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.

<table>
<thead>
<tr>
<th>St Helens Council</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Inspection Outcome</td>
</tr>
<tr>
<td>Overall effectiveness of the safeguarding services</td>
</tr>
<tr>
<td>Capacity for improvement</td>
</tr>
<tr>
<td>The contribution of health agencies to keeping children and young people safe</td>
</tr>
<tr>
<td>Looked After children Inspection Outcome</td>
</tr>
<tr>
<td>Overall effectiveness of services for looked after children and young people</td>
</tr>
<tr>
<td>Capacity for improvement of the council and its partners</td>
</tr>
<tr>
<td>Being Healthy</td>
</tr>
</tbody>
</table>
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 PCT, and CQC Regional Director. This report is also being copied to the Strategic Health Authority/Monitor as appropriate and CQC’s Regional Director, who has overall responsibility for this inspection programme.

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 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 NHS organisations listed above, but includes some areas which may apply to one or more NHS bodies where pertinent.
Context:

St Helens has a resident population of approximately 42,400 children and young people aged 0-19 years. They make up just under 24% of the Borough’s population. In January 2012 just under 4% of the school population were classified as being of an ethnic group other than White British. The largest minority ethnic group being of Traveller heritage. The January 2012 school census reported 1.3% of pupils with English as an additional language. (Ofsted, August 2012).

The St Helens Children’s Trust Board was established in 2005. The Trust is one of a number of thematic groups linked to the Local Strategic Partnership. The Children’s Trust Board includes representation from the local authority, health commissioners, service providers including local health providers, the voluntary community and faith sector, Director of Public Health, Merseyside Police, Job Centre Plus, school and college representatives and the Greater Merseyside Connexions Partnership. (Ofsted, August 2012).

The St Helens Local Safeguarding Children Board (LSCB) consists of representatives from the main organisations working in the area, as above. It has a number of sub-groups, including an Executive Board. There is an agreed protocol in place between the Children’s Trust Board and the LSCB to support complementary and collaborative working. The LSCB has had an independent chairperson since January 2010. (Ofsted, August 2012).

Commissioning and planning of children and young people’s health services and primary care are undertaken in conjunction with the public health team and the NHS Merseyside. A virtual joint strategic needs analysis (JSNA) team work together to produce and review the JSNA. The St Helens Clinical Commissioning Group has been established and is working closely with the local authority, public health and NHS Merseyside. The Shadow Health and Wellbeing Board has been established with senior representation from all key partners, and there are clear links to the LSCB and Children’s Trust Board. The council has recently appointed a Director of Public Health and there is also a Cabinet Member for Public Health. (Ofsted, August 2012).

In St Helens, acute services are mainly commissioned from one acute hospital trust, Whiston Hospital (St Helens & Knowsley Hospitals NHS Trust). Some children may attend acute trusts outside St Helens in Warrington or Wigan. Maternity and newborn services are delivered through the acute hospital trust, although some patients may choose to attend hospitals outside the area. The majority of community services, including a walk-in centre, health visiting, and school nursing are provided by Bridgewater Community Healthcare NHS Trust, with community paediatricians provided by Alder Hey Childrens NHS Foundation Trust. Some therapy services, commissioned by NHS Merseyside, are delivered by the 5 Borough’s Partnership NHS Foundation Trust. Tertiary Centres for paediatric and maternity services are provided from the Liverpool area. (Ofsted, August 2012).

Child and adolescent mental health services (CAMHS) are currently commissioned by NHS Merseyside following the clustering of primary care trusts (PCT) in 2011. The commissioning PCT is NHS Halton and St Helens which employs a dedicated commissioner for specialist CAMHS who works with the local authority commissioner to ensure that a comprehensive CAMHS is in place. The service is provided by the 5 Borough’s Partnership NHS Foundation Trust. (Ofsted, August 2012).
General – leadership and management

1. Priorities outlined in the St Helens Children and Young People’s Plan around integrated working, early intervention and Think Family are evident in the additional resourcing, innovative commissioning of services and some outstanding examples of partnership working to support vulnerable families and young people and to prevent escalation of risk. Learning from serious case reviews across all health providers is closely monitored through trust boards, commissioners and through the LSCB.

