

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

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

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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	5
The report	5
What people told us	6
The child's journey	8
Early Help	8
Children in Need	13
Child Protection	14
Looked After Children	20
Management	24
Leadership & Management	24
Governance	26
Training and Supervision	29
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 Lincolnshire. 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 NHS trusts, clinical commissioning groups (CCGs) and the local area team (AT) of NHS England.

Where the findings relate to children and families in local authority areas other than Lincolnshire, cross boundary arrangements have been considered and commented on. Arrangements for the health related needs and risks for children placed out of the 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 NHS 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 of children and their families who receive safeguarding services.
- We looked at
 - the role of healthcare providers and commissioners.
 - the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
 - the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.
- We also checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, Working Together to Safeguard Children 2013.

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 and families. This approach provided us with evidence that could be checked and confirmed in several ways.

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

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

In total we took into account the experiences of 53 children and young people.

Context of the review

Lincolnshire is the fourth largest county in England with an estimated population of 718, 000, of whom 22% are aged under 19 years. Approximately seven per cent of school age children speak English as a second language but in the Boston district, about one third of the population using local health services are from an eastern European country. The county has a spread of both urban areas and very rural, isolated areas. The percentage of children living in poverty ranges from 10% in a southern district to 24% in Lincoln. Approximately 580 children are looked after by Lincolnshire and another 400 have been placed in Lincolnshire by other local authorities. Approximately 400 Lincolnshire children are currently subject to a child protection plan.

Commissioning and planning of health services is led through the Children and Young People's Strategic Partnership, with the four CCGs and Lincolnshire county council as the lead commissioners. Acute hospital services are also commissioned jointly by the CCGs and are provided by the United Lincolnshire Hospitals NHS trust (ULHT). Lincolnshire community healthcare services (LCHS) provide health visiting, school nursing and children's therapy services, the looked after children's health service, sexual health services, two minor injuries units, two 24 hour access urgent care centres and a walk in centre. Health services for children with disabilities are provided through integrated arrangements between the council and CCGs, and joint funding arrangements are in place. Child and adolescent mental health services (CAMHS) and a targeted adolescent mental health service which works in partnership with schools are provided through integrated arrangements between the council and Lincolnshire Partnership NHS Foundation trust. A specialist mental health nurse works with the Barnados leaving care service in providing a care leavers' CAMHS transition service.

The last inspection of health services for Lincolnshire's children took place in June 2010 as a joint inspection, with Ofsted, of safeguarding and looked after children's services.

The report

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

What people told us

We heard from several foster carers about their experiences of looked-after children's health assessments and reviews.

One parent told us how his child is deteriorating because of lack of physiotherapy input. The foster carers told us that they tell the GP as part of the health review and then nothing happens.

Another foster carer had better experiences; *"I have a 30 mile round trip to see the GP who does the health review. She is interested and doesn't just tick the boxes."*

We heard a lot of praise from carers for a particular consultant paediatrician: *"She really listens and treats you with respect"*.

Sadly, we also heard some young people and carers' very poor experiences of health practitioners. One young person told us: *"health staff don't talk to you."*

"Some health professionals don't want to speak to foster carers. They say 'I need to speak to a professional'".

"We had to use A&E over the Christmas period, we were told to go home with an inhaler. This is for a child who was deteriorating with his shunt. They wouldn't listen to his foster carers".

Others commented on a range of communication and health planning issues impacting on children's health:

"We wait too long for essential equipment. His current wheel chair means he can't wear winter clothes because he won't fit in the chair"

"There is no numbing cream for his eyes in the local hospital so we have to travel to Boston Hospital".

"We have been waiting for important emergency surgery that couldn't proceed because of getting consent. This is for a child who has complex health needs"

Another foster carer told us: *"Getting the right equipment is difficult and we are told it's because of the budget. Why should our children suffer?"*

Foster carers we met were in universal agreement that the health professionals they meet do not understand the added needs of a looked-after child.

"I haven't been able to get support or training for family members to be able to tube feed my foster child. This means I have to be there to do every feed myself, even though other family members would like to give me a break". (Foster carer of a child with complex health needs"

One foster carer said how their 14 year old foster child was well supported by a nurse who made weekly visits and arranged for CAMHS and the smoking cessation service. However, the foster carer did not get any support or training.

We heard that the blue book, the local hand held record of looked after children's health history, hadn't been rolled out in a way that made it effective: *"The only reason he (the child) has his health history is because I save everything. GPs and other health professionals won't fill in the blue book, it's a complete waste of time."*(foster carer of a child)

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 General practitioners (GPs) have an important role in early help in pregnancy as they are often the first point of contact for pregnant women in Lincolnshire; the information GPs send to midwifery is variable and doesn't always ensure midwives have all the relevant information where early help might be needed. A new booking format has recently been introduced which carries more information and also gives more information to the mother and this should improve mothers' access to early help.

1.2 Systems such as antenatal chronologies are in place to help early identification and monitoring of safeguarding risks in pregnancy. We saw a range of cases where midwives appropriately identified risks to protect unborn babies. However, some risks may be missed when these systems are not consistently used as in a case we saw:

Some concerns had already been identified as the mother to be hadn't disclosed at booking that an older child was placed with another family member; this part of the system worked well. However, the key antenatal chronology was not completed. It was unclear whether the community midwife was notified when the mother failed to attend her first scan, which is important to ensure prompt follow-up.

1.3 Many children, young people and their families are helped by preventative and targeted support from health staff in seven local multi-agency teams in co-located bases such as community hospitals, health centres, children's centres' and GP's surgeries. Co-location helps handover arrangements between midwives and health visitors which are generally effective and consistent in protecting vulnerable babies.

1.4 Community midwifery services try to maintain the same midwife throughout pregnancy as this gives mother and baby continuity but capacity problems mean this isn't always the case. Never the less, we saw examples where pre-birth maternity care is very effective in identifying the need for support at an early stage.

We saw an exemplar case of obstetric care of a pregnant teenager. Risks were discussed with her with great sensitivity and the young person was given time to reflect and consider her options. The maternity record is clearly written and of excellent quality.

1.5 Vulnerable women or those for whom an increased level of risk has been identified are visited by community midwives for up to 10 days post natal, which is also good practice in protecting mothers and babies. Joint ante natal visits are common and the community midwife's final visit is usually a joint visit with the health visitor. We heard about some effective partnership work between health practitioners, social care, children's centres and schools to support families.

1.6 The well regarded peri-natal mental health service works with health visitors and school nurses to support improved outcomes for women in Gainsborough and Lincoln. Lack of service for new mothers in other areas of Lincolnshire is an acknowledged gap as the value of perinatal services is recognised; in the last two serious case reviews, workers had contacted peri-natal health for advice about the new mothers' mental health (recommendation 5.2). Many parents in the county access and benefit from IAPT¹ services to help manage anxiety and depression. The service works closely with the mother and baby unit (in Nottingham) and helps support gaps in local peri-natal services.

