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Dear local partnership

Joint targeted area inspection of the multi-agency response to children's mental health in Sefton.

Between 23 and 27 September 2019, Ofsted, the Care Quality Commission (CQC), HMI Constabulary and Fire & Rescue Services (HMICFRS) and HMI Probation (HMIP) carried out a joint inspection of the multi-agency response to abuse and neglect in Sefton.[1] This inspection included a 'deep dive' focus on the response to children's mental health.

This letter to all the service leaders in the area outlines our findings about the effectiveness of partnership working and of the work of individual agencies in Sefton.

The joint targeted area inspection (JTAI) included an evaluation of the multi-agency 'front door', which receives referrals when children may be in need or at risk of significant harm. In Sefton, the 'front door' includes a multi-agency safeguarding hub (MASH) with co-located partners from the police and health services. Inspectors focused on children's mental health and on how partners identify children who also need help and protection. Included was a 'deep dive' focus on children identified as being in need who have a range of emotional well-being and mental health needs. Inspectors considered the effectiveness of the support offered to individual children and of the multi-agency leadership and management of this work, including the new multi-agency safeguarding arrangements, which in Sefton have retained an independent chair and name of the local safeguarding children's board (LSCB).

The partnership has not taken effective action to use information about children's mental health needs in order to inform appropriate commissioning decisions or to

[1] This joint inspection was conducted under section 20 of the Children Act 2004.

strengthen governance of the quality and outcomes of service delivery. As a result, partnership working in Sefton is not always effective and does not ensure that children who are experiencing mental ill health get the support they need when they need it. There is ineffective partnership working at both strategic and operational levels, and poor information-sharing about children's needs. These have a negative impact on the arrangements to protect children from significant harm. Furthermore, when children need a specialist service from the child and adolescent mental health service (CAMHS), they are unable to access support from them quickly enough. The partnership is aware of these issues, but has been unable to resolve them in order to improve services for children and to ensure that children do not experience further harm. Because of the weaknesses in partnership working, areas for priority action have been identified during this inspection.

Senior leaders across the partnership have a clear willingness to support and help children who have been identified as having a range of emotional well-being and mental health needs. Short-term funding has been made available to support a range of pilot projects to promote children's resilience and positive mental health, including commissioning research about supporting young people's emotional health and well-being in schools, carried out by Liverpool John Moore University. This has provided partnership leaders with a wealth of information on children's resilience and on what works well to support children with their emotional well-being needs.

Leaders across the partnership have had a focus on children's mental health needs and service provision, primarily in the Health and Wellbeing Board (HWBB) and the Children's Overview and Scrutiny Panel. Children's emotional health and well-being are identified as priorities in the local authority children and young people's plan 2015–2020, but this has not led to strong provision of support and intervention for children.

Areas for priority action

Leaders across the strategic partnership need to take swift and decisive action to ensure that:

- the mental health needs of children in the borough are fully understood and addressed, with a particular focus on avoiding drift and delay and more effective service commissioning
- there is improvement in communication, information-sharing and the application of thresholds and, where appropriate, ensure that escalation processes are followed
- child protection procedures are followed to protect children who are at risk of harm

- there is improvement in the coordination and effectiveness of early help children's mental health service response.

Areas for improvement

- The relevant strategic partners are not always involved in decisions about which services are needed for children with emotional well-being and mental health needs. This reduces their opportunity to share information about children's needs effectively and reduces their capacity to optimise plans for the commissioning of services. The police are not represented at the HWBB and are not present and fully engaged with education partners on the CICG. This does not ensure that partners have a shared ownership of commissioning plans.
- Leaders do not seek analysis or detailed information on children's equality and diversity needs in Sefton. This is a significant gap in knowledge and it is not captured within the children and young people's emotional health and well-being strategy, 2016–2021, or the children's joint strategic needs assessment, August 2018. Furthermore, the diverse needs of children with emotional well-being and mental health needs are not known, which does not help leaders understand what the current or future commissioning requirements will be. Of note during this deep dive was that several professionals supporting children reported that they do not always feel adequately equipped to meet the diverse and complex needs of children with emotional well-being needs and mental ill health.
- Joint commissioning across the partnership is underdeveloped and is not supported by a needs-led strategy. For example, while there is a range of emotional well-being services at the threshold of early help in Sefton, there is no cohesive strategy for the way these services are commissioned. The vast majority of community and voluntary sector providers are not clear about how they fit into the local area's emotional well-being and mental health offer, and they often work in isolation from each other. Emergency department staff at both hospitals were unaware of services in Sefton that children could be signposted to that would provide support for their emotional well-being.
- While leaders across the partnership have a clear vision and commitment to implementing the research findings from pilot projects and to commissioning services for children with emotional health and well-being needs, this is not supported by a shared strategy and action plan. The current refresh of the HWBB strategy and local authority children and young people's plan remains in development.
- There has been repeated challenge from the children's overview and scrutiny panel, partner agencies, and the HWBB regarding the delays for children and young people accessing CAMHS. Investments have been made to address the shortfalls in capacity in CAMHS, but demand continues to increase, and there is no evidence that the additional resources are making a difference. This results in

