## Report on the Outcome of the Integrated Inspection of Safeguarding and Looked After Children’s Services in Halton

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<th>7-18 February 2011</th>
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<td>Date of final Report</td>
<td>18 February 2011</td>
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<tr>
<td>Commissioning PCT</td>
<td>NHS Halton and St Helens</td>
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<tr>
<td>CQC Inspector name</td>
<td>Tina Welford</td>
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| Provider Services Included: | Warrington and Halton Hospitals NHS Foundation Trust  
|                       | Halton and St Helens Primary Care Trust  
|                       | 5 Boroughs Partnership Foundation NHS Trust  
|                       | St. Helen’s and Knowsley Hospitals NHS Trust |

This report relates to the recent integrated inspection of safeguarding and services for looked after children which took place in the above Authority recently.

It provides more detailed evidence and feedback on the findings from the Care Quality Commission’s (CQC) component of the inspection, and links these to the outcomes requirements as set out in the Essential Standards for Quality and Safety.

Thank you for your contribution to the inspection and for accommodating the requests for interviews and focus groups with your staff and those of partner agencies at relatively short notice.

The team provided feedback to your local Director of Children’s Services at the end of fieldwork and the joint inspection report to the authority is now published on the Ofsted website and can be accessed via this link: [The joint inspection report](#).
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| **Looked After children Inspection Outcome**       |
| **Aggregated inspection finding**                  |
| Overall effectiveness of services for looked after children and young people | Good                                      |
| Capacity for improvement of the council and its partners | Outstanding |

This report includes findings from the overall inspection report, and provides greater detail about what we found, mapped where relevant to the Essential Standards, in order that your organisation can consider and act upon the specific issues raised.

A copy of this report is being sent to your commissioning primary care Trust (PCT), and CQC Regional Director. This report is also being copied to the Strategic Health Authority/Monitor as appropriate and CQC’s head of national Inspections, who has overall responsibility for this inspection programme.

*In respect of the recommendations in the report, please complete an action plan detailing how they will be addressed and submit this to CQC and your SHA Chief Executive within **20 working days** of receipt of the final report.*

**The Inspection Process**

This inspection was conducted alongside the Ofsted-led programme of children’s services inspections. These focus on safeguarding and the care of looked after children within a specific local authority. The two-week field work inspection process comprises a range of methods for gathering information – document reviews, interviews, focus groups (including where possible with children and young people) and visits – in order to develop a corroborated set of evidence which contributes to the overall framework for the integrated inspection.

CQC contributes to the inspection team and assesses the contribution of health services to safeguarding and the care of Looked after children relating to that authority. Our findings from the inspection contribute to the joint report published by Ofsted and also enrich the information we use to assess providers against the Essential Standards of Quality and Safety. This report sets out specifically the
evidence we obtained in relation to these standards and extracts from the published report are included and identified.

CQC used a range of documentary evidence in advance of and during this inspection, and interviewed individuals and focus groups of selected staff and, where possible, children and young people, their parents and carers in order to provide a robust basis for the findings and recommendations.

This document sets out the findings in relation to the organisations listed above, but includes some areas which apply to one or more other NHS bodies where pertinent.

Context:

Commissioning and planning of child health services and primary care services are undertaken by NHS Halton and St Helen’s (PCT) with universal services such as health visiting, school nursing and paediatric therapies delivered primarily by Community Health Services (CHS), the provider arm of the PCT. The acute hospitals providing accident and emergency services for children are Whiston Hospital (St. Helen’s and Knowsley Hospitals NHS Trust) and Warrington Hospitals (Warrington and Halton Hospitals Foundation NHS Trust). Maternity and newborn services are provided predominantly by Whiston and Warrington Hospitals. NHS Halton and St Helen’s has a community midwifery service that provides antenatal and postnatal care for women for women booked at local hospitals, and home delivery for those who choose this. Children and families access primary care through one of 18 General Practitioners (GP) practices and one walk-in centre in Widnes.