1.7 Although some health visitors and GPs work well together to identify families who might need help, this isn't consistent across the county. There is no agreed system in place, for instance for regular formal joint meetings between GPs and health visitors or school nurses (recommendation 4.2).

1.8 The needs of children in families where their parents have mental ill health are properly recognised through highly effective `think family` systems across adult mental health services. Safeguarding screening tools are embedded in mental health services working with adults and parents, ensuring that all adults accessing services are routinely questioned about children in their families so that the children's needs can be taken into account at an early stage.

The IAPT early help mental health service helps many parents and ensures that risks to all children in the household are picked up, rather than just those for whom the adult has parental responsibility. The screening tool it uses is good practice. With the introduction of the IAPTus management information system, an already very sound system is being further strengthened.

¹ Improving Access to Psychological Therapies (IAPT) provides access to brief counselling interventions

1.9 School nurses are engaged with all schools and provide school drop in sessions. They are kept up to date about current issues and risks, in order to offer early help, information and advice about issues that trouble young people. However, there is no countywide use of a substance use screening tool to assess young people's drug and alcohol use as part of any other needs assessments. Using a recognised screening tool to identify young people who might need more targeted help could improve their early access to services.

1.10 We found a general lack of clarity about any referral pathway from health services to Young AddAction which offers specialist help to young people who misuse drugs or alcohol (recommendation) A&E departments are also in a very good position to identify young people who are putting themselves at risk through drug or alcohol use. We heard that this is being addressed with a multi-agency protocol which is awaiting ratification by the LSCB. (recommendation 3.2).

1.11 Accident and emergency (A&E) staff make an otherwise fairly comprehensive assessment of the child or young person on admission, including details of parents. There are though, inconsistencies in clarifying who has parental responsibility. At Grantham A&E, children are prioritised and almost always seen within 15 minutes. The clinical triage notes indicate if the presenting injury or condition is consistent with the explanation offered. A note is also made of who is accompanying the child to the department. In A&Es and the minor injuries unit (MIU) we visited, we saw good safeguarding risk assessment by most clinicians.

Spalding MIU identified and responded appropriately to safeguarding risks, notifying the health visitor, social care and MARAC about domestic violence witnessed by children and informing the parent about the referral being made.

1.12 In case sampling at three acute care locations we saw that onward referral systems to ensure young people have access to early help are not robust. At the Pilgrim Hospital at Boston, A&E actions are not routinely recorded in the paediatric liaison nurse (PLN) folder and CAS cards are often left in a pile to await the PLN's twice weekly visit. Although the PLN and acute trust named nurse are working together to try to address this, compliance with the agreed safeguarding discharge protocol remains low. At Grantham we also saw a lack of clarity about cases referred to the PLN and their outcomes (recommendation 3.1).

At the Pilgrim hospital's A&E we saw good work from staff in assessment of risks, effective questioning of the incident and treatment of an 18 month old little girl who had swallowed a small amount of oven cleaner. This case wasn't entered into the PLN liaison book however, to ensure there would be community follow up.

1.13 Young AddAction provides a good quality, easily accessible drug and alcohol specialist service for young people that thoroughly assesses risks and engages young people very flexibly. On one file we were impressed how the Young AddAction service responded to the parent's concerns whilst respecting the views of the young person.

1.14 We saw examples of the work of the 'vulnerable children's team' (VCT) which provides a specialist health service to meet the health needs of vulnerable children and young people, including children in public care (0-19 years of age) within Lincolnshire and those at risk of social or educational exclusion.

1.15 Where community health services are using the same IT system, information sharing about children at risk is supported across a range of services. This helps health staff to respond to the needs of individual children. As a result of the shared information system, regular liaison between MIUs and school nurses is now routine practice and enables improved understanding of concerns about young people in the county.

1.16 Where risks to the health, safety, development and wellbeing of children are identified we found timely and appropriate follow up to ensure the child's health needs are met, particularly among health visitors and school nurses. We heard that progress is on track to meet national health visitor targets, although case loads and capacity are variable currently and there is widespread use of nursery nurses in order to deliver the core offer. Unless there are child protection or child in need plans to mitigate risks to the child and mother, new born babies are handed over to nursery nurses for the universal service after 6 weeks; this potentially impacts on the ability to identify early needs for help.

1.17 Integrated GUM, sexual health services and family planning are provided in one stop clinics across Lincolnshire. Dedicated clinics for young people are not provided, but reception staff make sure that young people are seen by experienced staff. Clinical guidelines reflect national policy in that any young person aged 13 or under as well as any young person or adult with additional vulnerability is referred to children's social care.

1.18 Agencies are working together to try to increase understanding and develop provision to meet the health needs of eastern European migrants and their children. We saw how mothers are supported by obstetric consultants who are sensitive to patient's ethnicity and ensure interpreting services are provided as required. Midwives and community services have taken steps to better meet the needs of the Polish community in the Boston district including information leaflets and recruiting a Polish speaking midwife in each area of the county; some midwives have developed a glossary of Polish terms to help them in working with this community. The community services named nurse lead for diversity is very involved in developing greater understanding of cultural norms and ensuring that potential risks to the wellbeing of children in migrant communities are recognised and addressed.

1.19 We heard from several sources including Healthwatch about the impact of the shortage of paediatricians in Lincolnshire. All paediatricians in Lincolnshire are currently employed by the acute hospital trust. We heard that around the county it is hard for a child to get a paediatric referral and children have to wait for appointments which often impacts on their well-being. The limitations of available paediatric resources impact on children entering into care who may have complex or hidden needs (recommendation 1.3). Only the 10% who are being considered for adoption are seen by a paediatrician for their initial health assessment, all others are seen by GPs and then have to join waiting lists if more specialist assessment is needed. Some children and foster carers told us that they are not always listened to when they see a paediatrician.

1.20 We saw consistently determined efforts across health services to engage young people and families who are challenging or hard to engage. Non-attendance at clinical appointments is well followed up by most partners. GPs told us that they hear about missed hospital appointments but could be better engaged about risks in families if they were also informed about missed community health appointments.

1.21 The school health service has good engagement with schools countywide. Practitioners identify needs effectively and target additional drop in work at schools where young people are most at risk. We saw some effective individual work too, for example, a teenager in a very chaotic family for whom engagement and support from the school nurse is instrumental in ensuring his fundamental needs are met.

1.22 Staffing turnover and reducing capacity in the school health service presents a threat to continuing the current level of engagement which is helping to safeguard all school age children, for example capacity in the north east sector, where there are high levels of need, has been significantly challenged during 2013.

1.23 Vulnerable children and families in Lincolnshire benefit from the range of children's centres and also have access to some health-led early help services which are effective in delivering positive outcomes; in particular the young expectant parents group (YEP) run by community midwives is accessible to all young parents. The 10 week course starts and finishes at different times ensuring there is no delay in young parents starting with the group. Young people can attain a qualification equivalent to a GCSE. Recently a YEP cycle has run for a small group of five 14 year old young people who all joined at the same time. Young people feedback that they found this highly supportive and helpful.