Outcome 1 Involving Users

2. There is evidence of good involvement of young people through the 5 Borough’s Partnership’s Investing in Children group who have redesigned the CAMHS reception area to meet their needs. Other examples of involvement include contributions to the design of information leaflets and posters that inform young people on the CAMH services.

3. The 5 Borough’s Partnership NHS Foundation Trust has recently offered four young service users apprenticeships in administration. These young people are being well supported to receive an accredited external qualification.

4. Young people are routinely offered a choice in venue for their health assessments. This choice helps them to make decisions about their health care and increase their engagement in the assessment.

5. All health practitioners we spoke to during the inspection confirmed that they have good access to a responsive translation and interpreter service that appropriately facilitate their communication with service users.

Outcome 2 Consent

6. Inspectors saw a good example of appropriate arrangements to seek consent from young people in the contraception and sexual health services (CASH). Comprehensive assessments are carried out on all young people under 16 seeking contraception. The assessments consider a young person’s capacity to consent as outlined in Frazer Guidance as well as to explore any vulnerability, including sexual exploitation and grooming. Any young person under 16 seeking emergency contraception from the local A&E is notified to the school nursing service through paediatric liaison so that appropriate follow up advice and support is offered.

Outcome 4 Care and welfare of people who use services

7. Effective arrangements are in place to identify and support vulnerability in pregnant women. Good processes are in place to ensure that midwifery staff complete comprehensive assessments on vulnerability early on in pregnancy and throughout the antenatal period. Information is shared in a timely way with health visitors and GPs who are also invited to contribute to the ongoing risk assessment process. Where midwives identify vulnerability, appropriate action is taken through either completing cause for concern/information sharing forms or referring the pregnant woman to the St. Helen’s Local Authority Children and Families Team.
8. A team of specialist midwives enable vulnerable pregnant women to access enhanced support. The substance misuse specialist midwives hold joint ante natal clinics with the local adult substance misuse service which are well attended and popular with pregnant women who misuse substances. A consultant obstetrician with specialist interest supports their ante natal care through a consultation service with the substance misuse midwives. The Partnership recognise the lack of an integrated perinatal mental health pathway and have recruited to the post of specialist midwife to take forward this development work.

9. Arrangements to support teenagers under 19 who are pregnant are good. Young people’s ante natal clinics are held at the hospital and home visits are available to support those young people who find it difficult to access universal provision. Pregnant teenagers are transferred from the specialist midwife to the community midwife mid way through their pregnancy; however, the teenage pregnancy midwife will continue to support both the young person and practitioner to provide continuity of care.

10. Health visitors and school nurses use skill mix effectively to deliver most of the core healthy child programme and in supporting vulnerable families through child protection, Common Assessment Framework (CAF) and Family Action Meetings. The use of E-CAF is highly regarded and practitioners spoke enthusiastically about how CAF and Family Action Meetings had successfully impacted on the lives of children and young people in St. Helens.

11. Good arrangements are in place to support the handover from health visiting to the school nursing service. A synopsis is completed for each family and for those families with more complex needs then a face to face meeting is scheduled between the practitioners. This ensures that any ongoing need or support that the family may require is maintained during the transition. School nurses send out and receive new entry into school questionnaires and in partnership with their education colleagues follow up any forms that are not returned.

12. Children and young people have their health needs supported well during school age. School nursing teams are engaged in the national child measurement programme, vision screening and in carrying out vaccinations. They work closely with families and education staff to ensure that any health care plans for children in school are created and reviewed regularly so that they remain up to date and relevant.

13. School nurses hold “drop in” clinics in all secondary schools, special schools, pupil referral units and in some primary schools. The drop in clinics are well used and in non faith schools young people can access contraceptive services through “clinic in a box.” The majority of school nurses are trained in sex and relationship education (SRE) and support PHSE according to the needs of the school. School nurses are extending their role to assessing young people for the C Card scheme so that they can access contraception during school holidays. School nurses have developed condition related groups to help children and young people meet other young people with a similar health condition such as diabetes, allergies and asthma. These have proved popular with young people who find it helpful to know that they are not alone in coping with their medical conditions.
14. Good SRE is available through a partnership approach between school nurses and the local authority teenage pregnancy team known as TAZ. Schools use a risk tool to assess vulnerability in young people and where there is identified need they have access to the Taz Team who deliver a local targeted programme called “Healthy Body, Healthy Mind”. The programme is not confined to sex and relationship advice and education but also looks at other risk taking behaviours and the risks around sexual exploitation. The programme has been positively evaluated by young people.