Child and Adolescent Mental Health Services (CAMHS) are provided by 5 Boroughs Partnership Foundation NHS Trust. Services for children with complex needs are provided by NHS Halton and St Helen’s.

Looked after children services are commissioned by NHS Halton and St Helen’s for Halton Borough Council. This includes the provision of specialist healthcare staff and a dedicated CAMHS and leaving care team, all based at Midwood House. The CAMHS team is provided by 5 Boroughs Partnership Foundation NHS Trust.

In terms of commissioning, NHS Halton and St Helen’s is the lead commissioner for St Helen’s and Knowsley Hospital’s NHS Trust and an associate commissioner for 5 Boroughs Partnership Foundation NHS Trust and Warrington and Halton Hospitals Foundation NHS Trust. The PCT and Halton Borough Council have created a Joint Commissioning Unit to jointly commission services for children.

Halton is a largely urban area of 119,500 people. There are approximately 28,000 children aged between 0-18 years. Its two biggest settlements are Widnes and Runcorn that face each other across the river Mersey and are joined by a bridge. As a result of its industrial legacy, particularly from the chemical industries, Halton has inherited a number of physical, social and environmental problems. Halton is ranked 30th nationally in the Index of Multiple Deprivation 2007 (a ranking of 1 indicates that it is the most deprived).
Warrington and Halton Hospitals NHS Foundation Trust accident and emergency department was inspected in January 2011, and therefore was not visited as part of this inspection. Outcomes from the January 2011 inspection identified that there were no areas of non compliance or concern within the children and young people accident and emergency department. The inspection found that there was effective notification to primary care and community care staff when children and young persons attend for emergency care.

1 General – leadership and management

1.0 Health partnerships are mature and well embedded within the children trust arrangements and the Halton Safeguarding Children Board. Further partnership working within both managerial and front line services is embedded and further integration is well underway to improve further working relationships. There is good representation and attendance by health partners at the HSCB and all the subgroups. Where health services are co-located with other partners, this has further enhanced effective and timely communication between these agencies and improved the sharing of intelligence relating to children, young people and their families. There is a shared vision and priorities for action between health and partner agencies.

1.1 All health safeguarding policies are in date, implemented and subject to regular review, as part of the ‘Pan Cheshire’ safeguarding policy process. The child death overview panel (CDOP) is fully embedded in the Halton Safeguarding Children Board (HSCB), which effectively disseminates information to practitioners relating to national child deaths (there have been no recent local child deaths). However, staff interviewed were unable to identify information sent from the CDOP, that had arisen from child deaths, but were aware of the safeguarding toolkits which were developed by CDOP as a result of a review of local, regional and national child deaths. Further, staff confirmed that these ‘toolkits’ were being used successfully, identifying the risks to children, raising awareness for both formal and informal carers, as well as their use as an education tool for families with the aim of keeping children safe from harm. It was ascertained during the inspection process that as the information form the CDOP is circulated under the ‘branding’ of the HSCB that staff were not aware that this information was related to the CDOP work.

1.2 The local health providers have effective safeguarding assurance committees with an embedded structure in place, which is providing assurance to commissioners and the HSCB with regard to the effective monitoring of safeguarding activity. There is good cross border notification of all secondary care attendances (mental health attendances by adults related to hidden harm and young carers), the latter being well used as part of the local benchmarking and auditing intelligence. There is no paediatric secondary care service in Halton.
2 Outcome 1 Involving Users

2.0 There have been a number of user engagement events and parents interviewed during the inspection reported being invited to feedback events, however some parents were unclear as to what action had been taken as a result of consultations. There is good awareness of equality and diversity issues amongst all those health staff interviewed, including the specialist looked after children health teams, who attend equality and diversity mandatory training. There is a good responsive whole systems approach used by the local health commissioners and providers to meet identified individual users’ ethnic, cultural and equality and diversity issues. A number of individual examples were stated, where support had been effectively provided to young people to meet their cultural needs. Examples included; a dedicated worker with the travelling families, specialist maternity support for Libyan women residing in the authority, and use of cross boundary access to faith groups for children who are looked after. All staff report good access to translation and interpretation services. Some staff have developed sign language skills, which has improved communication with children and families who have a hearing disability or are deaf.