1.24 The number of teenage pregnancies has reduced year on year, as in most parts of England though latest data shows that the rate of 1.7 is worse than the rate for the East Midlands region and the England average rate of 1.3. Teenage pregnancies are highest in the Lincoln area although we did not see targeted activity to address this or the impact on the life chances of these young parents and their children.

2. Children in Need

2.1 Midwives carry out thorough assessments of risk and where concerns are identified, these are shared early. Vulnerable mothers are supported by targeted ante natal care from health visitors from 26 weeks currently though this is changing and will be available as soon as a pregnancy is confirmed.

2.2 Children in need and their families are helped by multi agency team around the child (TAC) groups based on the common assessment framework (CAF). This is an embedded model of supporting children in need and may be led by a range of professionals including health staff and schools. This is delivering good outcomes where parents are in agreement with the setting up of a TAC. We saw a good example where a child protection plan was replaced by a child in need plan when the child moved into the county and the child is supported by a TAC in which her school nurse is an active partner.

2.3 Young people who may be reluctant to engage with CAMHS services are supported to access the service by a sensitive policy on non-attendances. We saw examples where workers sought to engage the young person for as long as possible and used different routes to try to do so rather than closing the case. Effective and separate work can be done with parents or foster parents to support them when a child is working through difficult issues supported by CAMHS.

We saw an exemplar case of effective, sensitive support by health services in Lincolnshire for a young person who had suffered serious sexual exploitation before being placed in Lincolnshire by another council

2.4 The contraception and sexual health service (CASH) appropriately explores risks to identify safeguarding concerns and potential sexual exploitation of young people. This includes asking the young person for the age and name of their partner and whether sex had been consensual. Services ensure that children aged 13 and under are identified as being potentially at risk by an automatic flag on the CASH database. All cases of concern had been referred to children and families social care. However, we did see a number of cases where children aged 13 and under had a contraceptive implant in situ and the CASH could not identify the source of these implants. This indicates that some GPs or other family planning practitioners are unaware of guidance and policy to safeguard these vulnerable young people (recommendation 4.2).

2.5 CAMHS employ some very good self-assessment tools and aids in working with young people to enable them to explore their emotional journey and to assess their progress and personal growth. Many young people have timely access to services, especially at tier 3 where the average wait is just over three weeks. However, increased demand and holiday arrangements led to some delays during several months in 2013, for example for tier 2 primary CAMHS, 61% were seen within the six week target (recommendation 5.1).

2.6 Significant numbers of young people in Lincolnshire have complex needs including self-harming behaviours. The most recent national data set on hospital admissions as a result of self-harm reported a rate of 127 (or 177 admissions), significantly higher than the England average rate of 115 and with increased numbers being seen since this data.

2.7 Many of the young people presenting at A&Es in Lincolnshire have been placed by other councils without first ensuring their health needs can be met in Lincolnshire. We saw several cases where health professionals in Lincolnshire had worked hard to engage with and try to ensure that young people received appropriate help.

2.8 Problems in access pathways from A&E services to CAMHS were flagged as an issue in the SLAC inspection in 2010. The LSCB has since co-ordinated work to simplify pathways. A case example suggested further exploration by commissioners would be warranted to ensure effective planning for Lincolnshire children returning from out of county placements ensures there are smooth and robust pathways to support them. The self-harm pathway of overnight admission to a paediatric ward and assessment by CAMHS is providing good support to many children and young people. However, there continue to be cases where this pathway does not work well and children's access to appropriate support is delayed as professionals try to balance these needs with the needs of other children on the paediatric wards (recommendation 9.1)

2.9 These cases are usually resolved through the intervention of the CAMHS consultant liaising directly with the paediatric consultant. We heard that work is in hand across partnership agencies to resolve this long standing issue including a trial at Lincoln hospital which is providing two additional members of staff to provide additional support where young people are admitted to the paediatric ward for CAMHS assessment. Use of the self-harm pathway at Pilgrim Hospital is also being closely monitored by the named nurse as it has not always worked effectively (recommendation 3.1).

3. Child Protection

3.1 Most health professionals recognise safeguarding thresholds and their professional accountabilities for keeping children and young people safe. School nurses, for example, understand their role in safeguarding and make appropriate referrals when they identify concerns. In one case we saw that a school nurse took appropriate actions in making a safeguarding referral when a 12 year old child disclosed sexual activity and concerns about a possible sexually transmitted disease (STD).

3.2 Health professionals are making prompt referrals to social care when they have concerns about risks to children. However, we saw a common theme across a number of services with examples as in the following paragraphs where risks to children are not being clearly articulated and health managers are not quality assuring referrals to support practice development in this key area (recommendation 7.2).

3.3 Most referrals from midwives to social care about pre-birth concerns are made electronically but not routinely printed off and placed on the mother's record. This approach means the named midwife or supervisory staff are unable to review and audit the quality of referral to ensure that the risks to the unborn are clearly articulated. Some midwives do print and file their referrals and this practice is to be encouraged (recommendation 7.2).

3.4 Midwives are skilled at identifying unborn babies who might be at risk, they are making early referrals to social care and alerting the named midwife. The recent introduction of a pre-birth protocol is a positive development but its effectiveness had not yet been reviewed by partners (recommendation 7.4). This review identified areas for development in the protocol to ensure health staff including GPs and midwives will in future be involved in core assessments through early establishment of a TAC² where concerns are raised about risks to unborn babies as this strengthens the involvement of health staff (recommendation 8.1).

The mother to be, a looked after child with complex needs herself, was well known to a range of health professionals who were concerned that her chaotic and risky lifestyle represented risks to the wellbeing of the unborn baby. These risks were inadequately identified in the notification to the named midwife. Though the poor history of the young woman was set out, concerns in relation to her ability to parent the child effectively and the likely early delivery were not mentioned (recommendation 7.2).

The core assessment inaccurately attributed the midwife as having "no concerns" despite high levels of concern among professionals familiar with the expectant mother. This case highlighted areas for development within the pre-birth protocol to ensure early multi agency involvement in decision making. We referred the case back for review and appropriate action was taken (recommendation 7.4).

² Team around the child

3.5 We reviewed a case where concerns about parenting capacity have been present since before the first child's birth three years ago. This case demonstrates a cluster of known risk factors including missed appointments, avoidance, deteriorating mental health, increasing misuse of alcohol, problematic living conditions, and risks from a large dog. Whilst there have been diligent attempts at engagement with the mother, health records we saw lacked clear assessments about the impact on the wellbeing and development of the small child or the then unborn baby and a lack of clear planning. We saw no evidence of multi-agency meetings prior to the second baby's birth or of decision making about parenting capacity or risks to the baby or young child. Although a TAC was suggested recently, as concerns multiplied, the protocol requires the agreement of the family. In this case when the parent declined a TAC, there was a further period of slippage during which concerns increased. The case had recently been escalated to child protection.

