blackpool and Lancashire LSCBs.

There are more children and young people in Blackburn with Darwen considered in need of additional services or protection when compared nationally. In 2017, 464 per 10,000 children and young people were referred to, or receiving support from, children's social care, with the biggest reason being abuse or neglect. This is significantly higher than the England average of 330 per 10,000 (*JSNA, 2018*).

The number of children and young people looked after by Blackburn with Darwen local authority is significantly higher at 98 children per 10,000 compared with 64 per 10,000 in England (*PHE Child Health Profile, 2019*). Most children are placed close to their communities and in stable placements (*Ofsted, 2017*).

The rate of emergency hospital admissions in Blackburn with Darwen is significantly higher than the England average across all stages of childhood and has the highest rate of admission for 10-14-year-olds in England (*JSNA, 2018*).

Alcohol related hospital admissions of young people under 18-years-old in Blackburn is similar to the England average. Admissions relating to other substances however, are significantly higher in Blackburn compared with the England average at 146.2 compared with 87.9 per 100,000 (*PHE Child Health Profile, 2019*).

Hospital admissions relating to mental ill health and self-harm are both similar to the England average (*PHE Child Health Profile, 2019*).

In 2017, there were significantly fewer first time entrants into the youth justice system in Blackburn compared with the England average (*PHE Vulnerable Children and Young People, 2019*).

Blackburn and Darwen local authority are expected to take a maximum of 350 asylum-seekers and/or refugees at any one time, although this was exceeded in 2018 with 377 people placed (*JSNA, 2018*). At the time of the review, we were told that Blackburn with Darwen local authority had received five unaccompanied asylum-seeking children (UASC) during the previous 12-months.

Commissioning and planning of most health services for children are carried out by Blackburn with Darwen CCG and Blackburn with Darwen Council.

Commissioning arrangements for looked after children's health are the responsibility of Blackburn with Darwen CCG. The CCG safeguarding team directly commissions an enhanced service for looked after children, care leavers and safeguarding. The named nurses for looked after children and safeguarding children are provided by Lancashire Care Foundation Trust (LCFT) but have a commissioned responsibility to provide advice and training for the whole health economy across Blackburn with Darwen.

The designated doctors for looked after children, care leavers and safeguarding are commissioned by the CCG and are responsible for the Pennine footprint which includes Blackburn with Darwen. The designated doctor for looked after children provides two programmed activities (PA) on a weekly basis and the designated doctor for safeguarding children provides three PAs weekly.

There is a head of safeguarding/designated nurse for looked after children and safeguarding function which is currently a job shared role within the CCG. To support the designated functions there is a deputy designated nurse and two band 7 specialist safeguarding practitioners within the CCG. The named GP for Blackburn with Darwen provides three PAs monthly.

Acute hospital services are provided by East Lancashire Hospital Trust (ELHT). The named nurse for safeguarding and the named midwife for safeguarding form part of the safeguarding team within ELHT.

Health visitor services are commissioned by Public Health (Blackburn with Darwen Council) and provided by Lancashire Care NHS Foundation Trust (LCFT).

School nurse services are commissioned by Public Health (Blackburn with Darwen Council) and provided by LCFT.

Contraception and Sexual Health (CASH) services are commissioned by Public Health (Blackburn with Darwen Council) and provided by LCFT. LCFT also have a sub-contract with Brook Advisory Service to provide sexual health services for young people under 25-years-old.

Child and Adolescent Mental Health Services (CAMHS) are provided by East Lancashire Children's and Adolescents Service (ELCAS) ELHT. The Children's Psychology services are provided by LCFT.

Specialist facilities are provided by LCFT.

Young person's substance misuse services are commissioned by Public Health (Blackburn with Darwen Council) and provided by Change, Grow, Live – Go2.

Adult substance misuse services are commissioned by Public Health (Blackburn with Darwen Council) and provided by Change, Grow, Live – Inspire.

Adult Mental Health services are provided by LCFT.

Our review considered the findings and recommendations from previous inspections, including those undertaken by Ofsted that relate to health services operating in the local area.

The report

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

What people told us

A woman on the postnatal ward at the East Lancashire Hospitals NHS Trust (ELHT) told us:

“The maternity care that I’ve received has been fantastic, hospital stay following a [caesarean] section has been good, and all staff have been very supportive”.

A woman on the postnatal ward at ELHT whose baby was in NICU (neonatal intensive care unit) told us:

“Care on the antenatal ward whilst in the early stages of labour wasn’t always good - communication from staff. Midwives would say there would come back but then didn’t – the ward was busy. Postnatal care is much better.”

The parent of a young person using mental health services told us:

“Everything is good. If it wasn’t for (ECLAS) and their service, we wouldn’t be where we are now; it’s all down to the support in place.”

The parent of a young person with autism told us:

“I’m speechless in terms of the support they (ELCAS) provide, they are helpful, they really help him with one-to-one support and we are happy.”

A young person accessing Go2 for their substance misuse told us:

“This is an absolutely amazing service. No-one judges you and they are always there for you”.

A parent receiving support from Inspire for their substance misuse told us:

“All I have to do is to pick up the phone and I can get the help I need.”

The foster carer of an unaccompanied asylum-seeking young person told us that the young person in their care has received ‘good treatment and care’ from a variety of health services. They have made good progress, are in education and have made friends.

The child's journey

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

1. Early help

1.1 The most vulnerable pregnant women who had booked to receive midwifery care from East Lancashire Hospitals NHS Trust (ELHT) benefited from a specialist enhanced midwifery service, which included the allocation of a named midwife to provide continuity of care. The team included perinatal mental health practitioners with access to specialist substance misuse midwives. This enabled pregnant women to access specialist support services when required, to assess and meet their needs and those of their unborn child.

1.2 Pregnant women without a known vulnerability, did not benefit from the allocation of a named midwife to provide their antenatal care. This meant that women did not receive continuity of carer, which increased the risk of missed opportunities for early identification of need, risk and vulnerability. Leaders acknowledged that continuity promotes better outcomes for pregnant women and subsequently, their babies. We recognise that the implementation of 'Better Births' had begun in ELHT, with the service developing a vision for continuity for women before, during and after the birth of their baby. [Recommendation 2.1](#)

1.3 Pregnant women receiving care from midwives at ELHT, were not routinely offered home visits during their pregnancy. This limited the opportunity for the early identification of previously unidentified risk through assessment of the home environment and circumstances.

1.4 Vulnerable pregnant women experiencing mental ill-health could access specialist support and intervention throughout pregnancy including pre-birth planning, until their child reached one-year-old. The launch of the perinatal mental health service provided by Lancashire Care NHS Foundation Trust (LCFT) was highly valued by practitioners within the adult mental health service and the trust's safeguarding team. There were robust safeguarding screening processes within the perinatal mental health service to enable early identification of risk and effectively safeguard the unborn or newborn infant.