15. Young people have good access to contraceptive advice and sexual health services through young people’s clinics which are available six days a week. Emergency contraception is provided at a good number of pharmacists, walk in centres and the local A&E which means that young people can access services 24 hours a day, seven days a week. There is an increasing number of young people choosing to use long acting reversible contraceptives and the take up of the c-card scheme across St Helens is good. Local, unvalidated data shows an improvement in teenage pregnancy rates during 2011/2012.

16. Access to a termination for those young women who decide not to continue with the pregnancy is good. The TAZ team support young people through the Choices pathway and will accompany a young person if this is needed. A new pathway to offer pre and post termination contraception counselling is being trialled, with initial findings showing increased uptake on contraception post termination.

17. The paediatric Accident and Emergency department is located in a new purpose built building that is well staffed by a complement of trained paediatric nurses and medical staff. The department sees the majority of children and young people up to the age of 18 unless a young person chooses to be seen in adult services.

18. Robust arrangements ensure that children and young people attending the St Helen’s Walk in Centre and Whiston Hospital paediatric Accident and Emergency are safeguarded well. There are established processes in place to identify repeat attendance of children at the A&E as well as at the local walk in centres. Alerts are in place to highlight if a child has a child protection plan in place, as well as whether a child has an agreed health plan in place such as managing a young person’s self harming behaviour or if they have complex health care needs. This comprehensive alert system ensures that the care provided to children and young people is appropriate and targeted. Paediatric nursing staff told us how they used the triage process to help identify potential non accidental injuries or other safeguarding concern. The assessment complies fully with NICE guidance; however, this has not been audited so it is not possible to evidence ongoing compliance with this good practice.

19. There is a comprehensive range of policies to protect children and young people attending A&E; these ensure that children and young people are seen and assessed by senior medical staff where they may be child protection concerns or prior to discharge.

20. Young people who may attend A&E following an incident of self harm are routinely admitted to the paediatric ward in accordance with NICE guidance. The CAMHS urgent Response Team offer a timely and responsive service to A&E in the event of a child or young person requiring CAMH services.
21. Early intervention services to support the emotional health and development needs of children, young people and their families are improving through the implementation and roll out of the Training Strategy for Young People’s Workforce. The third sector “Platform 51” offer counselling services to young people and has been very successful in increasing the number of clients it sees. CAMH services offer an appropriate and effective integrated CAMHS Learning Disability Service which is supported by consultant with specialist interest, a team manager and a care co-ordinator.

22. There is good access to effective core CAMHS through referral to the St Helen’s team who operate the Choice and Partnership model. All referrals are assessed on the day of receipt to assess for urgency, risk and appropriateness. Any referrals not accepted are returned to the referrer with suggestions of alternative providers or care pathways, such as Platform 51, CAF, school nursing or Family Action. Initial choice appointments are offered within a maximum of 4 weeks and a partnership appointment within a further 6 weeks. A named care co-ordinator is allocated to any young person who is waiting for their partnership appointment who can be contacted in the event of escalation of need. The CAMHS teams use outcome based tools to measure the impact of their interventions and are able to demonstrate improvement in the emotional health of their clients.

23. A CAMHS urgent response team (CURT) has recently been established that responds quickly to any urgent referrals and offer good support to the local A&E at Whiston Hospital. The CURT offer a rapid specialist mental health assessment, and will carry out a follow up visit which a further partnership appointment made. Additional contact will be made through the school nurse who will also invite a young person into the school drop in service.

24. Young people who require mental health in-patient provision have good access to in patient beds. Placement is determined by need following appropriate assessment and includes a number of options. (Ofsted, August 2012)

25. Transition from CAMHS into adult mental health services is good. A Consultant Nurse in Transition is employed to facilitate transition arrangements at an operational and strategic level. This is especially effective in where young people present with complex needs, either in Borough or placed out of Borough. We heard of how partnership working helps support young people with a phased approach to transition, with agencies not all withdrawing services at the same time when a young person reaches 18.