3.6 Identifying risks to children through the use of a vulnerability and resilience matrix is a good model is now being used in health visiting and, we heard, more widely in other agencies undertaking assessments of risk. This can support practitioners to evaluate a case more effectively and to make good quality referrals to children's social care. The very newly implemented electronic version should further help community health practitioners to make referrals which set out risks more clearly. Some staff are currently unclear on the expected usage of the electronic matrix however (recommendation 8.1).

3.7 Another of the cases we saw involved long standing neglect which has continued for many years despite CP and CIN plans but the mother's behaviours and needs impact on her ability to parent her children. Since recent re-escalation to child protection brought an experienced school nurse's involvement to the family, she has used considerable skills to win acceptance of the mother and has started to address the son's unmet health needs.

3.8 We also saw an example case where the GP took prompt and appropriate safeguarding action in response to a disclosure that a child had witnessed a domestic violence incident. The GP did not however, clearly articulate the risks to the child in his report to conference (recommendations 4.1, 7.2).

3.9 Overall, GPs are keen to improve their safeguarding practice and positive progress has been achieved under the leadership of a very committed named GP. GPs recognise how important it is for the GP to attend child protection meetings if possible. Short notice periods and scheduling during surgery times are obstacles to improving GP attendance. Alternative means of securing GP participation such as teleconferencing have not been explored.

3.10 Where child protection plans are in place and adult mental health, including peri-natal mental health, are engaged with the parent, practitioners are very clear on their role in protecting the child. We saw an example where adult mental health practitioners were actively ensuring that the mother was compliant with the child protection plan and reported this back to conference.

3.11 We saw a *'think family'* approach in the work undertaken by LPFT's Drug & Alcohol Recovery Team (DART) with adults who misuse drugs and alcohol and who have children. Risk assessments, screening tools and a parenting check list ensure there is a joint focus on the needs of any children present in the family. We also saw good examples of contingency planning within recovery plans should a client fail to engage which is good practice.

3.12 However, outside of formal safeguarding meetings and conferences there was some evidence that the Drug and Alcohol Recovery Team (DART) workers did not always share information and concerns with other agencies in a timely manner. Other agencies who are monitoring risks to children are often reliant upon the client passing on and disclosing information that may be unreliable. We saw a lack of consultation between the adult drug and alcohol service and midwives for their clients. In one case we saw, the woman had disclosed on going substance misuse to the drugs worker but this information had not been shared with the midwife. This means that the midwife was not aware of information that could impact on the safety and wellbeing of the mother and the unborn baby (recommendation 7.3).

3.13 The drugs and alcohol team advised us that they are not asked to provide information to children in need meetings involving parents who receive support from their service. They also advised us that they are not consistently invited to relevant child protection meetings and often experience late receipt of minutes of CP meetings (recommendation 7.3). We heard that work is underway between LPFT and children's service managers in respect of drug and alcohol issues for parents based on the Ofsted/CQC 2013 report, "*What about the children?*"

3.14 Health professionals routinely participate in strategy meetings when they are invited; the expert knowledge about the child from school nursing, health visiting and midwifery can be instrumental in decision making about the level of intervention likely to deliver the best outcome for the child. Pressures on the school health service and the skill mix of a very limited number of more senior nurses, risks capacity for this valuable part of the role.

3.15 Health professionals prioritise attendance at child protection conferences and core groups and prepare reports as needed. Some reports lack the detail that would make the best contribution to multi-agency decision making. GPs are unclear what information to include when they submit reports. There is no agreed report template which they would find helpful and which would optimise their professional contribution to case conferences (recommendation 4.3).

3.16 Resources available to young people in the county aged 16 or under who have significant mental health needs include T4 CAMHS in-patient service provision. Young people are sometimes placed out of county in accordance with NHS England's commissioning protocol either to suit their circumstances or when the local places are already full. It is rarely necessary to admit a young person aged 16-17 to an adult ward. Though we noted from Trust papers that this had occurred on two occasions in 2013, reports provide assurance that both of these young people were supported by appropriate safeguards.

CAMHS are providing good support to a young person who had experienced significant abuse resulting in criminal proceedings. The tier 3 CAMH service liaises carefully with other agencies including the Crown Prosecution Service (CPS) to ascertain whether outside issues are likely to impact on the child's mental health and to take the work at the child's pace. This is more likely to result in positive outcomes for the young person.

3.17 Where child protection plans are in place and adult mental health, including peri-natal mental health, are engaged with the parent, practitioners are very clear on their role in protecting the child. We saw an example where adult mental health practitioners were actively ensuring that mother was compliant with the child protection plan and reported this back to conference.

3.18 Our case sampling in A&E identified that processes and arrangements do not currently ensure that A&E attendances by children for whom risks are identified will be robustly followed up. This is especially important where children move between areas or live out of county. We saw an example of a young person for who effective follow up was required but the notification was a brief, routine, system-generated letter to a GP although staff have the option to provide individualised information. In cases of risk and self-harm, these arrangements are insufficient to alert receiving primary care team (recommendation 3.1):

A 13 year old girl from a neighbouring county was brought to Grantham A&E after taking a deliberate and significant overdose of medication to harm herself. Staff also identified previous self-harm and did a good job of triage, assessment, gleaning important information and alerting receiving hospitals. Some inconsistencies in the circumstances needed more exploration but suggested additional concerns. The case number was added to the PLN's list for her next weekly visit. A routine PAS system generated letter to her GP contained insufficient details to prompt any special follow up.

3.19 Young people from 14 years old are well supported by the sexual assault referral centre (SARC) at Spring Lodge, Lincoln when they need to access this service. Effective work by the ISVA³ ensures the young person receives appropriate aftercare.

3.20 We saw some good, persistent work by skilled community health practitioners to promote the health of children in vulnerable families and children subject to child protection plans. In one case, since the school nurse's involvement as part of the core group, she has successfully gained the trust of the mother and has started to address the child's unmet health needs by getting him registered with a GP and dentist. We also saw an example of good multi-agency working to explore strategies to manage a child at high risk of serious self-harm. An appropriate out of area placement has been secured and the child is doing well.

³ LPFTs Independent Sexual Violence Advisors (ISVA) service

3.21 Barnados are commissioned to provide an effective care leaver service. All young people have a pathway plan which includes a health component but a positive new development, also provided by Barnados, is the CAMHS transition service. This has been particularly effective in helping young people who have left care to overcome often long standing and unresolved emotional and mental health concerns. The Barnados services working closely with the vulnerable children's nurses and also act as advocates for young people. We saw a number of examples of the impact of this work, including:

Case example: *Barnados worked closely with the community mental health team to successfully maintain a female care leaver in education. A positive outcome from multi-agency working.*

Case example: *A young male care leaver with autism. Helped into supported living and employment. Targeted CAMHS was able to clarify which of his needs were down to the autism and which were functional mental health issues. As a result, he was able to access the right level of support.*

3.22 Care leavers have not until now had the support of a dedicated pathway to ensure that their needs and those of their unborn or new babies are addressed. However, having identified an increasing number of pregnancies amongst care leavers, the looked-after child health team and Barnados are putting together a work plan for this (recommendation 2.4).