1.5 Pregnant women in Blackburn with Darwen benefited from an antenatal assessment completed by a health visitor in LCFT's 0-19 public health nursing service. Women were offered a home visit from the 30th week of their pregnancy onwards. In addition to providing an opportunity to assess the home and family circumstances, this enabled the health visitors to identify safeguarding concerns at the earliest opportunity, share information of concern with midwives, and be better informed of any challenges faced by the family to plan effective care.

1.6 The youngest children in Blackburn with Darwen benefited from effective and holistic assessment of need by health visitors in LCFT, through family health needs assessments (FHNA) and ages and stages questionnaires (ASQ). Families categorised as requiring a universal level service had the FHNA commenced in pregnancy and reviewed at a variety of contacts throughout the early years. The assessments used the 'risk sensible model' to support effective articulation and understanding of risk. This was evidenced via data reporting and through the review of children's health records. Consequently; babies, children and families were able to have their needs identified and assessed, and appropriate intervention provided.

1.7 Record-keeping by health visitors was comprehensive and clearly captured the voice of the child. We saw good use of templates to prompt the practitioner to document appropriate and necessary information in the electronic care records (ECR). The ECR contained family and social history, clear identification of risks as well as consideration and exploration of adverse childhood experiences (ACEs). The risks were weighted to ensure the child was given the correct level of support. An analysis of the risks was undertaken and clearly articulated to include any protective factors which described the impact on the child. This meant that all practitioners accessing the records were able to get a picture of the child's experiences of daily life to inform their plan of work with the family.

1.8 We were told that all health visitors are proficient in newborn behavioural observation (NBO) techniques. Some health visitors are also trained in completing the newborn behavioural assessment scale (NBAS) which provides a more in-depth assessment and outcome and was used for those at higher risk of infant mental ill-health and attachment difficulties. This allowed the health visitors to better represent the voice of the child through observation of their physical interactions, which was clearly demonstrated in records.

1.9 The co-location of midwives, health visitors and school nurses created opportunities for better information sharing. Clinics were held in children's centres in the heart of communities, which led to good attendance by families. Named health visitors were linked with GP practices, and attended vulnerable families' meetings when invited, although some GPs were less engaged in joint working. The positive impact from the co-location of universal services however, was not evident in the children's records, due to silo working practices. *This will be brought to the attention of the public health commissioners. **Recommendation 6.1***

1.10 Children and young people generally had access to a comprehensive school nursing service. The school nursing offer included drop-in sessions for primary and secondary school aged children and each school had a named health practitioner as a point of contact. This meant that children could access support with emerging needs in a timely manner. Furthermore, each school was offered a school health assessment to profile the needs of the school on a population level, which helped to identify themes and trends.

1.11 Children and young people under 16-years-old who attend the emergency department (ED) at ELHT benefited from a separate provision to adults. The children's waiting area was observable to staff to ensure ongoing monitoring including parent-child interaction, in addition to parents also being encouraged to highlight to staff if any signs of deterioration. There were paediatric nurses and senior adult nurses trained in paediatric life support on all shifts. A senior nurse and consultant undertook two-hourly ward rounds in all areas of the ED to identify early signs of deterioration and assess risk to children and young people. This strengthened safeguarding processes within the ED to ensure children and risks to children and young people's safety were reduced.

1.12 Children and young people from minority backgrounds had their diverse needs effectively explored and considered in health services. Blackburn with Darwen is an area with a large population from South Asian origin, yet this was not reflected in the ethnicity of service users accessing sexual health services. Brook carried out a consultation with Asian young men to understand why they did not access services and what could be done to increase accessibility. This work resulted in an increase in the number of young people from Asian origin accessing services and meant that risks to this ethnic minority group from unmet sexual health needs were reduced.

1.13 Young people from the Lesbian, Gay, Bisexual and Transgender (LGBT) communities benefited from regular support appropriate to their needs. For example, Brook sexual health practitioners facilitated a peer support group within the community on a weekly basis. This meant that these often-marginalised young people were provided with a safe space to gain support and advice specific to their needs.

1.14 Young people with sexual health needs benefited from coaching from Brook sexual health services. This has evaluated well with young people and has had a positive impact on their self-esteem, promoted positive behaviour change as well as improved their sexual health.

1.15 Young people aged 16-years and under accessing sexual health services provided by both LCFT and Brook, and those of any age considered to be vulnerable, were supported through an additional, detailed risk assessment. The risk assessment, which incorporated 'Spotting the Signs' child sexual exploitation (CSE) assessment tool, had mandatory fields which supported the practitioner to consider wider risks and vulnerabilities. Such risks included female genital mutilation (FGM) and substance misuse, as well as exploitation. A separate safeguarding proforma was completed for young people with significant safeguarding concerns which was closed when concerns were reduced. This meant that the most vulnerable young people had their holistic needs effectively explored, including analysis of impact of their circumstances and behaviours on wider health and wellbeing.

1.16 Good attention was paid by East Lancashire Child and Adolescent Service (ELCAS) to ensuring that families of children and young people with mental ill-health received targeted and culturally sensitive support by ELCAS to help strengthen their parenting capacity through the delivery of specific parenting courses.

1.17 The approach to the early identification of the vulnerable hidden population who are dependent on alcohol or drugs was well developed in substance misuse services provided by Change, Grow, Live (CGL) in Blackburn with Darwen. Targeted work with sex workers, members of minority ethnic groups, and with primary care services was helping to build confidence and promote steady improvement in the access of local services. Good progress was seen in the increase in numbers of young people from black and minority ethnic (BME) backgrounds who are now using the young person's Go2 service. The increase noted was from 15 young people in 2017-18 to 30 young people in 2018-19 accessing the service.

1.18 The 'Think Family' approach was embedded in the risk assessments in LCFT's adult mental health services, with children being considered at the first contact. Children were identified within the adult service users' record. However, there was no evidence in records of ongoing consideration to 'Think Family' after the initial contact, nor any analysis of risk from parental mental ill-health on children. This meant that the impact on the child or young person were not always fully explored, articulated or shared with appropriate services. Furthermore, partners were not routinely considered or documented within records. In one case reviewed, a service user who had young children was known to have a new partner however, no professional exploration or consideration of risk this may pose was evident in the record.

[Recommendation 3.1](#)

2. Children in need

2.1 Strong transition arrangements were in place for children moving from the health visiting service to the school nursing service. We saw evidence in records where health visitors had liaised with school nurses to perform comprehensive transfers. The use of the same electronic record system enabled this to be seamless. This meant that all practitioners working with a child held the most up to date information relating to their needs at the time of transfer to school.

2.2 School aged children requiring their health needs to be formally assessed by a school nurse, benefited from comprehensive and sufficiently detailed health needs assessments and were reviewed within appropriate timescales. Clear analysis of risk to the child was demonstrated in records examined. This meant that children and young people's risks were understood, clearly articulated and effective consideration was given to the impact for the child or young person, to inform effective care planning.

2.3 There was a linked health visitor and school nurse working in partnership with a women's refuge, for families affected by domestic violence and abuse. Health practitioners liaised with refuge staff weekly, to share information appropriately on the needs and risks to children. This meant that health practitioners worked in partnership to support children and families who have experienced domestic violence and abuse, to reduce the risk of ongoing harm to those affected.