26. Therapy services in St Helens are joined up and work collaboratively as far as possible, offering children and young people multi disciplin ary appointments at Bridgewater or home visits as appropriate. For both physiotherapy and occupational therapy services, referrals are triaged to determine level of need. This triage process takes between two and four weeks, and from this point children wait on average a further two to four weeks to see the therapist dependent upon the triaged level of need.

27. Speech and language therapy services send letters out following referral inviting families to telephone for appointments. The total waiting time from referral to assessment, including the allocation phase can be four to six months. Waiting list clinics have been implemented and are felt to have been effective to date in addressing the waiting times for SALT.
28. The role of the integrated therapy assistant also acts to minimise numbers of contacts with professionals, delivering competency assured therapy overseen by the named therapists.

29. Dietetic services are available for any child or young person meeting the dietetic criteria, and letters are sent following referral for families to make an appointment. From this contact the current average wait is around eight weeks, again based upon clinical need, with priority appointments given where appropriate. Often in less than five days where there are enteral feeding needs. There are sound joint working arrangements and plans in place between dieticians, community children’s nurses and health visitors around monitoring and reporting of intakes, tolerances and weights, minimising numbers of contacts with professionals.

30. Therapy and dietetic services are served by the SQL I.T system, and this is not linked with the Paris system. The SQL system does not flag children who are subject to child protection interventions, or those who are Looked After. Therapists and dieticians are not confident that they would be aware if they were presented with a child or young person with ongoing safeguarding concerns. This would be evident only if concerns were recognised during assessment and follow up enquiries were made.

31. Gap analysis work identified the need for and there is now a practitioner in post for services around autistic spectrum disorders (ASD). It is envisaged that this practitioner will promote implementation of the pathway for children and young people presenting with ASD and work closely with the assessment and diagnosis panel in achieving timely interventions.

32. Community Children’s Nursing (CCN) services are available routinely Monday to Friday between 09.00 and 17.00. The service predominantly works with children and young people presenting with complex health needs or oncology needs. There is scope within the service to offer on-call services where appropriate for children and young people facing palliative care needs. This is written within the service specification and there is supportive funding available allowing implementation of the out of hours on-call service when required.

33. For children and young people presenting with the need for continuing healthcare, assessments are done and recommendations are made by the CCN team within provider services. These recommendations are considered at and final decisions around allocation of hours are made at the complex care panel, where multi-agency funding of packages is also agreed. The CCN service, with the support of appropriate therapists deliver training and ensures ongoing competency assurance for the carers of children and young people with complex health needs.

34. Young people have good access to highly effective drug and alcohol services that work collaboratively with partners to ensure a comprehensive package of support and advice. Young people receive a holistic assessment of their needs and contribute to their care plan. The team are available to meet their young people in a number of community settings and offer a range of interventions, including access to holistic therapies. The majority of young people leave the young people’s drug and alcohol treatment service in a planned way and there are vigorous efforts made to re-engage those young people who fail to attend appointments.
35. Adult substance misuse services have very recently been re-commissioned with the new provider “Addactions” now in place. There are a number of enhanced services to support the “Think Family” approach including the appointment of a “Breaking the Cycle Worker” who works intensively with families where there is an adult with alcohol or substance misuse. It is too soon to comment on the impact of the new services.

36. Families of adults who misuse alcohol or other substances are able to access good support through a third sector provider, Footprint. Footprint contribute well to the think family approach by using CAF to either put together a support package for the family or where there are safeguarding concerns about the impact of adult behaviours impacting on the safety of children making appropriate referrals to the local authority’s children’s team.

37. Children and young people looked after by the St Helen’s Local Authority benefit from good healthcare. Outcomes for vaccinations, number of children visiting a dentist and receiving their health assessment are better than national averages and statistical neighbours.

38. All children entering the care system receive a comprehensive initial assessment carried out by the named doctor for looked after children or another suitably qualified community paediatrician. However, not all children are receiving their health assessment within the statutory timescale as medical workforce capacity had been reduced by long term sickness. An action plan is in place to address the capacity issues and to improve the notification process from the local authority.