4. Looked after Children

4.1 The number of children in the care of Lincolnshire county council has steadily risen since 2010, to approximately 580. Additionally, children in the care of other local authorities are increasingly being placed in new private sector care homes within Lincolnshire, currently about 400 children. Assuring the health and wellbeing of such a large number of children, many of whom have complex needs is a significant challenge. Health agencies are fully involved in the safeguarding partnership's work to identify themes and seek resolutions. This is most notable in last year's project in which analysis of intelligence about a cohort of children most frequently reported as missing identified and intervened in respect of child protection and sexual exploitation concerns for all. The continued influx of children placed by other areas into private residential services in Lincolnshire without first ensuring their complex health needs can be met is presenting a particular challenge to a range of local services.

4.2 Whilst there is a protocol for moderate to high scores in strengths and difficulties questionnaires to be reviewed, there are no arrangements to monitor this or to collate outcomes to ensure that children in care are receiving the right services to meet their needs. The arrangements needed to be strengthened by developing monitoring and audit to ensure that individual SDQ scores of 14 or above are reviewed by specialist professionals; that changes to the health care plans are considered and implemented where necessary and that there is more visible tracking of subsequent scores to indicate outcomes of interventions (recommendation 2.1). Since this review, children's services re-launched the SDQ review group and procedure to monitor children with scores over 14 at a children's services team managers' meeting. Attendance at the group includes educational psychologist, CAMHs, LACES (education services) and LAC managers. This is in its early stages and should be monitored for process and outcomes, including the involvement of practitioners who undertake assessments and reviews.

4.3 We found that more needs to be done to ensure the link of general health and mental health evaluations in order to provide timely specialist help. The SDQ⁴ scores of a high proportion of young people who have been in care for longer than a year indicate concerns deserving closer analysis and attention given that they are significantly higher than national averages. The designated doctor has flagged up the need to ensure that health reviews take into account all available information about the holistic health needs of looked after children including their emotional wellbeing but progress is slow (recommendation 2.1).

4.4 The specialist vulnerable children's team has oversight of the health needs of children and young people as they move through care. We identified positive relationships with children and young people and the VCNs effectively engage with children and co-ordinate their support. Outreach work by VCNs and CASH staff in some children's homes is valued by care staff.

⁴ SDQ – strengths and difficulties questionnaire, an annual national survey to assess the emotional well-being of young people who have been in care for one year or more

4.5 Management of the extensive volume of health assessments is supported by a co-ordinator and administrative staff. Even so, children's initial health assessments (IHAs) are too often affected by delays, often as a result of late notification of placements by social care staff. GPs are being encouraged to direct requests for health assessments for children placed by other areas through the co-ordinator but at present there is no reliable system to ensure oversight and quality assurance of these assessments (recommendation 2.5).

4.6 Looked after children can access support from a dedicated primary CAMHS service which engages well with a range of other health practitioners who support the child. We saw examples where children are benefitting from imaginative child focused interventions which move at the child's pace, providing every opportunity for the child to evaluate their own progress.

4.7 Unfortunately with the increased number of children in care locally, demand for the looked-after children primary CAMH service can outstrip supply. At times children wait longer than the four week target for initial appointments; as many were waiting as were being seen in some periods. In August 72.5% of looked after children were seen within four weeks, compared to the 95% target. This worsened in September when only 49% of looked-after children who were referred were seen within 4 weeks. LPT monitors performance closely and ensures that commissioners of CAMHS services are aware of difficulties. Positively, we understand that some additional resources were found to increase service capacity during 2013 (recommendation 5.1).

4.8 Care leavers who have accessed CAMHS and meet adult service thresholds have a seamless transition pathway from CAMHS, as CAMHS and adult mental health have the same provider. A looked-after child can usually access CAMHS up to the age of 18 with a transition starting at 17.5 although this can be extended for example, to support a young person moving onto university. This is good practice.

4.9 Work has been done to improve compliance with statutory expectations that all children and young people coming into care benefit from a timely assessment of their health (an initial health assessment) and a comprehensive plan to meet their health needs. More children are having their health needs assessed within the statutory timeframe but this is from a low base and less than half (40 – 45%) of children entering care have an assessment within the timeframe with some considerably delayed. Recently introduced reporting now clearly sets out points of delay and this has assisted the improvement. Even so, the reasons for delays are not always clearly set out or understood.

4.10 The quality of GP initial and review health assessments is highly variable and is a priority area for development. From examples of very good practice, reflecting a comprehensive assessment of the child's health and wellbeing and highly reflective of the child as an individual; we have seen assessments of unacceptably poor quality: hand written and mainly illegible containing the most basic information, with no sense of the child as an individual and no attempt to reflect the voice of the child. Despite the efforts of a highly committed designated doctor, the quality assurance process for health assessments and reviews lacks rigor and is not sufficiently robust (recommendation 2.5).

4.11 The quality of health plans is also very variable. Some are comprehensive and child centred with good efforts made to engage children, others are not. Some good assessments are weakened by poor quality health plans which lack measurable objectives, timescales and accountabilities (recommendation 2.5).

4.12 It has been recognised for a number of years that looked after children have not had the quality of health support service which they need :

Several foster carers we met felt that their role in supporting and advocating for children with disabilities was not recognised by health professionals. They are not routinely sent copies of the child's assessments or health plans and are often excluded from assessments, reviews and important discussions about health needs. One foster carer told us how health professionals had held an end of life discussion about the child she has fostered since infancy and had not included her.

4.13 A looked after child's health plan should identify the health support each child needs and be reviewed and revised after each assessment. However, foster carers told us about their experiences of the ineffectiveness of arrangements in meeting the children's needs.

4.14 They explained how assessments and reviews are stand alone, not linking into other medical assessments and appointments. Case files also showed that reviews and health plans could have greater impact if all available information, such as annual and specialist SDQ's, or updates from specialists was drawn together in advance, so that all needs including emotional well-being are considered at the time of the health review.

4.15 Looked after children have good access to primary care, they are promptly registered with GPs and dental checks and immunisations are arranged for almost all looked after children. Community health staff use IT to record heights, weights and immunisations which helps to track progress and identifies gaps.

4.16 The records we saw showed that most health reviews are episodic and are not informed by the previous review although these are routinely sent to the GP to inform the current assessment. The child's own GP is not asked to contribute their often extensive knowledge of the child before the review. As we saw and heard from foster carers, where other services such as paediatricians or other specialists, CAMHS or therapies such speech and language SALT are involved with the child, their knowledge of the child is not contributing progress information to the health review (recommendation 2.5). We heard from a foster carer about their concerns that health reviews give insufficient attention to the health needs of young people with disabilities who will be leaving care: *"There is no preparation for young people turning 18. I told my young person about the birds and the bees."*

"Now he does get fast tracked to the paediatric ward but it has taken ages and lots of admissions for that to happen."