2.1 Teenage girls who become pregnant are well supported by the maternity services at Halton Community Healthcare Services, enabling them to make an informed choice about their pregnancy. The service design is reviewed by users and adapted to meet their recommendations. Good support is also given to the young father-to-be. Those teenagers who choose to have termination of the pregnancy are well supported with good follow-up care, based on their individual wishes including contraceptive advice.

2.2 There is a good multi-agency care leaver’s team, working well together to support the young person to remain in education or find suitable employment, depending on their wishes and aspirations.

2.3 Looked after children are actively involved in their annual health assessments and have a choice of a suitable time and venue for the assessment to take place. Children who live out of the borough are also given the same choices, with examples cited including staff travelling some distances to different parts of the country to ensure that health assessment are completed and that transition plans are developed with the child/young person to meet their individual needs.

3 Outcome 2 Consent

3.0 Consent has been gained and clearly documented prior to looked after children health assessments, and further for any other treatments and assessments taking place. However, a few young people reported that there is confusion at the time of immunisation and vaccinations within school health programmes, as to who is able to consent, with consent forms signed by foster parents not being accepted. This often results in the young person not receiving the immunisation/vaccination and identifies them to their fellow pupils as being ‘in care’. Young people felt that the situation could be dealt with in a more sensitive manner. Further, they may then have to attend for another appointment, either with the school nurse or looked after health team, for their ‘missed’ immunisations and vaccinations, which may mean them being taken out of lessons, which again identifies them to other peers.
4 Outcome 4 Care and welfare of people who use services

4.0 All front line health staff interviewed are aware of referral thresholds and reported effective working with social care staff when referrals are made, with only limited need to use the escalation policies and procedures. Where the escalation policies and procedures have been used, they have been effective. However, the staff based in the walk-in centre, who access the out of hours duty team, report that there are often delays in getting a response and it is difficult to keep the young person within the service whilst awaiting a response from social care. This is due to the nature and ethos of the walk-in services. Staff at the walk-in centre currently rely on the child/young person or the adult with them to disclose if they are ‘looked after’ and who has consenting rights. The social care database is to be introduced into the walk-in centre shortly, with the aim that staff will be able to be able to check if a young person is known to social care on assessment in the centre.

4.1 There is a good rate of completion of health assessments ‘in date’. January 2011 data shows that the rate of completed health assessments is recorded at 82%, immunisations rate 87% and dental access 89%, which are in line with national trends and better than some comparators. Health action plans are well monitored and databases were being amended at the time of the inspection to enhance this still further and provide more robust performance monitoring data. The strength and difficulties questionnaires (SDQs) are effectively used, with good analysis of scores with weekly and monthly monitoring meetings to review the scores and ensure that the emotional well being and mental health needs identified are addressed. There is good health support with a dedicated worker for care leavers ensuring that health needs are met and independence promoted. However, young people who had left care reported that they are not receiving a copy of their health history from their social workers. All care leavers seen during the inspection confirmed that they were registered with both a general practitioner and a dentist. There is good prioritised access to the dedicated dental service for children and young people known to social care, which includes both looked after children as well as children subject to child protection proceedings or identified as a child in need.

4.2 There have been delays in some ‘initial assessments’ being completed within four weeks, due to lack of timely notification from social care. Training has been given to social care managers, and training now in place for front line staff. The situation is improving; however, this still remains a challenge and concern for health staff. Route cause analysis methods (RCA) are now being effectively used when a case of delayed assessment is identified, to prevent further reoccurrences.