39. Health reviews are carried out in a timely way and there are good arrangements in place to ensure that those children placed out of area are not disadvantaged in terms of access to health care and high quality health reviews. Health reviews are usually carried out by either the child’s health visitor or school nurse as appropriate to the age of the child. All health reviews are quality assured to ensure that they remain of a high standard and children’s needs are identified and met. Health visitors and school nurses regularly attend the statutory reviews for looked after children on their caseload and provide the review with either a copy of a recent health review or an updated health report. This enables the review meeting to fully consider the health needs of the child.

40. Health reviews consider the findings of the young person’s completed strength and difficulties questionnaire to explore if there is any additional emotional health and wellbeing support needed. The local substance misuse screening tool is also completed to highlight any potential alcohol or substance misuse problem. The health records seen as part of this inspection were of a good standard and demonstrated that any referrals for additional health care needs were made promptly and followed up appropriately.

41. The local authority has recently recommissioned CAMHS for looked after children and it is too soon to comment on the impact of this new provision. However, great effort has been made to sensitively manage the transfer of children and young people who were already receiving intervention to ensure that this happened appropriately, with some young people remaining with their existing practitioner until the care plan has finished.
42. CAMH services offer a support to care leavers up to the age of 19 and young people can be referred to the team from their leaving care worker. This service helps young people access additional support during the critical transition into adult services.

43. Young people have good access to effective contraceptive and sexual health services and to the local young people’s drug and alcohol team. If a young person has difficulties in engaging with universal services there are appropriate arrangements in place to provide one to one support. The looked after children health team are trained in family planning services and the school nursing service is able to offer ‘Clinic in a Box’.

44. The specialist nurse works flexibly to support the health needs of young people aged 16 and over, as well as carrying out some health reviews for those children and young people who are placed out of area. She works assertively to engage those young people who may initially be reluctant to have their health review and with good success.

45. The looked after children health team recognise the need to improve the quality of the health summary provided to young people when they are leaving care. Work is ongoing and the team are consulting with young people, looked after and also care leavers to ensure that the final product will meet the needs of this population.

Outcome 6 Co-operating with others

46. There are regular multi agency, multi disciplinary healthy care meetings to discuss the health needs of children and young people, looked after. A database is used to record health issues and to identify themes and trends that are used to inform training and commissioning of services. This ensures that services are appropriately targeted to identified need and is good practice.

47. Health partners are well represented on the complex care and placement panels which discuss those children and young people who require a specialist package of care that often require an out of area placement. This means that the health needs of those young people are considered during the commissioning process.

48. Good partnership working between A&E and the local substance misuse services ensures that any young person attending Whiston A&E through alcohol or substance misuse are offered screening and a referral to the substance misuse service. Young people are offered support at an early opportunity and this is a good example of early intervention practice.
49. All staff interviewed are confident in when to refer to children’s social care. A&E staff spoken to gave several examples of when they had made referrals because of child protection or safeguarding concerns and how the trust’s information sharing forms were used. Comprehensive and highly effective paediatric liaison ensures that attendance of any child under 18 is notified to the child’s GP and to the appropriate health visitor or school nurse, as well as screening all attendances of children to ensure that appropriate action was taken at the time. Paediatric liaison extends to adults who have attended A&E following incidents of domestic violence, substance misuse or mental health concerns.

50. Adult A&E nurses and medical staff have good awareness on the impact of harmful behaviour by parents on children. The A&E teams are well supported by two hospital social workers who are able to facilitate communication with children and families service to help safeguard children and young people.

51. Health visitors and school nurses are located geographically to reflect the local authority neighbourhoods and have good relationships with colleagues in social care and in the children’s centres. Health visitors encourage families to engage with children’s centres and with consent, share information on new families at the earliest opportunity. This enables families to access appropriate targeted support to help identify and support any vulnerability.

52. Attendance at child protection conferences by health visitors and school nurses is good and closely monitored by the Bridgewater Trust’s safeguarding team. For those children and young people who are being supported by a child protection or child in need plan, the relevant health visitor or school nurse carries out a comprehensive health assessment to ensure that any health needs are identified and met. All practitioners spoken to during the inspection commented on the improvement in feedback and response from the local authority since the introduction of the First Response team.

53. Health visitors and school nurses confirmed that they routinely receive the notifications of attendance from the local A&E department at Whiston Hospital, along with copies of any “cause for concern” from paediatric liaison. There has recently been a change in how domestic violence notifications are received and now they receive notifications through the safeguarding team only where they are considered relevant. This new process is being audited to assess its effectiveness and impact on families.