children continually waiting too long for specialist support when they need it, which leaves some partners supporting children who have high levels of mental health needs until provision is available.

- In addition to those children waiting for CAMHS interventions, disabled children also wait too long for other services to meet their needs. There are significant delays in disabled children receiving appropriate services, such as positive behaviour support services, short break provision, paediatric and specialist therapies. Therefore, the impact of mental ill health on children is not being assessed or reduced to improve their emotional well-being and safety. This not only affects the child's well-being, but also has a negative impact on the coping capacity, physical and mental well-being of members of the wider family.
- All the children reviewed within the deep dive experienced drift and delays in having their needs met, with little or ineffective challenge by professionals. Opportunities to improve the children's emotional and mental well-being in a timely way were missed, and professionals did not effectively escalate their concerns about children receiving interventions at the wrong threshold. This has left some children experiencing further harm. While some schools are effective in developing support for children to ensure that their needs are met, this is 'filling the gap' when other services are not available. The LSCB has recognised that the formal escalation policy is not being used by partners, but has not addressed this effectively or sought to understand the impact for children.
- Each partner agency has areas identified from this inspection that require strategic oversight and intervention to improve their operational responses to help and protect children. This includes support for children identified with emotional well-being and mental health needs. Social workers, including newly qualified social workers, have a high number of children on their caseloads, and this has an impact on the quality of their intervention with families. Local authority leaders are aware of this and have a commitment to increasing the social work workforce to meet demand.
- In addition, some social workers report that having high numbers of children to support reduces their ability to access training. Leaders acknowledge this and also that the current training offer for children's mental health is a basic awareness-raising course. Further training is required to enable staff to apply learning to the improvement of the quality of children's assessments and plans. The appointments of a principal social worker, a quality assurance and improvement manager and a learning programmes coordinator to support newly qualified social workers are all too recent to have had an impact on workforce development.
- Although emergency department staff in Alder Hey children's hospital have received training on using positive behaviour management techniques, they report that they did not feel competent in using these techniques with children who presented with extreme challenging behaviour. To address this gap in

knowledge and skills, trained security staff and/or police are involved with the management of these children, which is poor practice for the children and does not align with trust or the National Institute for Health and Care Excellence guidance.

- Leaders at Ormskirk District General Hospital report that the absence of a 24-hour crisis mental health team has resulted in some children being admitted to hospital who might otherwise have been safely discharged home with CAMHS follow-up. Furthermore, while staff in the emergency department have accessed the psychiatrist at Alder Hey children's hospital out of hours, there were no established procedures or pathways to underpin this practice.
- Alder Hey children's hospital is not currently commissioned to provide a specific speech and language therapy service to young people known to the Youth Offending Team (YOT). There is a universal offer of speech and language to all children and young people across Sefton, including children in the youth justice system. The YOT management board does not monitor whether this provision meets the specific needs of their children and young people, and so cannot assure themselves that children and young people's speech, language and communication needs are being met.
- Alder Hey children's hospital emergency department has made a positive decision to create a new record for all children when they receive information on outcomes from the MASH. This ensures that the hospital already has information about children when they present to the emergency department, to help inform decision-making on next steps. In contrast, Ormskirk District General Hospital emergency department has requested that it is not included in such information-sharing unless it has an open record for the child, which means that there is an inconsistent response for Sefton children.
- There has been a recent reduction in the frequency of joint monthly meetings between the safeguarding team at the Rainbow centre and emergency department safeguarding leads due to pressure on resources. The Rainbow centre offers a range of sessions with tailored support to help children develop their mobility, motor, sensory, communication, emotional and self-help skills. When established, this meeting provides opportunities for health professionals to discuss good safeguarding practice and identify practice that requires improvements. While safeguarding advice can be sought outside of this platform, this is a missed opportunity to share information about children in a meeting that is highly valued by staff.
- A mental health triage car, staffed by a police officer and an approved mental health practitioner, provides early intervention for young people aged 16 years and over who are identified to be in crisis. At present, there is no rapid intervention response for children aged 10 to 16 within the Sefton area. Approval is in place for an all-age provision, and the police force is currently in discussion with the provider about how and when this will be implemented.