4.3 Looked after children specialist nursing staff provide a good range of training on sexual health, healthy lifestyles and positive parenting for foster carers, looked after children and young people residential home staff. This is continuing to support the maintenance of placement stability, with many individual examples being cited.

4.4 Looked after children and young people are effectively encouraged and supported to attend universal health service provision. Those young people spoken to during the inspection felt confident about how access provision and had been able to access universal sexual health and preventative services when required.
4.5 There is good access to child and adult mental health services (CAMHs), with good dedicated pathways for more vulnerable groups including; an accessible service for children and young people on the cusp of care and for looked after children and young people (including those with learning difficulties and or disabilities), care leavers, and young people undergoing transition, all of whom are well supported. There is good access to Tier 4 beds.

5 Outcome 6 Co-operating with others

5.1 The common assessment framework (CAF) has been in place for a number of years (2005) as the area was a pathfinder site. All staff reported being fully trained in the use of CAF with regular updates being available and accessed as required. However, since the recently introduced Integrated Working Support Team (IWIST), which provides dedicated support and administration of the CAF, this has enabled the increased use of e-CAF used more efficiently as the administrative burden felt by some practitioners has reduced. Many examples were given where CAFs have improved the outcomes for children and young people. However the parents of children with learning disabilities were either unaware of CAF or had been informed that education staff need to start the process and not social care staff, resulting in them being confused as to whom they should be contacting for support. As a consequence, parents were often repeating their ‘story’ to a number of professionals on a number of different occasions and felt that the support they were given was often uncoordinated and that they had to ‘find out for themselves’ what they were entitled to (including access to benefits) and that this was often from other parents. Some parents have made good use of the local internet sites but this relies on the parent being able to access information technology. Staff reported that communication has improved since CAFs have been introduced across all partner agencies, most notably within housing, as housing staff are now contacting the health visitor with concerns following home visits they have made to a family.

5.2 There is good medical attendance at adoption and fostering panels (over 90%), as a result of good advance notice given of meetings and cases to be discussed. However there is variable rate of general practitioner (GP) contribution to child protection proceedings, due to the reported short notice of requests from social care for reports. Commissioners are aware of this and action is currently being taken to improve the notification processes.

5.3 Notification of looked after children who are placed out of the authority has recently improved, including those from other authorities where children and young people are placed in Halton, since the use of the cross Merseyside and Cheshire notification form. Due to this success the notification form is now being implemented across the Greater Manchester area.

5.4 There is effective joint commissioning and integrated partnership working with substance misuse services and the safer community partnerships, (including youth offending services) which is reducing the rate of antisocial behaviour complaints related to substance misuse and the duplication within services.
5.5 Staff at the children centres and the child development centre offer a highly valued range of support to parents and their families, with a child with a pre-diagnosis of autism spectrum disorders. This support for parents and siblings, along with an effective use of play therapy, is enabling families to 'play and stay together' and further is improving the families emotional well being. Parents interviewed are keen to commence the programme which supports sensory integration techniques. Where this has been implemented there is evidence that from outcomes that there is an improvement in the behaviour of the young person and a coordinated approach by the family and professionals, but it is too early for full impact assessment. Families report a more co-ordinated approach between them and professionals, enabling them access to universal provision and promoting social inclusion, this includes access to mainstream education provision which was seen by parents as the most successful outcome.

5.6 There are effective termly tracking transition panels for young people with learning disabilities, ensuring that the provision and transition plans are relevant and meeting the needs of the young person. These panels continue until the young person is 25 years old to ensure good ongoing support, or until the young person has successfully transferred to adult services.