54. Partnership working with GPs is good, with all GP practices having a named health visitor and most GP practices holding regular practice meetings around vulnerable families which health visitors attend. There are other supporting processes to ensure good communication with GPs, including the use of contact books, diaries and formal referral letters. This means that vulnerable families receive co-ordinated support from primary care and public health nurses.

55. Partnership working to safeguard the unborn child is good. Midwives are able to refer into the children and families service as soon as is practicable and effective monitoring systems ensure that pre birth plans are in place to co-ordinate the support to the new family and protect the new born baby.
56. Young parents to be are seen by the dedicated teenage pregnancy midwife and are referred to the teenage pregnancy team who then co-ordinate referrals to the local Connexion Service and Children’s Centres. All pregnant teenagers are assessed using a pre-CAF and an appropriate package of support put in place to support the new family. There is appropriate and effective information sharing across the partnership and the teenage midwives and other key health professionals have access to the local authority’s IT system.

57. There is a good support offered to young people who are diagnosed as diabetic, with the paediatric diabetic nurse well integrated into local CASH services and with the teenage pregnancy midwife and TAZ. This means that those young people who are pregnant can receive advice and support at the earliest opportunity, including support in attending the joint adult obstetric and diabetic ante natal clinic.

58. Good partnership working helps to effectively resolve operational issues around safeguarding and child protection activity through a number of multi agency meetings. The named nurse BCHT meets monthly with the children and young people’s service and there is a front line operational meeting that takes place quarterly at which statutory agencies attend, including police and youth justice.

Outcome 7 Safeguarding

59. Arrangements for the line management, supervision and training of the designated safeguarding children professionals are appropriate. The designated nurse for St Helens PCT is part of a team of designated nurses for NHS Merseyside and is lead for St Helens and Sefton PCTs. This shared arrangement across the cluster is working well and the designated nurse explained how it had benefited her in terms of support both professionally and personally. The designated doctor is employed as a consultant paediatrician within Alder Hay Children’s NHS Foundation Trust and there is a service level agreement between both organisations which forms part of a commissioning collaborative for a safeguarding service that includes SARCS and a full child protection service. Designated professionals are appropriately represented at the St Helens LSCB and attend or chair relevant sub groups.

60. The designated nurse for looked after children is employed full time by the Bridgewater Community Healthcare NHS Trust and is supported in her role by a full time specialist nurse for looked after children who works with young people aged 16 and over. The team have dedicated administrative support. There are additional specialist looked after nurses who work in the local secure children’s homes for whom the designated nurse for looked after children has line management responsibility.

61. The named nurse for safeguarding children for St Helen’s BCHT is employed full time and is supported by 3 specialist safeguarding nurses who work geographically to support health practitioners in safeguarding practice. The trust’s medical director is currently the interim named doctor until new arrangements are in place. The named professionals have appropriate access to supervision and training and feel well supported.
62. Audit is well established in the BCHT and there is an annual audit plan. Recent audits have included effectiveness of escalation where there are areas of professional disagreement. Ongoing, annual audit on the quality of referrals to the children and families service continues to show improvement on the quality of referrals which are described as being analytical, with better risk assessment and more child focussed. Good support is offered to health visitors and school nurses who are holding child protection cases and a member of the safeguarding team accompanies them to all initial case conferences.

63. The named nurse post for St Helens & Knowsley Hospitals NHS Trust is currently vacant. The post has been advertised at a Band 8a and the proposed line management and accountability arrangements are in line with Working Together 2010 and the Intercollegiate Guidance 2010. The strategic role of the named nurse is currently being carried out by one of three named managers for safeguarding children.

64. The named doctor is new in post and has been allocated 1 session per week to the role. He is receiving good support from the designated doctor for St Helens to help him settle into the post.

65. The line management and resourcing of the named safeguarding children professionals for 5 Borough’s Partnership NHS Foundation Trust are appropriate and meet the requirements of Working Together 2010 and the Intercollegiate Guidance. The named nurse is employed full time and is well supported by a team of safeguarding champions and safeguarding leads. The trust has been through significant change and not all champions and leads have been provided with the role description for these posts, however, they have been allocated protected time to carry out the work which is good practice.