2.4 Children and young people attending the ED at ELHT and the nurse-led non-serious injuries' unit, did not have their holistic needs considered. There was a lack of safeguarding screening prompts incorporated into assessment paperwork. There was an over reliance on individual practitioners' professional curiosity to explore safeguarding risks. Exploration and analysis of risks was not evident in records reviewed. This restricted the opportunity to identify children in need of additional support and intervention, and hindered effective information sharing with multi-agency partners to keep children and young people safe. **Recommendation 9.1**

2.5 Conversely, comprehensive safeguarding assessments were completed on the paediatric assessment unit in ELHT by a specialist paediatrician. In records reviewed, the assessments were child-centred with clear analysis of risk to ensure safety planning to safeguard children and young people.

Two children who seemingly had no connection, were admitted to the paediatric unit in ELHT at different times. There was a significant safeguarding history between the two families, which was unknown to the staff upon admission. The staff within the paediatric unit took immediate action to assess and manage the situation. There was clear evidence within both children's records that a comprehensive risk assessment was undertaken, which included good multi-agency liaison and appropriate information sharing. Appropriate measures were put in place to mitigate the risks and safeguard both children and their families.

2.6 Children attending ELHT in mental health crisis benefited from initial mental health support whilst awaiting specialist intervention. There were mental health practitioners based within the emergency department as well as a designated room on the paediatric unit for children and young people experiencing mental health crisis. This ensured a swift response to assess risk and respond to immediate health and well-being needs. However, no evidence was seen in records of environmental risk assessments being carried out to determine risks to safety from ligature points for example. **Recommendation 2.3**

2.7 Young people aged 16-17-years who accessed services provided by ELHT were treated as adults. There were limited measures in place to ensure the safety of these young people. In one case reviewed, a vulnerable looked after young person attended the ED in ELHT twice within a 24-hour period, in mental health distress. There was a lack of consideration about the age and vulnerability of the young person, and there was no comprehensive assessment or analysis of risk. This resulted in the young person not having their needs met or their safety ensured. **Recommendation 2.4**

2.8 Children and young people experiencing mental ill-health have timely access to mental health support from ELCAS. Waiting times were short and continue to improve, with most children and young people being seen for assessment within three-and-a-half-weeks of referral. The average length of wait from referral to treatment was six weeks. This meant that children and young people were able to receive appropriate treatment to improve their mental health and emotional well-being early to reduce the risk of deterioration.

2.9 Practitioners and managers within ELCAS were alert to wider concerns where children and young people were not brought to appointments and worked to both prevent clinic appointments being missed and to promptly follow up young people to promote their continued engagement. Data provided indicates a 'Was not brought (WNB) rate of 9 per cent which compares well with other similar services. Support was provided in a range of settings, with flexibility to provide home visits when this was required.

2.10 Young people who were not brought to substance misuse appointments were followed up with vigilance. Processes to respond to missed appointments had been strengthened in the light of learning from serious case reviews. This prevented vulnerable young people who had difficulty in engaging with support services from being discharged without support.

2.11 Young people who used alcohol or other substances could receive support for their sexual health and substance misuse needs in one place. Brook and CGL's Go2 – the young persons' substance misuse service, offered a joint clinic. This improved accessibility for the most vulnerable young people and responded holistically to young people's risk-taking behaviours.

3. Child protection

3.1 A multi-agency pre-birth pathway encouraged midwives to submit referrals into the multi-agency safeguarding hub (MASH) from early pregnancy, although we did not see evidence of consistent adherence to the pathway by midwives. There is an incorrect assumption that children's social care will not accept referrals until a pregnant woman reaches 16-weeks' gestation. This may prevent additional support and assessment being offered at the earliest opportunity. **[Recommendation 2.2](#)**

3.2 Women who have been subject to female genital mutilation (FGM) are identified well through effective practices of routine enquiry that are well embedded into maternity documentation in EHLT and sexual health documentation in LCFT and Brook. A clear pathway for midwives and nurses to follow, and the prompts on templates evidenced in records reviewed ensured that midwives and nurses were applying the same thresholds when assessing potential risks.

A young woman attended the sexual health service with her husband for routine contraception. She had been in the UK for less than a year and had very young female children. The woman was appropriately seen without her husband until the end of the assessment and an interpreter was used throughout the appointment. Through sensitive questioning around the routine enquiry of FGM, the woman disclosed she had undergone FGM as a young child. The 'Think Family' approach was evident in the records, including assessment and analysis of risk to the children. The sexual health nurse acted swiftly and appropriately to ensure that multi-agency partners were aware, to safeguard the children.

3.3 Assessment of risk in health visiting documentation was supported by specific, measurable, achievable, realistic, and time-bound (SMART) action plans, which were followed-up. Where applicable, specific toolkits were also used such as the child neglect toolkit. Records demonstrated that when invited, health visitors attended multi-agency meeting such as child protection conferences. Minutes and plans were stored in the child's records and any required actions were documented, completed and followed-up.

3.4 Other health services across Blackburn with Darwen however, did not routinely receive minutes or plans from child in need meetings or child protection conferences when they had been invited to contribute, and did not have a robust system for follow-up. Records were therefore often incomplete, and it was not always clear how children, including unborn babies, were being protected and safeguarded appropriately. [Recommendation 6.2](#)

3.5 The child protection information system (CPIS) was implemented within the children's (ED) and maternity department at ELHT when women attended unbooked, and at the nurse-led non-serious injuries unit. This process enabled staff to gather information about children's safeguarding status when they are looked after or subject to a child protection plan. However, in records we reviewed, there was limited evidence demonstrating how this safeguarding information had been used to contribute to the clinicians' exploration of risk or decision making. [Recommendation 9.2](#)

3.6 The non-serious injuries' unit had recently implemented an electronic record, but this was only used to document demographics. Staff reported that they did not routinely notify other professionals such as the child's GP of the attendance of the child or young person. This lack of reporting meant the primary care providers did not have a full picture of the child or young person's needs and risks. The service immediately implemented a change in practice in response to this review, to ensure that GPs, health visitors and school nurses are routinely informed of all future attendances.

3.7 There was a paediatric liaison service to facilitate effective information sharing with universal services of children and young people who attended the ED at ELHT. Clinicians were required to complete a paediatric liaison form to notify health visitors and school nurses in the 0-19 public health nursing service at LCFT. However, not all emergency attendances were shared with relevant health professionals due to a criteria system. This prevented staff in universal services from having oversight of the child's health needs or changing risks within the family. *This will be brought to the attention of the public health commissioners.* **Recommendation 9.3**

3.8 Referrals from a variety of health services to the MASH were of inconsistent and often poor quality. Of eight referrals reviewed, two captured the voice of the child and only one demonstrated analysis and impact of risk. This limited the opportunity for professionals within the MASH to make informed and timely decisions about the most appropriate action required to safeguard the child. *This will be brought to the attention of the public health commissioners.* **Recommendation 7.1**

3.9 Safeguarding practice within primary care was under-developed and often weak. There were no safeguarding templates within the electronic record system used by GPs in the practices we visited. There was an over reliance on professional curiosity to identify and screen for potential risk to children and young people. This meant there were missed opportunities and a lack of assurance that children received effective risk assessment and intervention to keep them safe.