5.7 The learning disability CAMH service and the physical disability teams including the therapy services (physiotherapy, speech and language, connexions advisors and education psychologists) are well integrated and are effectively and successfully coordinating transitions to adult services through multi agency working. This is also extended to include youth offending staff, with the ethos of a 'team around the child/family' approach effectively meeting individual needs. Therapy services are well integrated into the education key milestone meetings (and at transition times), which is ensuring that transfer plans are robust. Parents report that the early interventions, especially those provided through the child development centre over the last two years, has greatly improved the support and transition services that they now receive. The support for new parents was perceived as being provided in a timelier manner and that this was as a result of feedback from previous parents who had used the services. There is a dedicated nurse consultant for transitions, who works closely with children and adult mental health services ensuring that transitions are successful. The post holder also visits looked after children placed out of area, to identify their individual wishes for transition to adult services or successfully back into the Halton area.

5.8 Some parents of children with disabilities who have formed their own support groups report that health and the council are open and fully engaged with then, openly wanting to hear their views and acting on issues that they raise. However, other parents felt this was not always the case with the council, especially when complex needs panels are not in agreement with medical recommendations, and that in these cases the decision making rationale is not well communicated, leaving the parents feeling frustrated and concerned for the future safety and welfare of their child.
6 Outcome 7 Safeguarding

6.0 There are highly visible designated and named health professionals, who are suitably qualified for their respective roles. The dedicated liaison posts between secondary, primary and community staff are effective. All notices of attendance relating to children and young people visiting unscheduled care (between 300-400/week) are received by the named nurse in the safeguarding office and then forwarded on to the relevant community practitioners, GP and to the LAC health team. Appropriate follow up action is taken, ensuring that the child is supported and remains safe. There is good cross border notification of all secondary care attendances (there is no paediatric secondary care in Halton) including young carers and hidden harm cases from adult services.

6.1 The named GP and designated doctor roles, at the time of the inspection, were vacant, however, there are good cover arrangements in place and the recruitment process had recommenced at the time of the inspection. General practices have safeguarding leads in place. Some General Practitioners (GP) hold within their practices effective ‘family meetings’, which are highly valued by those staff who attend. At these meetings, community and primary care staff discuss ‘high risk’ families and any notifications received from unscheduled care attendances and notifications from adult services related to hidden harm and young carers. Actions are agreed to ensure that families remain safe, with effective monitoring of the agreed actions, also at these meetings. There have been no recent serious case reviews.

6.2 All health staff reported good notification of domestic violence incidents (CAVAs) from the police. These are reviewed, case notes flagged if the risk is assessed to be high enough according to the policy and appropriate action taken as required. There is good involvement of health staff within both the multi agency risk assessment conference (MARAC), and the multi agency public protection arrangements (MAPPA). The outcomes of which are also discussed at the family meetings, or at team meetings with flagging on medical notes to ensure that risk can be identified and needs addressed.

6.3 There is good prioritised access CAMHS for looked after children. There is a dedicated CAMHS post for looked after children and regular meetings of the dedicated specialist looked after children nursing team. However, community staff reported that there remains a lack of information sharing on case progression between CAMHS staff employed by 5 Boroughs Partnership NHS Foundation Trust and Halton and St Helens’ Community Health school nursing and health visiting staff. Action taken to rectify this has just started to have an impact. There is a robust ‘did not attend’ and ‘failed to engage’ policy and process with continued monitoring of the young person case until a satisfaction conclusion for that individual is achieved. There is good access to Tier 4 CAMHS beds as required.
6.4 Community health professionals, as well as those working in the sexual health services, are providing good and accessible sexual health services. All staff interviewed were aware of the referral pathway to the out of area Sexual Assault and Referral Centre (SARC), which on the rare occasions it had been used, worked well. The teenage clinics are highly accessible with a large increase in attendance - from 1400 to within 3 years 7800 (in last 8 months). The Halton walk-in centre provides a good range of accessible young person’s sexual health services. The rate of teenage conceptions however, still remains above the England and Northwest region averages although the rate has declined (40.2/1000 rolling quarterly data June 2009 overall 57.3/1000 equates to 119 fewer conceptions than in 2008). There is a dedicated teenage pregnancy posts in place supporting the young women as well as young men and young fathers. There is good follow-up of all young women who miss a maternity appointment, as part of the concealed pregnancy pathways, as well as follow-up support with the commissioned private termination of pregnancy service. Local maternity data shows that within the last 12 months there have been no pregnancies in young women up to 16 years of age.