66. The named nurse for 5 Borough's Partnership NHS Foundation Trust is well supported by senior managers. Safeguarding practice is considered as part of any serious untoward incidents and in the development of any new policy. This ensures that consideration is given to embedding good safeguarding children across the organisation. The trust’s IT system and good use of electronic communication forms enables the named nurse to effectively monitor requests for practitioners to attend child protection conferences, any referrals to child protection conferences and subsequent reports. The form also captures any ad-hoc requests for advice or support on safeguarding or child protection concerns. The effective use of IT supports comprehensive reporting and analysis of safeguarding activity across the organisation.

67. There is no named GP in post. The involvement of general practitioners in safeguarding children and child protection conferences is too variable. Training remains a priority for GPs in St Helens and a training package and pathway has been developed but not yet rolled out across the district. All GP practices have a GP safeguarding lead, however, they have not yet met as a group to share good practice and the impact of how local and national policy on safeguarding children impacts in primary care.
68. Adult mental health practitioners demonstrated good awareness on the impact of parental mental health on children. There are robust systems in place to collect details of children in the family or where an adult has significant child caring responsibilities. Ongoing record audits demonstrate good compliance with organisational policy on collecting children’s date of birth, general practitioner and school. Practitioners use the electronic communication form to share any safeguarding concerns and refer to the local authority’s children and families service if there are any potential child protection issues.

69. Children’s social workers attend care programming meetings as well as discharge meetings if there are concerns around the safety of children in the family. This partnership working helps to ensure that children of adult mental health patients are safeguarded well.

70. Children visiting their parents who are in-patients are appropriately protected. A designated family room is available for children to visit their parents and all visits must be pre booked and risk assessed. Risk assessments include checking that if a child is protected through a child protection plan in place, then any contact arrangements that are specified are adhered to. Service users and carers were involved in the development of the policy alongside the trust’s named nurse for safeguarding children following a serious incident.

71. The St Helen’s Child Death Overview Panel (CDOP) is now part of a pan-Mersey CDOP that is appropriately constituted and reports to the local safeguarding children boards across the region. Membership is shared across the local authority areas with a rotational membership and chair. The CDOP makes recommendations and these, along with the action plans are monitored through the relevant LSCB. There has been no formal evaluation of bereavement support; however, this is reviewed following each death. The strategic involvement of primary care into CDOP remains an area for development in St. Helens as there is no named GP in post.

Outcome 11 Safety, availability and suitability of equipment

72. Equipment and aids for children and young people are funded solely from a health budget and therapists feel that access is timely and efficient for families, with some equipment available immediately from stock and very short waiting times for items such as communication aids. Where items are complex or specialist, funding may be via the complex needs panel. There can be longer waits for wheelchairs and specialist seating. However, where the wait has been assessed as impacting upon the quality of a child or young person’s life, professionals have ensured swift remedies and minimised disruption for the child or young person.

Outcome 13 Staffing numbers

73. Health visitors describe their caseloads as within acceptable limits. Cases are weighted according to deprivation and numbers of health visitors has improved during the last twelve months to allow health visitors to hold a manageable caseload. All high schools have a named school nurse.
Outcome 14 Staffing support

74. Progress on training staff in safeguarding children in BCHT is variable and whilst there is good compliance at Level 1, it is poor at Level 2 and Level 3. The trust has a recovery action plan in place and expects to achieve full compliance by March 2013.

75. Supervision in safeguarding children practice in BCHT is outstanding and is used to support health practitioners effectively when they are attending child protection and child in need conferences. Supervision is used to ensure that the relevant health professional has a clear plan in place to ensure that a child or young person’s health needs are met and regularly reviewed. This was evident in the files reviewed during the inspection where good supervision records were contained in the child’s health file with timely referrals to other health teams such as speech and language therapy or community paediatricians.

76. Nursery nurses and staff nurses are assessed against a set of competencies and work appropriately to support families, with the named health visitor retaining responsibility for the case. There is a comprehensive period of preceptorship available to support any new public health practitioner that includes a more intensive period of supervision around safeguarding practice and the care of looked after children. Practitioners interviewed were clear about how to refer to the St Helen’s children and families service and there is a clear escalation policy in place to support staff where there are areas of professional disagreement.