One GP informed inspectors that they worked in a very deprived area with many families having complex safeguarding needs. However, despite working in the area for many years, the GP had only completed a 'handful' of referrals. This demonstrated how GPs were not part of the multi-agency network to support and safeguard children and young people. Another GP was unaware of any area wide resources provided by the CCG to support safeguarding practice. This lack of standardised practice by the primary record holder meant that risks to children and young people may not always be identified, understood, or appropriately responded to. **Recommendation 7.1**

3.10 Children, young people, parents and carers accessing health services in Blackburn with Darwen did not experience a co-ordinated approach to care. There was a lack of effective joint working and information sharing between services and agencies. GPs were not routinely invited to contribute to safeguarding processes including MASH assessments, strategy discussions or child protection conferences. GPs therefore did not have the full picture to inform the care they provide to meet the needs of the need effectively. Sexual health practitioners were also not invited to contribute to child protection conferences by way of report or attendance. This increased the risk of multi-agency decisions being made without complete health information. Furthermore, in cases examined in midwifery and adult mental health services, where multi-agency involvement was known, there was no evidence of effective joint communication. This silo working often led to services not holding accountability when other services were involved with a family. *This will be brought to the attention of the public health commissioners.* **Recommendation 6.3**

3.11 Case records kept by CGL provided a clear picture of the voice and experiences of children and young people, with a strong 'Think Family' focus underpinning practice. CGL's Inspire routinely provided safe storage boxes and additional checks were made of home circumstances where adults had caring responsibilities for children. Child protection documentation clearly articulated and analysed risks to children and young people and provided a child-centred focus what needed to change to reduce risks of harm. CGL practitioners were actively engaged in a range of child safeguarding forums and records reviewed demonstrated a holistic approach to meeting needs.

Young parents aged 17 and 20 years who were both previously in care had been using illicit drugs for several years. The young couple accepted the offer of substance misuse support when the young woman discovered she was pregnant. There were issues of domestic abuse and high usage of cannabis at the time of referral. Their unborn baby was made the subject of a child protection plan given concerns identified about their tolerance of domestic abuse within the relationship and the minimisation of risk of harm from use of illicit drugs. An early referral to the specialist midwife was made with regular follow up support provided throughout the pregnancy including joint visits with the young person's substance misuse practitioner. Both parents researched and were open to learning about baby brain development and demonstrated a strong shared commitment to getting it right for their baby. The new born remains in their care as they continue to build their parental capacity through placement in a mother and baby home with ongoing contact and support from the CGL team.

3.12 In response to learning from a serious case review, adult mental health managers from the Community Mental Health Teams regularly attend social care transition meetings to enable contribution to multi-agency decision making in order to support consistency of care across adult and children's social care services and to support keeping children and young people safe.

4. Looked after children

4.1 A strong child and young person-centred approach was the basis for the work of looked after children's health practitioners. This included taking care to effectively engage young people and to identify and co-ordinate the support they need to address their individual needs.

4.2 The local health offer for looked after children and care leavers was well-developed and recognised the complexity and diversity of children and young people's needs. Specialist looked after children's health practitioners were vigilant to the impact of previous adverse childhood experiences (ACEs) and were actively engaged with a range of partner agencies to help reduce health risks and promote safety and wellbeing.

4.3 Managers reported positive recognition of the equality and diversity needs of looked after children, including unaccompanied asylum-seeking children (UASC), with good access to appropriate interpreting and translation services. Looked after children's health practitioners reported effective joint working with the youth offending team (YOT) as well as health practitioners supporting children who were disabled, including those with education, health and care plans (EHCP).

4.4 Children and young people coming into care did not benefit from a timely assessment of their health needs. Only nine percent of children and young people received their initial health assessment within the statutory timescales of 20-days from becoming looked after in the last quarter, which was a slight improvement from three percent. Consequently, challenges remain with the timely scheduling and completion of review health assessments for the looked after children's health practitioners in LCFT. Blackburn with Darwen CCG and ELHT are aware of the need to improve the performance and an action plan has been developed, although the delivery is in its infancy and improvements in performance are not happening quickly enough for children and young people. **Recommendation 2.5**

4.5 The quality of initial health assessments for looked after children was variable. Assessments we examined were not all fully completed and demonstrated limited consideration of important aspects of young people's health. One assessment did not contain sufficient information to show effective exploration of the child's physical and dental health or education history. This meant that assessments did not always accurately reflect the health needs of children and young people to inform an adequate health action plan that would meet need and improve health outcomes for those most vulnerable. We acknowledge however, that there had been an improvement in the quality of assessments completed for 16-17-year-olds for whom the process had recently changed. **Recommendation 2.5**

4.6 Children who were new to care did not consistently have their health needs and interventions informed by a complete family health history. Initial health assessments we reviewed did not always provide a clear picture of the health of birth parents or siblings, which may have been relevant to the future health needs of the child or young person. We acknowledge that this information would require consent, but we did not see evidence in assessments we reviewed that consent had been sought. This also impacted on the quality and effectiveness of the health action plans. However, the recording of parental health histories for children and young people at pre-adoption was stronger. **Recommendation 2.5**

4.7 The quality of record-keeping for looked after children by the 0-19 public health nursing service in LCFT was inconsistent between the different parts of the service. Looked after children under five-years-old who required review health assessments had them completed by health visitors generally in a timely manner, with less than six percent of children waiting longer than the statutory six-months. The assessments were conducted at the home where the child was residing and involved the foster carers. A quality checklist was consistently used for quality assurance purposes. The completed assessments were reportedly routinely shared with all the relevant professionals involved with the child including the looked after children's health practitioners. Records in the three GP practices visited however, did not have health assessments attached.

4.8 Conversely, although timeliness was good with 94% of children and young people having the review health assessment completed within 12-months, those completed by school nurses did not always have the demographic information accurately completed or updated as required. Leaders and practitioners told us that they were not permitted to change the details recorded in section A of the review health assessment, despite often finding errors. This gap was not identified as an area for improvement in the quality assurance process and meant that practitioners did not always have accurate information or get a full overview of the children and their backgrounds. Furthermore, equality and diversity information such as religion, ethnicity and language, was not always known, explored or considered. *This will be brought to the attention of the public health commissioners.* **Recommendation 3.2**

4.9 The risk assessment tool completed by the health visitor for looked after children in two of the cases we tracked, demonstrated good exploration of parental risks. The risk sensible model was used, relating to the reasons for the children becoming looked after. In a further four records reviewed for looked after children the quality was not as strong. Records were often incomplete with minutes and plans, and details of multi-agency professionals involved with the child or young person missing. *This will be brought to the attention of the public health commissioners.* **Recommendations 3.3 and 6.2**

4.10 Looked after children and young people had a choice of where they were seen for their health assessments. Acting on feedback from young people in response to concerns about the location of the sexual health clinic for example, a more appropriate location was secured that provided more privacy. Children and young people were seen alone or with a supportive person of their choice. There was good co-ordination of support for looked after children and care leavers who were pregnant, with prompt action taken to ensure the GP, midwife and school nurse were informed of the looked after status and vulnerabilities, and available to provide additional support.