4.17 The high numbers of children placed into Lincolnshire from other areas challenge all facets of the service. School nurses demonstrate dogged determination in obtaining information from professionals in other placing authorities about children for who there are safeguarding concerns. Diminution of the capacity of school nursing risks losing the most effective part of the safeguarding system in its reach to school age children.

4.18 Looked-after children are well supported by knowledgeable and committed vulnerable children's specialist nurses. They work closely with residential staff, foster carers and a wide range of other professionals and are well regarded.

4.19 There are significant difficulties in ensuring that appropriate equipment to meet the assessed needs of looked-after children with complex disabilities is provided in a timely way. This is a long standing frustration for foster carers. One told us that as her foster child has outgrown his wheelchair, he cannot wear his winter coat when he goes out as he cannot fit in the chair. These difficulties are indicators that health services and health care plans are not effectively supporting looked after children's health needs (recommendation 2.2 &2.5).

"We got him a new chair and it took four and a half months for someone to come out and fit the parts so he could use it." (foster carer of a child with disabilities)

"Depends on the social worker in terms of what support you get. Therapy support helps you maintain the placement".

4.20 We saw case examples where help for young people was delayed because the access pathway for the looked-after child CAMHS service does not accept referrals from the vulnerable children and young people specialist team. They often know the child best and in some cases this would have expedited a child's access into a service likely to result in good outcomes. We understand this was addressed following our review.

4.21 Insufficient attention is paid to ensuring that care leavers have access to their full health history and this is an issue which is of great importance to many young people who leave care. While the provision of the blue book has the potential to provide a comprehensive health history for when the young person leaves care, foster carers told us that most health professionals, GPs, dentists and specialists are reluctant to make entries, diminishing its value to the young person (recommendation 2.3).

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 CCGs and NHS England's area team (AT) provide good leadership to continuously improve health safeguarding and children looked after arrangements.

5.1.2 Lincolnshire's CCGs have put in place a reporting and accountability framework for safeguarding children, including those who are looked after. This has the potential to deliver improvements and ensure effective governance. There is a shared acknowledgement of the challenges and priorities for improvement. Strengthened governance arrangements are in place for the early identification of learning points from serious case reviews (SCRs) for monitoring and evaluation and to ensure timely action is taken to improve services.

5.1.3 At the time of the SLAC in 2010 completion of health assessments was poor. Revised arrangements were developed to recruit GPs on local extended contracts for this work. This has involved a great deal of work and has improved access to health assessments though such a disparate service has struggled to achieve the expected quality and more sustainable arrangements are needed. Senior managers recognise that more needs to be done to secure quality across their responsibilities for both safeguarding and health care for children who are looked after (recommendation 1.2).

5.1.4 Challenges to the leadership resource for the significant task of driving both safeguarding and looked after children's health agendas across a large county is recognised by the CCGs. An external review has been commissioned. The designated professionals all have limited capacity to develop and drive comprehensive plans for changes across the health economy (recommendation 1.1). We found that they are all respected and committed professionals working hard to address challenges many of which are long standing and require more strategic solutions.

5.1.5 Prompt investigative action has been taken in response to our concerns about a case we sampled at A&E where an inadequately managed discharge from an out of county in-patient mental health unit resulted in the child self-harming and requiring emergency treatment.

5.1.6 Information technology is increasingly supporting timely and effective exchange of information especially in the community. Increased use of NHS secure internet and more electronic records has speeded up notification processes. As in many areas, lack of connectivity between the main health providers remains a barrier to effectiveness. Wide use is made of electronic records in many services but LPFT, ULHT and CASH all use different systems which cannot connect. A bid to link these health service data bases is with NHS England.

5.1.7 There are some strengths here, for instance the data base used in community services, therapies, by community paediatricians based in ULHT, and all but one of the looked-after children GPs. Not all GPs use the system, but where they do they can enable other LCHS staff to view specific records. The community health data base has also been provided for read-only use by A&E staff in the acute hospitals. However, A&E and other key health professionals do not have direct access to terminals with the social care data base which is possible in many other areas of the country. This means staff need to make phone calls to check whether children and families are known to social care and it is acknowledged that there can be difficulties in making timely contact in this way. Positively, health partners have been consulted in relation to social care's planned system upgrade.

5.1.8 The use of audits has contributed to improvements in the quality of some looked-after children's health assessments but overall quality remains inconsistent.

5.1.9 There remain unmet pressures on capacity and skill mix for carrying out health assessments compared to the volume of work and complexity of needs of children coming into care. The 2011/12 Annual Report on the health of looked after children highlighted the variability in the quality of health assessments and health care plans and recommended that community paediatricians should undertake IHAs (recommendation 1.2). Children and young people have not benefitted from any progress towards this recommendation though audit evidence was used recently to request a review of arrangements for IHAs at safeguarding steering group.

5.1.10 Strategic partnership working is good. Health strategic leads describe positive relationships across the partnership and particularly with the director of children's services who also has a health background. Strategic leads meet regularly and partners are able to have a mature dialogue about a range of issues and common themes. Strategic managers identify an improved connectivity between strategic management and frontline operational staff. Operational managers are increasingly seeking multi agency solutions when issues are identified though some intransigent problems have yet to be resolved fully. CASH services in Lincolnshire are not formally represented in the partnership that is addressing sexual exploitation and this is a gap since the service will be able to contribute strategically and in respect of operational issues and individual cases (recommendation 4.2).

5.1.11 We heard about an example where the named GP was able to liaise with social care when an issue was identified by GPs. As a result, social care's processes were amended to ensure that GP calls are now logged to contribute to risk assessment about children and their families.

5.1.12 Partnerships with and in CAMH services are improving but case examples showed a range of issues where better coordination between services could improve outcomes for young people and their families. This is evident where support for young people who attend A&E's with emotional, behavioural and mental health needs continues to be inconsistent as professionals struggle to reconcile the needs of different groups of children. We also saw the significant impact of poor discharge arrangements and communication from an external T4 CAMHS which failed to ensure that local services are in place (recommendation 5.3).

5.1.13 Families with foster children told us how better co-ordination between health professionals would benefit the young people by ensuring their health needs are fully taken into account.

5.1.14 We saw little evidence that the views of children, their families and carers are regularly heard and taken into account. Much more focus is needed to ensure that children and young people are encouraged to regularly share their views and experiences in evaluating the quality and impact of local health services (recommendation 7.1).

The community health trust's recently strengthened arrangements for safeguarding leadership were bringing the important health perspective to child protection strategy discussions. Through a rota system, the county-wide team of deputy named nurses is available at any time and this is an imaginative response in a large county area.

5.1.15 We found that health professionals recognise the value of team around the child work but in some areas of work, capacity issues prevent their involvement, with this being a particular issue for staff employed by ULHT. Capacity within the ULHT safeguarding team generally has been flagged up in CQCs compliance inspection of this trust. The children's safeguarding team of two health professionals liaises with the named midwife team and the adult team. Operating across several disparate sites and ensuring an effective safeguarding partnership with other providers adds to the challenges of the role.