77. The looked after children health team support foster carer and social work training on the health needs of looked after children. Those health visitors and school nurses who have looked after children on their caseload are expected to attend supervision and this is good practice. The designated nurse for looked after children issues regular, informative newsletters to foster carers which are well received.

78. There is insufficient progress in ensuring that health staff employed by St Helens & Knowsley Hospitals NHS Trust receive appropriate training and supervision in safeguarding children. Ninety three percent of staff have received their Level 1 training, however only 37% have attended Level 2 training and 70% of staff at Level 3. The trust has a recovery plan in place and anticipate being able to demonstrate compliance by the end of March 2013. A new supervision policy is awaiting ratification and sign off by the trust’s patient Safety and Experience Council. The policy will address the shortfall in trained supervisors and introduce the requirement for all staff who case manage a family where a child protection plan is in place to receive one to one formal supervision.
79. 5 Borough’s NHS Foundation Trust are committed to making progress in ensuring staff are trained and receive appropriate supervision in safeguarding children. In excess of 80% of staff have attended Level 1 training, 61% of staff have attended Level 2 training and 56% of staff have attended part of the trust’s new modular approach to Level 3 training. The trust have been working to supplement the new Level 3 e-learning module with face to face training, however, this is not yet available to staff. Current arrangements for providing staff with supervision on safeguarding children practice rely on safeguarding practice being included as part of a practitioner’s clinical supervision. However, the practitioners providing the supervision have not undertaken any specialist training and therefore the impact and effectiveness of this approach is limited.

Outcome 16 Audit and monitoring

80. Governance across NHS Mersey on safeguarding practice in provider organisations is good. A designated health professional attends each of the provider safeguarding assurance groups and key performance indicators have been built into contracts. Performance against key performance indicators is regularly reviewed during contract monitoring meetings as well as through the NHS Mersey Quality Groups and there is regular reporting to the NHS Mersey Board through the Joint Integrated Governance Group.

81. BCHT is a new organisation and is in the process of re-organising the safeguarding children service and the governance structure to improve reporting to the trust and provide assurance to the trust board. Current arrangements reflect local safeguarding children practice at PCT and local authority level, with reporting through local divisional management meetings to the trust’s Integrated Governance Committee which is a formal sub committee of the trust board. The trust recognise the need to adopt a corporate approach to safeguarding children practice and the limitations that the current structure has in terms of influencing practitioners across the remit of the trust, in particular adult services.

82. Appropriate governance arrangements provide the St Helen’s & Knowsley Hospitals NHS Trust with adequate assurance on safeguarding children practice across the organisation. The trust has recently introduced a new incident management system that will enhance reporting on risk. The trust has a Trust-wide Safeguarding Children’s Committee meets quarterly and is chaired by the trust’s executive lead for safeguarding children. The committee has a wide range of senior managers representing the majority of divisions across the trust as its core membership, including the St Helen’s designated professionals for safeguarding. The committee reports to the Patient Safety and experience Council which is a formal sub committee of the trust board. The trust has a Safeguarding Children Working Party which monitors and drives forward implementation of the trust’s safeguarding children work and audit plan.
83. 5 Borough’s Partnership NHS Foundation Trust has good and well embedded governance arrangements in place to provide appropriate assurance to the trust board. The trust board has attended safeguarding children training. Safeguarding activity is monitored through regular reporting to the Strategic Safeguarding Committee through the safeguarding operational group. There is a range of key performance indicators that are measured and reported to meet the requirements of commissioners and also to provide evidence of compliance with national and local policy on safeguarding children.

Recommendations

Immediate

Ensure that GPs routinely attend or provide reports to support child protection conferences. (Ofsted, August 2012).

Ensure all children receive their annual health assessment within the statutory timescale. (Ofsted, August 2012).

Within 3 months (from report)

Accelerate plans for health practitioners to access safeguarding training and supervision. (Ofsted, August 2012).

Strengthen the designated role of GPs in promoting safeguarding and for collating and coordinating responses to quality assurance and audit findings. (Ofsted, August 2012).

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 your SHA copied to CQC through childrens-services-inspection@cqc.org.uk and it will be followed up through the regional team.