4.11 Good attention was paid to ensuring the emotional well-being and mental health needs of looked after children were recognised and effectively responded to. Children and young people in Blackburn with Darwen who did not meet the threshold for specialist mental health support from ELCAS, could access a specialist emotional wellbeing service through the REVIVE team. REVIVE comprises mental health and social care professionals offering consultation to staff working with children and young people, and in some cases undertook direct work. We saw evidence in two cases that this service had been offered and accepted, and for one young person direct support was provided regarding risk taking behaviours, which led to a referral to Forensic CAMHS. This meant the young person was supported to find alternative strategies to reduce the risks to themselves and their peers. Furthermore, the strengths and difficulties questionnaire (SDQ) process was embedded within review health assessment processes and ensured a strong shared focus on the emotional and mental health of children and young people.

4.12 The service specification for LCFT looked after children's team provided a focus on identifying and supporting the health needs of care leavers, through the routine provision of health summary letters. It was documented that 100% of care leavers had received a letter but we were not able to see any in records to review the quality.

4.13 The offer for looked after children and care leavers from CGL's Go2 is strong. Records demonstrated effective joint working with partner agencies including the youth justice service and staff from local authority children's homes. There was also evidence of joint working with practitioners for children and young people who were at risk of exploitation or were missing from home or care. Contact arrangements for mothers whose babies were taken into care pending the outcome of court decisions, were sensitively informed by guidance from the specialist substance misuse midwife to encourage skin-to-skin contact and ongoing breastfeeding as appropriate to the best interests of the child and strengthening of parental capacity.

A mother accessing substance misuse support had been misusing drugs and alcohol for many years. She had her previous children removed from her care and was determined to change things in her life through accepting support when she became pregnant. The support she received from the Inspire team including the co-located specialist midwife, ensured shared understanding, management and monitoring of her and her baby's safety. This mother has abstained from illicit drug use and is working to access additional training to enable her to have greater choice and control in her future. Her baby remains in her care.

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 safeguarding teams within ELHT and LCFT provided strong safeguarding leadership and support for acute and community staff. The team in ELHT provided a duty safeguarding practitioner every week-day for the trust, and a paediatric ward round was attended daily. The LCFT safeguarding team also provide a duty nurse every week day for safeguarding advice and consultancy. Regular audits of routine enquiries into domestic abuse by midwives were undertaken to ensure standards were maintained and highlighted where further training may have been needed. The safeguarding nurses were involved in strategy discussions and had management oversight of all safeguarding referrals to the MASH, although the referrals we reviewed were of poor quality which indicates that improved training in the completion of referrals is needed.

A safeguarding database for vulnerable children and young people was also maintained, including the recording of information about domestic abuse and child sexual exploitation. There was an effective process in place whereby all police notifications of domestic incidents involving families with children were shared. The safeguarding team reviewed these and disseminated them to the appropriate clinician for follow-up action. These systems reduced the risk of important information being missed, meant the appropriate practitioner was notified of incidents, and ensured that the safeguarding team had oversight of practice.

5.1.2 Children, young people and families who were referred to the multi-agency safeguarding hub (MASH) and progressed to assessment, benefited from an effective health contribution to the process. Daily cover was provided by appropriately skilled and experienced, specialist safeguarding practitioners. These practitioners could access all children's health records from within LCFT. Other health professionals identified as being involved with the child, were contacted via telephone for further information.

However, there was a lack of a consistent approach to requesting information from primary care. GPs were not routinely invited to contribute to MASH assessments, which prevented effective decision making based on holistic health information. Furthermore, GPs were not always notified when a MASH referral had been received, which meant that GPs were not in possession of all relevant information to inform decision making regarding appropriate actions or care and treatment.

[Recommendations 6.1, 6.2 and 6.3](#)

5.1.3 Capacity within the school nursing service to fully meet the needs of school-aged children was a challenge. There was a vacancy rate of 25% which leaders and practitioners told us impacted upon the team's ability to always fulfil all aspects of their role in a timely manner. Caseloads were higher than the national average which also meant that not all school nurses were accessing safeguarding supervision sessions due to time constraints. *This will be brought to the attention of the public health commissioners. [Recommendations 3.7 and 8.1](#)*

5.1.4 The oversight by school nursing team within the 0-19 public health nursing service of children and young people who were home educated was under-developed. Performance data for home educated children and young people showed that while 95% of children and young people were offered a service, less than 42% had accepted a service. To strengthen practice for this vulnerable group of young people, team leaders kept a list of children who were home educated to enable the monitoring of any risks to ensure appropriate action could be taken. However, in one case reviewed, a referral was sent to the MASH for a young person who was considered at risk from chaotic parenting, without any follow-up. This restricted the opportunity for the young person to have their needs effectively assessed and met in a timely manner. *This will be brought to the attention of the public health commissioners. [Recommendation 8.1](#)*

5.1.5 The joint strategic needs assessment (JSNA) did not provide a clear picture of the local needs and health inequalities experienced by looked after children or care leavers in Blackburn with Darwen. Although there was evidence of health practitioners' championing unmet health needs at an individual level, the local looked after children's service did not yet have oversight of how they were supporting improved outcomes in the health and wellbeing of children and young people. *This will be brought to the attention of the public health commissioners. [Recommendation 1.1](#)*

5.1.6 Strong joint working arrangements were evident between LCFT, ELHT and Blackburn with Darwen CCG. Work was underway to address previous gaps in the capacity and working practices of health agencies to safeguard the health and wellbeing of looked after children and care leavers.

5.1.7 The previous arrangement for initial health assessments saw young people who became looked after at 16-years-old and above being seen by the GP they were registered with for the completion of their initial health assessment. This was recognised as ineffective and action was taken to ensure that all initial health assessments were undertaken by a paediatrician to ensure equity of the health response to all young people entering care. This arrangement was in its infancy at the time of our review therefore, it was too early to demonstrate impact.

5.1.8 Partnership working between Blackburn with Darwen local authority and LCFT's looked after children's team was well developed. Close joint working with the child's social worker was evident in looked after children's health records, with weekly joint scrutiny and review of risks to children where concerns were high. Managers reported strong joint working with children's social care to ensure vigilance to the management of risks to children in a range of circumstances including those placed out of area or at home with parents, but we did not see evidence of this in health records.