6.5 There are a number of recently commenced initiatives, aimed at promoting culture change to continue to support the decline in teenage conceptions. These include an education programme with potential grandparents and great-grandparents. Further, there is a good range of opportunities for young people through connexions and through the local rugby and football clubs, raising self esteem and aspirations. These are organised in conjunction with both the substance misuse and youth offending services, leading to further support for education and employment opportunities. An adequate provision of sexual health and relationship education and personal health and relationship education in schools is provided by either the school nursing service or by education staff. The ‘drop-in’ sessions run by school nurses have had a mixed reception from young people, with variable rates of attendance. This was being evaluated at the time of the inspection to establish the views of young people and what services they would access. Some schools are able to offer the ‘C card’ scheme and emergency contraception and where offered in schools are well accessed by both genders. More recently, sexually transmitted disease screening has become more freely available, which is improving the rate of take up and repeat testing. A text messaging service is in place for young people, (for those young people who are registered), which informs them of the location of sexual health clinics and the opening times, which has improved attendance.

6.6 There is an effective and well accessed mobile outreach bus, which is used in ‘hotspot’ areas of high teenage pregnancy, delivering sexual health services including sexual health screening, reducing antisocial behaviour and where there is high substance misuse activity. The location of static sexual health clinics have been reviewed with young people, to ensure that the location meets their needs and where this has occurred there has been an increase in attendance.

6.7 Dental services, both private and NHS contracted, are fully engaged and meet their safeguarding responsibilities, with practitioners attending the range of available multi agency safeguarding training.
7 Outcome 11 Safety, availability and suitability of equipment

7.0 There is no dedicated childrens waiting area at the Halton Walk-in Centre. This is due to lack of physical space, resulting in children remaining within the same waiting area as all attendees at the centre.

7.1 Parents of children with disabilities reported that there is often a long wait (6 months in one case) for an occupational therapist assessment for home adaptations, and then a delay in the equipment being delivered and fitted. However, there were no complaints or concerns with medical and personal hygiene supplies.

8 Outcome 12 Staffing recruitment

8.0 All staff interviewed, reported having received a criminal records bureau (CRB) check on employment.

9 Outcome 13 Staffing numbers

9.0 There is a robust joint workforce strategy which reflects the local populations. The ethos of integrated working embraces the good workforce development and competency based training which is enabling staff to effectively meet the needs of young people.

9.1 The community health staff workforce and skill mix has been reviewed, due to a lack of qualified health visitors and difficulties in recruitment. Effective business continuity plans have been implemented, ensuring that the healthy child programme can be maintained and no child is put at risk. A new cohort of qualified health visitors is due to come into post by August 2011, and plans are in place to review the service delivery again at this time. Staff interviewed report that caseloads, generally, are manageable and are fully aware of the service delivery and continuity plans.

10 Outcome 14 Staffing support

10.0 All staff interviewed confirmed that they have received and are up to date with, the appropriate level of safeguarding training. There are a good range of multi agency and bespoke training programmes. However, performance data and management systems are not yet sufficiently sophisticated to map the level of compliance and identify further training needs. There is no formal evaluation of the impact of training. There is very good access to safeguarding supervision training, and ongoing supervision, which is highly valued by all practitioners. The designated and named health professions have a high profile within health and partner agencies, staff reporting good levels of support and timely access to advice when required. Designated and named health professions have good access to supervision and support, which enables them to undertake their roles with a degree of confidence and competence.
10.1 A behaviour support programme has recently been implemented, with a number of health staff participating and training educational staff, foster carers and parents, including a newly developed sensory awareness programme. Early feedback has shown an increased awareness of the needs of these young people and better management of challenging behaviours. The new sensory awareness programme is yet to be evaluated for impact.