- The police vulnerable person referral form (VPRF) has no mechanism to help police officers identify children reported to have mental ill health. Data and information cannot be retrieved about children who are subject to a section 136 arrest, associated waiting times and bed availability. This limits the ability of leaders and managers to develop a shared local understanding of the current mental health needs of children coming to the notice of the police. It also reduces the opportunity to identify emerging themes and partnership work required to deliver an appropriate response. When children who are in police custody for a criminal matter are subsequently assessed under the Mental Health Act and are sectioned following assessment, there are difficulties finding beds for them. This results in children remaining in custody inappropriately.
- The quality of information on referrals to the MASH about children who need help and protection is inconsistent. Some referrals are weak and do not provide information on children's views. Referrals do not provide enough information to support effective decision-making about next steps, and this results in delayed decision-making and delayed support for children. The majority of referrals do not help staff to identify whether children have needs relating to their emotional well-being and mental health. This restricts their ability to consider the impact of children's circumstances on their mental health needs in addition to the primary reason for the referral.
- Children and young people referred to the front door who do not immediately appear to need social work intervention do not benefit from a gathering of information to inform holistic decision-making. Even when referral information is initially weak, health information is not routinely sought to contribute to decision-making. This results in children being passed to early help services inappropriately without a clear evaluation of their needs. Some children remain supported by early help services for too long, when concerns should trigger further information-gathering or a social work assessment. When partner agencies recognise this, they do not formally escalate their concerns. As a result, some children experience delay in getting appropriate support and, for a small number, this results in them experiencing further harm.
- When children attend school regularly, school staff know children well and they understand the risks in the children's lives. Staff know the procedures to share and escalate concerns, and they try to action these, but this is not effective enough. Staff are sometimes frustrated that thresholds are applied in a way that means that their requests for escalation are not successful when children's needs change or deteriorate. Positively, school staff felt that generally they were consulted or involved appropriately at the point of referral.
- Significantly, inspectors found that children considered within the deep dive who live in long-term neglect situations do not always receive appropriate or effective intervention. They experience repeat periods of early help support or child in need planning without any significant change or intervention. This does not help to improve their lives, and their emotional well-being and mental health needs

are not supported. Children's voices are not sufficiently well captured to understand their experiences and inform practice. Children are not routinely involved or engaged in decisions being made about their future.

- When children are referred to the front door and identified as being at clear immediate risk of harm, this is recognised and responded to well. However, there is limited identification of children's mental health needs, and concerns do not always result in formal strategy meetings to consider and plan if a child protection investigation is required. Social workers often visit children to seek further information rather than holding a multi-agency strategy discussion. This reduces effective information-sharing about children's needs between partners and results in poor planning and incomplete investigations of the risks for some children.
- The quality of recording, sharing and coordinating information across the partnership is not of a consistently good quality. Referrals that are sent to children's social care from the YOT are not then recorded on the YOT system, which means that they do not retain an audit trail of the referral. Some children's details are not correctly recorded on police systems and there are sometimes delays in recording information. This means that information to inform risk is not readily available should a further incident occur, and this places children at potential risk.
- While mental health concerns are often identified by professionals, this does not always result in the most appropriate, timely action to keep children safe. For most children, multi-agency plans are developed that identify appropriate actions to meet children's needs and reduce risk. These are not recorded within all partners' records, which limits the extent to which professionals are able to meet children's needs and to hold each other to account.
- There is a delay in domestic abuse notifications being processed by the police. This results in some children being referred to the front door several days, and sometimes weeks, after the incident has taken place. Chronic risks to children in domestic abuse incidents are not considered if the immediate risk to the potential victim reduces. It can be several days before police officers take comprehensive details of incidents and the details of children to populate the VPRF, which in its current form is not explicit enough to effectively capture information about children's mental health or the voice of the child. This leads to a delay in response and assessment of risks to children, and, therefore, delays in children receiving help.
- General practitioners (GPs) are not well sighted on risks to children living in high-risk domestic abuse situations and are not asked to contribute information to the multi-agency risk assessment conference (MARAC). This prevents staff from effectively sharing all information on known risks to children in order to inform safety plans.