5.1.9 Performance relating to the timeliness of ensuring children who enter care have their health needs assessed within 20 days in line with statutory requirements, remained an area for urgent improvement. Delays meant that recent performance of the completion within statutory timescales was just three percent, although this had improved during the last quarter to nine percent. The delay has been partly attributed to foster carers not bringing children to appointments. A multidisciplinary working group has been established to address this, but the impact has yet to be demonstrated. **Recommendation 2.5**

Gaps in the expected standard of practice regarding the arrangements for initial health assessments were recognised but were not secured through the timely implementation of an effective improvement plan, although monitoring of progress made in accordance with the action plan had begun. The CCG had been working to drive improvements in the quality of initial health assessments undertaken by ELHT, including the routine quality assurance of practice. ELHT did not routinely capture feedback from children and young people regarding their experience of the assessment process. This meant that children and young people entering care did not receive an equitable service to assess and meet their health needs. We acknowledge however, that additional resource has been provided to increase looked after children's nursing capacity to help provide for a more efficient and co-ordinated process, and to support the additional work emerging from the change in process for 16-17-year-olds at the point of their entering care. **Recommendation 2.5**

5.1.10 Safeguarding practice within primary care was inconsistent and unsupported. GPs did not routinely contribute to safeguarding processes and were not supported to easily identify emerging risks. Capacity of the Named GP role was a challenge, with the post having three programmed activities (PAs) per month for this role, rather than the six PAs recommended for the population the size of Blackburn with Darwen as stipulated in '*Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff. Intercollegiate Document. Fourth edition: January 2019*'. The Named GP was not fulfilling all the functions required by the role. Despite support from a skill mix safeguarding team within the CCG, this gap meant that GPs were not sufficiently supported or challenged to embed children's safeguarding practice within their work. **Recommendations 5.1 and 5.2**

5.1.11 Inspire and Go2 managers in CGL provided clear strategic leadership in working with other agencies. This helped to continuously strengthen individual and joint approaches to the identification, support and achievement of improved outcomes for children and families affected by substance misuse. The local service offer was strong and recognised the complexity of needs and family circumstances. There was a shared exploration of the impact of adverse childhood experiences on adult service users. This supported a robust person-centred and inclusive approach to identifying and managing risk. Effective work was seen in the co-location of specialist midwives (ELHT) to ensure strong early support throughout the pregnancy and the postnatal period, including for women who had had their children removed from their care. Such approaches led to positive outcomes for children with fewer babies being born with withdrawal symptoms –estimated at approximately one baby per year at the time of our review.

5.1.12 Well-established participation and peer support arrangements were in place in CGL to shape the design and delivery of services. High levels of satisfaction were evident from feedback from service users. Services included out-of-hours support including social media, a telephone crisis line and Saturday drop-in session. These approaches were highly valued to help reduce the risk of relapse, social isolation and emotional wellbeing issues.

5.1.13 Joint working relationships between urgent care centres, the ED and CGL's services was not sufficiently embedded to ensure timely identification and follow-up of children, young people, and adults presenting in crisis under the influence of drugs and alcohol. This was recognised by leaders in response to learning from serious case reviews however, resulting in work to develop easier referral processes. *This will be brought to the attention of the public health commissioners.* **Recommendation 6.1**

5.1.14 Strong collaborative approaches were evident in joint work between public health commissioning and CGL, including in the creation of the quality improvement plan with regular contract monitoring and tracking of improved health outcomes. Commissioners had been supportive to changes suggested to shared care arrangements with GPs and in promoting stronger joint approaches with sexual health services.

5.1.15 Young people from 16-years-old and over were deemed as adults within mental health services. We heard from practitioners that transition was a challenge as the service model for children differed significantly to adult services. Clear guidance was available to support the transition of young people requiring in-patient support. Transition meetings were held to prepare young people and families, but this did not always happen. Some practitioners did highlight difficulties in relation to information sharing. In one case reviewed, an adult mental health practitioner attempted to contact ELCAS to obtain information about a young person previously known to the service. After failed attempts to make contact the information was unable to be obtained. This delayed the young person be able access to the most appropriate service. **Recommendations 2.4, 4.1 and 4.2**

5.2 Governance

5.2.1 There was good health representation within the MASH. A specialist safeguarding practitioner rotated into the MASH from the LCFT safeguarding team daily, to gather and co-ordinate health information to inform multi-agency decision making upon receipt of referrals.

5.2.2 The specialist safeguarding practitioner providing health representation within the MASH did not have oversight of all referrals into the MASH. Referrals made that fit a specified criteria were forwarded to the specialist safeguarding practitioner for further health information gathering. This increased the risk of decisions being made without relevant and complete health information and did not support joint working to effectively meet the needs children and young people. **Recommendation 3.4**

5.2.3 Despite the MASH being well represented by all relevant agencies, there was no oversight to ensure that professionals who submitted referrals to the MASH received a response informing them of the outcome of the referral. The social worker completing a MASH assessment was prompted to contact the referrer, but there was no audit or monitoring process to ensure this was always completed. Practitioners from all health services told us that they rarely received information following referral to the MASH. This does not support joint working to effectively meet the needs of the child. *This will be brought to the attention of the public health commissioners.* **Recommendation 3.5**

5.2.4 Information technology (IT) was a challenge for all health professionals working with children and young people across the health economy, and in some cases, systems were not fit for purpose. The electronic systems used by different health services in both LCFT and ELHT had issues with frequent 'crashing', and practitioners often found they could not attach or retrieve important documents. These IT challenges increased the risk of incomplete records and inaccurate record-keeping. *This will be brought to the attention of the public health commissioners.* **Recommendation 4.3**

5.2.5 Furthermore, IT challenges between children's social care and ELCAS impacted upon the ability for all mental health practitioners to effectively participate in child protection conferences. The secure email system for inviting practitioners to conference was not always accessible. This increased the risk of invitations being missed and ELCAS not contributing to child protection conferences. Leaders were aware of the difficulties with IT, and the intention was for systems to be improved, but there was no implementation or delivery plan to achieve this. The IT difficulties at the time of the review affected how complete and robust the records were and impacted upon practice. Children risked not having their needs met as a result. **Recommendation 6.3**

5.2.6 The electronic record keeping system used by both LCFT and Brook sexual health services however, was effective. It was a shared system by both providers, which ensured that young people could access any of the sexual health services and have their historic and presenting needs and risks appropriately inform their care and intervention.

5.2.7 The use of flags and alerts on electronic record keeping systems was generally effective across health services. The sexual health services, substance misuse services, adult mental health services and ELCAS made good use of a comprehensive list of flags and alerts on electronic record keeping systems. Furthermore, they were updated or removed as soon as the service are made aware of changes in circumstances relating to safeguarding. This meant that all practitioners were in possession of the most up to date information relating to risk to children and young people to inform risk assessments and care planning.

5.2.8 The use of flags and alerts in primary care however, was less robust despite guidance from the CCG. Systems for alerting GPs and other practice staff when a child was identified as having safeguarding concerns, were not audited and there were no data cleansing procedures to ensure the alerts in the records were current and correct. This meant that practice staff were not always fully aware of the risks that needed to be considered when assessing and planning care for a child or young person. **Recommendation 5.3**

5.2.9 The quality assurance of the review health assessments carried out by the looked after children's specialist health team in LCFT was strong. There was a quarterly dip sampling audit of 10 children to ensure the required standards set out in statutory guidance are achieved. This resulted in stronger practice with looked after children and their carers, with rigorous challenge to ensure information about individual health needs were effectively shared and followed up. The process could be further strengthened through reporting of the level of use of illicit drugs and alcohol by children in care and care leavers.