11 Outcome 16 Audit and monitoring

11.0 There has been no health looked after children annual report presented to health governance boards or HSCB as required by the current Statutory Guidance ‘Promoting the Health and Well-being of Looked After Children’. Commissioners and providers have access to a range of performance monitoring dashboards, which are used with varying degrees of sophistication to inform service delivery and monitor outcomes. There are well embedded audit and monitoring process in place, with a recent refocusing on a whole systems approach to audits. Safeguarding executive leads also undertake unannounced visits to front line services, to ascertain if policies and procedures are fully embedding into practice and that actions from audits have been fully implemented within services. Section 11 audits are completed and action plans in place as required. All Section 11 audits are subject to scrutiny and monitoring by a specific group from the HSCB.

11.1 The priorities identified in the children and young person plan for health are effectively monitored. One example relating to dental health which showed good multi-agency partnership working to improve the rate in the reduction of tooth decay, with the principles have been embraced across all agencies, with successful tooth brushing and oral hygiene initiatives commencing at birth and continuing to be effectively delivered through the children centres.

12 Outcome 20 Notification of other incidents

Staff were aware of whistle blowing policies; however they had not been required to use them.

13 Outcome 21 Records

13.0 All health files seen during the inspection were of a good quality and comply with the statutory guidance on promoting the Health and Well-being of Looked After Children 2010 and the Nursing and Midwifery Council guidance on record keeping. However, in the files seen there was no evidence of case supervision. Good regular case audits are in place, with well monitored action plans. Data systems are under review and an improved dedicated health system is being introduced as a result which aims to map Joint Strategic Needs Analysis (JSNA) health needs information and geographical profiling data. There is an adequate medical peer case review process in place, especially with more complex cases. Lessons learnt are effectively shared. However this is yet to be fully embedded. There are regular nursing health record audits and sharing of learning which is improving practice, however the medical notes audits are not as robust and there is less opportunity to share practice and ensure that lessons have been learnt.
Recommendations

Within 3 months

NHS Halton and St Helen’s to ensure that there is a robust assurance system in place which clearly identifies the mapping of the level of safeguarding training required by all staff and identifies training needs.

NHS Halton and St Helen’s and the Halton Safeguarding Children Board to ensure that there is formal evaluation of the impact and outcomes of safeguarding training across all organisations.

NHS Halton and St Helen’s and the Halton Safeguarding Children Board must ensure that there is an annual health looked after children report, presented to the health governance boards and scrutinised effectively at the Halton Safeguarding Children Board as required by the current Statutory Guidance ‘Promoting the Health and Well-being of Looked After Children’.

Halton Safeguarding Children board must ensure that there is a robust notification system in place in order that general practitioners submit reports on time to child protection proceedings.

NHS Halton and St Helen’s must ensure that nothing impedes the successful recruitment to the designated doctor and named general practitioner.

Looked After Children 3 Months

The Halton council must ensure that there is a robust notification system in place in order that looked after health staff and general practitioners are aware in a timely manner of all new looked after children within the authority.

NHS Halton and St Helens and the Halton Safeguarding Children Board must ensure that there is an annual health looked after children report, presented to the health governance boards and scrutinised effectively at the Halton Safeguarding Children Board as required by the current Statutory Guidance ‘Promoting the Health and Well-being of Looked After Children’.

NHS Halton and St Helens and the Halton Safeguarding Children Board must ensure that the consenting processes for looked after children are fully embedded including for the administration of child health immunisations and vaccines.

Next steps

An action plan is required from the commissioning PCT within 20 working days of receipt of this report. Please submit the action plan to CQC through childrens-services-inspection@cqc.org.uk and it will be followed up through the regional team.