5.2 Governance

5.2.1 Each trust has governance arrangements in place which include regular reporting on local safeguarding arrangements.

5.2.2 NHS England and the four CCG's have given high priority to the work needed to continuously improve safeguarding and children in care health services. The priorities for safeguarding are currently clearer than for children in care. Through a memorandum of understanding between the four CCGs, this work is led by Southwest Lincolnshire CCG, its chief nurse, and the designated professionals.

5.2.3 Progress has been made in some areas and the designated nurse for safeguarding and looked-after children is providing strong leadership. However, she and other designated professionals have insufficient capacity for strategic planning, comprehensive quality assurance of operational delivery and ensuring continuous improvement (recommendation 1.1).

5.2.4 The capacity of the looked-after children health team has not kept pace with the growth in numbers of looked-after children in the county, including high numbers of children placed by other councils and the complexity of needs. Well over 1000 health assessments and reviews are required each year, with significant preparatory and follow up work including quality assurance of the assessments and health plans. Although efficiently supported by the co-ordinator and administrative support, the designated doctor's allocated one session per week is inadequate to deliver the strategic role and quality assurance work. The designated nurse role is also challenged in seeking to deliver the full statutory role with approximately one third of a post for LAC work and one third for children's safeguarding leadership. These pressures impact on capacity to drive and embed quality standards across the large county (recommendation 1.1 and 1.2).

5.2.5 We found that performance reporting arrangements around the holistic health needs of all looked-after children, the services to meet their needs and the outcomes that are achieved is insufficient to ensure that looked-after children receive the help they need (recommendation 2.2). The format of the annual report on the health of looked-after children is quite narrow in scope. This misses the opportunity to set out the full picture of their needs and outcomes and to identify key issues that are of concern to looked-after children generally or to local children in particular. Limited performance reporting about needs, outcomes and gaps in services for looked-after children impacts on the ability to make robust plans to deliver improvements. Information about the health needs of looked-after children with long term conditions is not currently collated from their individual health assessments. This results in a lack of oversight of the capacity of services to meet their current needs and that their health needs are recognised in transition planning for their future. This remains an outstanding action although identified by the looked-after children service to be addressed during 2012/2013 (recommendation 1.2).

5.2.6 The community trust provides paediatric liaison nurses (PLNs) in A&E departments run by ULHT and at the minor injuries units (MIUs). In some locations we found un-explained gaps in referrals to the PLN and a lack of managerial oversight or quality assurance. As a result, it is not clear that staff across acute services properly regard this as a whole system approach and there are inherent risks that children are not effectively protected. The addition of the new MIU at Peterborough to the portfolio of the paediatric liaison service has added significant pressure on the capacity of the service, which is already stretched (recommendation 3.3).

5.2.7 Within ULHT strengthening of safeguarding has started to progress with the appointment of an interim named midwife, a new post currently at Band 7 created in response to a serious case review as the role did not exist before March 2013. The named midwife post is an integrated role within ULHT, supported the safeguarding leads for adults and children. Managers recognise that the role requires the greater seniority and experience of a Band 8 midwife and a business case is being developed to seek appropriate recruitment of suitably qualified midwife. The current post holder is doing a good job from a zero base but has insufficient experience in safeguarding to put in place a fully robust framework and monitoring for effectiveness and quality.

5.2.8 Midwifery services are being reconfigured to best meet local need with the Louth community midwife team being transferred to Grimsby hospital. This makes good sense as most deliveries in that area happen at Grimsby hospital. The Grantham stand-alone unit is to close in February. This has been subject to consultation and services will move to Lincoln site to focus resources where most required.

5.2.9 The LPT safeguarding consultant named nurse oversees safeguarding activity in CAMHS, SARC, DART and adult mental health. She provides strong and effective leadership and has put a good system in place. The LCHS's safeguarding team also operates very effectively in most areas of work and makes good use of its management information.

5.2.10 The oversight and clinical governance of safeguarding in A&E and MIU locations we visited is not fully effective. Paediatric liaison arrangements lack a systematic, county wide approach. The paediatric liaison nurse records any actions she takes on her visits to review CAS Cards and holds this data. Recognised safeguarding issues within ULHT and LCHS are cascaded upwards through the Trust's Safeguarding Committee's and downwards via the Trust's Safeguarding Champions Network / deputy named nurses. However, the details of PLN activity are held by the PLN. It is not collated to provide useful performance information which ULHT and LCHS could use to monitor departmental and clinicians' safeguarding practice, identify trends and drive continuous improvement and is not subject to reporting through clinical governance arrangements (recommendation 3.3).

5.2.11 A&E staff routinely seek advice and guidance from the ULHT safeguarding team when they have concerns about individual children. We saw examples of recent improvements by the named nurses which are helping to strengthen safeguarding systems. Where staff do identify safeguarding concerns, the advice sheets then generated by the ULHT safeguarding team provide a useful audit trail of the issue and the advice or instructions given to address the safeguarding concern.

5.2.12 Arrangements are not in place to collate the health needs of looked-after children or to track their access to treatment and subsequent outcomes (recommendation 2.2). We heard about children waiting unacceptably long times for a range of services and equipment. Collation of this data would help to inform commissioning and ensure that there are appropriate, effective services in place.

5.3 Training and Supervision

5.3.1 Safeguarding champions provide a structure for sharing learning within their localities and teams. A&E at Grantham has particularly strong leadership from its A&E sister who is very well respected. As a safeguarding champion she has brought in bespoke training which has helped to skill up all the staff. Her leadership helps to mitigate for against any systems difficulties and she personally takes a role in ensuring issues are followed up.

5.3.2 Ensuring that health practitioners are trained to levels of safeguarding competence commensurate with their roles remains a priority challenge for some services. Since the previous inspection, additional investment by the LCSB has increased the availability of multi-agency safeguarding training. We saw how health staff are taking advantage of the programme, using on line booking arrangements to access targeted training to fit their roles.

5.3.3 Health visitors and school nurses are well trained in safeguarding and looked after children work and their competencies are checked to support compliance with *Working Together* and intercollegiate guidance.

5.3.4 There is now a clear grip on safeguarding training requirements for all staff of the acute trust following a period when compliance and oversight of safeguarding training was poor. This remains a priority area for improvement at ULHT and is being well monitored. As additional staff are recruited, more are able to be released for training. A good trust wide initiative by ULHT's safeguarding practitioner, in conjunction with the PLNs, is open surgeries / workshops allowing all A/E staff to access advice and guidance. These are aimed at developing safeguarding practice and confidence in addition to offering reiteration of the Safeguarding / PLN Teams' roles, unfortunately, take up is low.

5.3.5 It is not clear whether safeguarding training at level 1 is fully equipping reception staff at A&Es and MIUs to undertake risk assessment involving a high proportion of children, as they are doing on a day to day basis. Examples were given however, of cases where reception staff had identified safeguarding risks and had acted promptly in notifying clinical staff of their concerns.