5.2.10 The service offered by CGL's substance misuse services for adults and young people was strong. We saw some examples of positive support for children in local authority care home settings, but the links could be further strengthened to ensure young people's substance misuse needs are fully considered including early signposting of young people to the Go2 service.

5.2.11 Learning from serious case reviews was shared and disseminated with staff across the health economy in numerous ways. These included closed social media groups, seven-minute-briefings, annual training days, safeguarding champions' meetings, quality and safety meetings, and learning and development training days. This provided a range of opportunities to increase the skills, knowledge and expertise of staff working with children and families; and strengthened early identification of need to mitigate risk.

5.2.12 Specific learning from a recent serious case review had been embedded into practice for looked after children and care leavers. Recent practice ensured strong vigilance of children and young people at risk of child sexual exploitation, ensuring all relevant health practitioners were kept informed about risks and appropriately involved in wider safeguarding forums.

5.2.13 There was a reciprocal information sharing agreement in place between LCFT and the sexual health providers in neighbouring boroughs, to alert each other of young people at risk of significant harm. A blank record was created and flagged in anticipation of the young person accessing the neighbouring service. This strengthened the opportunity for the most vulnerable young people to have their sexual health needs met in a holistic manner.

5.2.14 Complaints were analysed and used to drive improvements within ELCAS. We heard that children and their families were not always informed of the decision to reject their referral. Consequently, a system was introduced to ensure children, young people and families were sent a standard letter to inform them of the reasons the referral was not accepted, including recommendations of more appropriate services that were available.

5.2.15 Participation with children and young people to shape services was inconsistent across health services. User participation in substance misuse services was strong for example but needed to be strengthened in ELCAS. We were told that mental health practitioners had difficulties with engaging children and young people to seek their views on how they wished the service to be run. ELCAS recognised this was area required further development. [Recommendation 3.6](#)

5.3 Training and supervision

5.3.1 Newly qualified midwives at ELHT benefited from a robust preceptorship programme to ensure that they have the required competencies to become band 6 senior midwives. This meant that women were cared for throughout pregnancy, labour and postnatally, by midwives who were appropriately skilled, competent and well supported. Although safeguarding children training was incorporated, safeguarding children competencies were not included in the programme, which hindered the development of safeguarding practice and did not ensure that midwives would have the required skills to effectively identify and manage cases where the unborn or newborn was at risk. [Recommendation 2.6](#)

5.3.2 Quarterly training was provided by the looked after children's specialist health team to a range of health practitioners. This ensured a shared recognition and accountability for delivering practice in line with expected standards.

5.3.3 Safeguarding children training in accordance with national guidance is generally compliant in Blackburn with Darwen in accordance with *Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff. Intercollegiate Document. Fourth edition: January 2019*. Compliance with level two and level three training for staff in LCFT was 98%. Compliance with level two and level three training for staff in ELHT was 97% and 90% respectively, with 100% of required practitioners trained at level four.

5.3.4 Primary care staff and nurses working within the non-serious injury unit however, are not all trained to the required level. Leaders were aware of this gap but there was no localised action plan to ensure that all staff would attain the correct level. The impact of these gaps in training was evident by the lack of understanding of safeguarding and lack of professional curiosity when assessing children. **Recommendation 10.1**

5.3.5 GPs worked in clusters in locality areas and were invited to attend monthly safeguarding champions meetings to share information, good practice and learning. These meetings were not mandatory for Blackburn with Darwen GPs, and attendance was low across the practices. This restricted the opportunity for GPs to keep updated with safeguarding issues across the area, or to increase and maintain their safeguarding knowledge. **Recommendation 5.1**

5.3.6 The looked after children's specialist health team in LCFT benefited from a range of additional training that equipped them to recognise and appropriately respond to a range of complex needs or individual experiences that are impacting on children's safety, health and wellbeing.

5.3.7 Training on specific health conditions such as asthma and epilepsy was offered to education staff by school nurses to support children and young people with complex health conditions. Furthermore, the team developed a school health profile for each school which was informed by the needs of the school population, to raise awareness, knowledge and understanding of staff to better meet those needs.

5.3.8 Training was offered by Brook sexual health service's education team to the multi-agency workforce, including other health professionals such as school nurses. The sexual health education team also offered training sessions to parent groups as well as assemblies to children in year eight and year 11 in schools. This led to increased knowledge for practitioners, parents and most importantly for young people to keep themselves safe.

5.3.9 Good leadership was demonstrated by CGL through the delivery of 'Hidden Harm' training for LSCB partners including GPs. CGL had distributed a bulletin to GPs using a video approach to help them understand how to refer to the service. The aim was to improve the early identification and support for 'hidden drinkers.'

5.3.10 The EmBRACE training delivered within CGL had effectively equipped its workforce to ask about adverse childhood experiences (ACEs) and support service users to have a better understanding of what has happened to them to promote their ongoing personal growth and resilience. Oversight and review of individual training records had also been strengthened, with the teams encouraged to attend local safeguarding children board (LSCB) training to help build relationships and sharing of expertise between local agencies.

5.3.11 The delivery and effectiveness of safeguarding supervision across the health economy was variable.

Safeguarding supervision for clinicians working with children and young people in ELHT was delivered in a group format monthly. There was an expectation that clinicians in midwifery, the ED and the paediatric wards, attend three sessions per year however, it was unclear if this was currently being audited or adhered to. Most staff in LCFT were also required to attend group safeguarding supervision sessions. There was limited evidence or assurance to demonstrate how staff were effectively challenged by this format to improve practice and safeguard.

5.3.12 One-to-one safeguarding supervision was expected to be accessed by caseholding practitioners, and was reliant upon non-caseholding practitioners making a request. One-to-one supervision helps to deliver better outcomes through exploring ideas, improves clarity and objectivity in decision making. The impact of not having regular, reflective one-to-one supervision to offer challenge as well as support, was evident in the records reviewed which demonstrated a lack of professional curiosity, clear analysis or impact of risk. *This will be brought to the attention of the public health commissioners.* **Recommendation 9.4**

5.3.13 The process for one-to-one safeguarding supervision for health visitors and school nurses was managed effectively with oversight from the leaders in the 0-19 public health nursing services. For example, the health visitors discussed all children categorised as requiring a universal partnership plus level of service at least once during a six-month period and updated the risk analysis associated with that child. Supervision was clearly documented in children's records with SMART action plans that were followed up.

5.3.14 Appropriate arrangements were in place to ensure looked after children's health practitioners could access regular monthly one-to-one supervision to support effective oversight of concerns and progress made in the management of current and escalating risks.

5.3.15 Supervision and management oversight of safeguarding practice in CGL had been strengthened to ensure ongoing monitoring of risk. Group supervision was available on a weekly basis for young person's workers and monthly for adult substance misuse workers. One-to-one supervision had embedded the review of safeguarding cases with updates clearly recorded on individual case records. Managers sought additional assurance of practitioner competencies through the promotion of observed and reflective practice.