5.3.6 We visited three emergency care centres which treat both children and adults and asked about arrangements to ensure staff had appropriate training to equip them to nurse children. Grantham hospital A&E is usually able to offer nursing care by at least one paediatric –trained nurse at all times. However, arrangements to ensure staff working with children across the acute trust (ULHT) and in the MIUs can access and maintain EPLS training are not sufficiently rigorous and practitioners are overdue essential refresher training (recommendation 3.4).

5.3.7 The NHS England area team (AT) and CCG leadership are working together to secure a sustainable approach to safeguarding training arrangements for GPs and this is recognised as a current area of risk. The county initially undertook a series of level 3 training sessions to cover all GPs between 2010 and 2011 but for about one third of all of those who attended then, that training is now over three years old. Training sessions for GPs are available from ULHT or the LCSB and attended by some GPs.

5.3.8 A new system is being put into place to track individual GP's training needs and attendance and ensure that arrangements are also in place for practice staff. Work is also starting, with the NHS England area team, to develop a university accredited training programme for primary care practitioners alongside an in-house programme and this is very positive.

5.3.9 Safeguarding supervision is at an early stage of implementation in some health services. However, LCHS performs well overall, with very good visible performance management information across a range of safeguarding themes including safeguarding supervision which is reported quarterly. Compliance with planned supervision in the summer quarter was 91.08%. Health visitors are routinely receiving quarterly 1:1 and also group supervision. All LPFT staff discuss safeguarding at every managerial supervision session which is a minimum of 6 weekly.

5.3.10 In some other service areas such as the MIUs (LCHS) and in midwifery (ULHT), supervision is a recent introduction which is not embedded. It is early days for group supervision and no individual supervision is in place. Although there are safeguarding champions in midwifery services, there are no safeguarding supervisory staff other than the named midwife. There are no formal safeguarding supervision arrangements for A&E staff at ULHT (recommendation 6.1). Without regular formal supervision as set out in statutory guidance, practitioner's annual appraisal cannot be fully informed as part of a robust workforce development model.

Recommendations

1. **Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG should:**
 - 1.1 Review the leadership capacity for safeguarding children and children in care to fully meet statutory requirements and secure the timely delivery of quality services for safeguarding children and children who are looked after.
 - 1.2 Ensure commissioning governance and assurance provide effective scrutiny of the experiences and impact of local health services in delivering improved outcomes for children and young people who are looked after.
 - 1.3 Use the opportunity of the local strategic review to consider the commissioning of specialist paediatric care and ensure its effectiveness in enabling children who have specialist needs to have access to timely, child centred assessment and treatment.

2. **Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG and LCHS should :**
 - 2.1 Ensure the emotional wellbeing and mental health of children in care is fully addressed in health care assessments, reviews and health plans.
 - 2.2 Regularly report on child health outcomes for children in care, proactively identifying local trends, and robustly addressing risks to their health and wellbeing.
 - 2.3 Fully implement holistic health summaries for young people leaving care and ensure they are responsive to their individual wishes and needs.
 - 2.4 Ensure that arrangements are put into place to provide consistent support for looked after young people and care leavers who become pregnant or become parents.
 - 2.5 Ensure that all children in care have prompt and high quality, holistic assessments of their needs and regular reviews followed by SMART health plans that ensure their needs are met.

3. Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG, LCHS and ULHT should:

- 3.1 Ensure that discharge pathways from MIUs, A&Es and other settings are effective in ensuring the sharing of information about risks and involving appropriate professionals to secure best outcomes for the young people.
- 3.2 Ensure that opportunities are maximised to offer young people help through drug and alcohol support services by embedding the LSCB led multi-agency protocol which provides clear referral pathways from health services including urgent care settings to Young Addaction .
- 3.3 Review paediatric liaison capacity, seniority and clinical governance arrangements to ensure that robust, effective arrangements are in place across all services so that risks to children are effectively identified and followed up.
- 3.4 Ensure all children and young people requiring urgent care in the MIUs and Accident and Emergency Departments are cared for by appropriately trained nursing staff with updated specialist paediatric skills.⁵

4. NHS England, Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG and LCHS should:

- 4.1 Ensure that GPs are properly equipped and competent for their roles in safeguarding, child protection and meeting the needs of children in care through robust development opportunities.
- 4.2 Ensure that GPs and others who may provide contraceptive services to young people are aware of the law in relation to the age of consent, particularly in relation to their responsibilities where a girl is under 13 years of age.
- 4.3 Ensure there are robust local systems for GPs to regularly share information about children and families where risks are identified.

⁵ *"In district general hospital mixed emergency departments, a minimum of one registered children's nurse with trauma experience and valid EPLS/APLS training must be available at all times"* (RCN and RCPCH 2010; RCPCH, 2012).

- 5. NHS England, Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG and LPFT should:**
 - 5.1 Continue to work in partnership to ensure that commissioning and operational arrangements enable children needing CAMH services to have timely access to early help, specialist assessment and treatment.
 - 5.2 Ensure that mothers and their babies in all areas of Lincolnshire have access to perinatal mental health services to secure effective early intervention and support.
 - 5.3 Review arrangements for young people placed out of county so that discharge protocols from or between CAMH tier 4 services and to other services ensure that these young people receive the support they need. .

- 6. Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG, and ULHT should:**
 - 6.1 Ensure an appropriate system of supervision is in place for all staff who are involved in safeguarding and child protection work, including urgent care and midwifery, in line with inter-collegiate professional requirements.

- 7. Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG, LCHS, ULHT and LPFT should:**
 - 7.1 Expand opportunities for listening to and learning from the experiences of young people and their families/carers, actively engaging them in service improvements.
 - 7.2 Ensure that robust arrangements are put in place to assure the quality of referrals by health professionals and ensure that children for whom risks are identified receive prompt support.
 - 7.3 Ensure, through working with partners, that staff across all health disciplines including adult drug and alcohol services are fully engaged in robust, consistent information sharing about children and their families for whom risks or concerns are known.
 - 7.4 Ensure that the pre-birth protocol is audited for effectiveness in all cases including those where there is a known high degree of risk around the expectant mother

8. LCHS:

- 8.1 Ensure that all relevant staff are properly equipped prior to any roll out of new policies or systems including the electronic version of the vulnerability assessment matrix, to ensure use is consistent and effective.

9. NHS England and Lincolnshire West CCG; South Lincolnshire CCG; South West Lincolnshire CCG; Lincolnshire East CCG should:

- 9.1 Review commissioning strategies, local needs analyses and pathways to ensure children benefit from sufficiency of CAMHs provision, including tier 4, tier 3+ and community based alternatives to in-patient care, to facilitate care close to home and to ensure that other young children on paediatric wards are not put at risk of harm or distress

Next steps

An action plan addressing the above recommendations is required from South West Lincolnshire CCG on behalf of the federation 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 team.