5.3.16 Safeguarding supervision for adult mental health practitioners was limited. Safeguarding was seen to be a part of all meetings at an operational level, but formal, structured supervision was ad hoc despite there being a trust policy requiring compliance. The safeguarding team documented supervision discussions when they did occur, but these were not routinely stored within health case records. This means that there is lack over management oversight of safeguarding cases, a lack of effective challenge, and an increased risk of drift and delay. There was also no assurance that children and young people were being safeguarded effectively. **Recommendation 9.4**

5.3.17 Practitioners working within the GP surgeries visited were not offered routine safeguarding supervision. Consequently, there was a lack of clear analysis of risk and voice of the child in records reviewed, which limited the opportunity to effectively identify or meet children's needs. There were no robust processes to ensure oversight of co-ordinated care for vulnerable children registered within the practices.

Recommendation 5.4

Recommendations

1. **Blackburn with Darwen CCG should:**

- 1.1 Work with Blackburn with Darwen Council to establish robust assurance and oversight processes that ensure how looked after children and young people are achieving improved outcomes.

2. **East Lancashire Hospitals NHS Trust should:**

- 2.1 Ensure that pregnant women benefit from a therapeutic relationship and continuity of care provided by their midwife throughout pregnancy and the postnatal period.
- 2.2 Work with the local authority to ensure that vulnerable pregnant women benefit from the support of midwives who understand and actively contribute to a strong multi-agency response at the earliest opportunity, to safeguard unborn children.
- 2.3 Ensure that children and young people in mental health crisis are kept safe whilst in ELHT, with the mitigation of any risks that they may pose to themselves.
- 2.4 Ensure that young people aged 16-17-years have their holistic needs fully assessed by practitioners who understand the increased risks that vulnerable young people may experience.
- 2.5 Ensure that all children and young people who become looked after, have their needs effectively supported through a high-quality initial health needs assessment and subsequent health action plan within 20 days of becoming looked after.
- 2.6 Ensure that women and their unborn or newborn babies are cared for by midwives who are competent to effectively identify and respond to safeguarding as well as clinical needs and risks.

3. **Lancashire Care NHS Foundation Trust should:**

- 3.1 Ensure that children and young people who are in regular contact with, or are cared for by adults experiencing mental ill-health, have their needs and risks fully considered at every stage of the adults' episode of mental health treatment and care.
- 3.2 Ensure that children and young people have their cultural and diversity needs explored and considered during assessment and care planning.

- 3.3 Ensure that children and young people accessing universal health services benefit from a robust risk assessment to inform effective planning.
 - 3.4 Work with Blackburn with Darwen Council to ensure that children and young people referred to the MASH all have their health needs considered as part of their assessment, and co-ordinated via the specialist safeguarding practitioner.
 - 3.5 Work with Blackburn with Darwen Council to ensure that all professionals working with children and young people who refer to the MASH are consistently notified of the outcome, including monitoring and assurance.
 - 3.6 Work with young people to strengthen service user participation in the shaping and development of services.
 - 3.7 Ensure that children and young people aged 5-19-years, including those who are home educated, can benefit from a school nursing service which can effectively identify, assess, and meet needs as well as provide support and intervention to improve outcomes.
- 4. East Lancashire Hospitals NHS Trust and Lancashire Care NHS Foundation Trust should:**
- 4.1 Ensure that young people aged 16-18-years with mental ill-health can access a comprehensive service to fully meet their needs.
 - 4.2 Ensure that young people approaching 16-years-old with mental ill-health experience a smooth transition to adult services when required and are supported to continue to receive the appropriate care they need at the time they need it.
 - 4.3 Ensure that children, young people and their families are cared for by practitioners who are supported in their documentation by secure and robust record-keeping systems.
- 5. Blackburn with Darwen CCG together with primary care practices should:**
- 5.1 Ensure that children and young people visiting their GP practice benefit from practitioners who are skilled, experienced and sufficiently supported in assessing and analysing safeguarding risks.
 - 5.2 Ensure that GPs and practice staff working with children and young people are effectively supported by a Named GP who, with support from the CCG safeguarding team, can adequately fulfil all aspects of the role, for them to fully understand and fulfil their safeguarding obligations.

- 5.3 Ensure that children and young people accessing primary care services have their risks clearly alerted to practitioners through effective and updated flagging systems to allow them to effectively plan appropriate care and intervention informed by holistic information and risks.
 - 5.4 Ensure that primary care staff including GPs are effectively supported and challenged to improve safeguarding practice, particularly the assessment and analysis of risk, timely intervention and co-ordinated care through reflective supervision.
- 6. Blackburn with Darwen CCG together with primary care practices, Lancashire Care NHS Foundation Trust, East Lancashire Hospitals NHS Trust and Change, Grow, Live should:**
- 6.1 Ensure that children, young people and families benefit from a multi-disciplinary workforce who share information safely and appropriately and work together effectively to meet needs and improve outcomes.
 - 6.2 Work with Blackburn with Darwen Council to ensure that children and young people who are subject to child in need or child protection plans, and those who are looked after, benefit from a multi-agency workforce who have a full picture of their holistic needs and circumstances following meetings and conferences through consistent sharing of minutes and plans.
 - 6.3 Work with Blackburn with Darwen Council to ensure that children and young people who have been referred to the MASH or subject to statutory assessments or plans, benefit from the active contribution of all health professionals involved in their care.
- 7. Blackburn with Darwen CCG with primary care practices, East Lancashire Hospitals NHS Trust and Lancashire Care NHS Foundation Trust should:**
- 7.1 Ensure that children and young people who are identified as requiring additional multi-agency support to meet their needs and keep them safe, are referred by practitioners who can assess and analyse risk and understand how to articulate this effectively.
- 8. Blackburn with Darwen CCG and Lancashire Care NHS Foundation Trust should:**
- 8.1 Ensure that children and young people aged 5-19-years, including those who are home educated, can benefit from a competent workforce with adequate capacity who can effectively identify, assess, and meet needs as well as provide support and intervention to improve outcomes.

9. East Lancashire Hospitals NHS Trust and Lancashire Care NHS Foundation Trust should:

- 9.1 Ensure that children and young people accessing unscheduled care at the emergency department at ELHT or the non-serious injuries unit, benefit from robust assessments and practitioners who are well supported to be professionally curious.
- 9.2 Ensure that children and young people accessing unscheduled care at the emergency department at ELHT or the non-serious injuries unit, benefit from practitioners who make the most appropriate use of information available to inform treatment and care planning and to keep them safe.
- 9.3 Ensure that children and young people accessing unscheduled care at the emergency department at ELHT have their needs followed up effectively by universal services to support further intervention as required.
- 9.4 Ensure that children and young people access services provided by professionals who are adequately supported and challenged to improve their practice.

10. Blackburn with Darwen CCG with primary care practices and Lancashire Care NHS Foundation Trust should:

- 10.1 Ensure that children and young people accessing primary care and non-serious injury services benefit from a workforce who are adequately trained in safeguarding children, and competent in assessing needs and analysing risks.

Next steps

An action plan addressing the recommendations above is required from Blackburn with Darwen CCG within **20 working days** of receipt of this report.

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