- The working relationships between the integrated 0–19 public health nursing service and GPs in Sefton require further development to ensure that both services better understand safeguarding risks to children on practice lists. For example, there is often an absence of information in GP files about child protection conferences and looked after children health assessments. This means that if children attend the GP with ill health, GPs do not have access to all relevant information to support effective decision-making for children. Information about adults who accompany children to GP appointments is often vague in children's records and this prevents GPs from fully understanding any risks within a family.
- Routine information-sharing between Alder Hey children's hospital and the 0–19 public health nursing service is not fully established, and, while they have tried to address this, improvements have not always been effective or sufficient. This increases the risk of health partners failing to identify children with additional needs and risks.
- The use of an agreed dedicated risk assessment tool to help identify children who may have poor mental health and who self-harm is not embedded in the paediatric emergency department at Ormskirk District General Hospital. There is inconsistent safeguarding practice in the emergency departments at both hospitals. For example, the quality of safeguarding assessments was variable, with the voice of the child sometimes missing from these, and the professional curiosity by the staff was often not demonstrated.
- The quality of safeguarding practice in CAMHS is inconsistent. Some children's records clearly identify the child's views and wishes, and their voice is captured well, while other records are superficial. CAMHS staff do not always understand thresholds, and risks to children are not well described in referrals made by CAMHS staff to partner agencies. Children who are discharged from CAMHS at the point of triage or following their initial assessment are signposted, rather than supported with transition to alternative support, to the front doors of other services. This leads to delay in children receiving help when they need it.
- Analysis of children's experiences in the deep dive identified that children and their families have multiple assessments unnecessarily carried out, and there is a lack of professional challenge to prevent this. Professionals appear to halt their work with children and their families while waiting for the outcome of assessments, and this creates delays in required action being taken to improve children's circumstances. In addition, parental capacity to respond to the needs of vulnerable children is not always considered in assessments and planning by agencies. Parents who are themselves struggling with personal vulnerabilities, including mental ill health, are not always receiving appropriate support that would assist them in improving their capacity to parent effectively.
- Children's assessments and plans completed within the YOT do not always include information that is available from partner agencies. Children who have

children in need, child protection or care plans do not have the benefit of all the information about their needs being incorporated in their YOT plan. The out-of-court disposal panel use an assessment to help inform their decision-making. However, children's plans do not comprehensively identify the risks to children's safety, or the actions required to promote their well-being, and so children may not receive the multi-agency risk-management approach needed to reduce their vulnerability.

- Most children's assessments carried out by social workers use the right information to inform evaluations on risk and need. This results in clear recommendations for future action and includes the views of children and their families. Other assessments do not have the same depth or quality of analysis, so it is not easy to understand children's lived experience, or their parents' capacity to change. Children's needs in respect of their identity are not adequately described or evaluated in social work assessments.
- Social workers visit children and speak to them alone, and some children benefit from thoughtful direct work. Some social workers spend time with children and develop good relationships that form the basis of meaningful intervention and planning. This is not consistent across the service as some social workers have reduced capacity because of higher caseloads, meaning that not all children can spend quality time with their social worker. Within the deep dive, it is evident that changes in social worker lead to a 'start again' approach, and have created a lack of continuity in relationships for children.
- Assessments to inform decisions in relation to children missing from home or care, children in police custody and those being considered by the out of court disposal panel are inconsistent. There are gaps in information about children's needs, and the assessment quality is variable. This is resulting in key actions to mitigate risk to vulnerable children not always being completed in a timely and holistic way. In addition, criminal exploitation is not well recognised or understood. This results in delay in sharing significant risks in relation to a child within the deep dive. Trigger plans can be used in respect of a child who repeatedly goes missing to collate key information and identify agreed actions with the intention of tracing the child as quickly as possible. These plans are not always being used.

Case study: area(s) for improvement

Poor assessments of one child's experiences, and risks to her safety and her mental health have led to a lack of joint decision-making and planning to effect positive change for her.

As a result, the child was supported under a child in need plan for five years, with no positive impact on the level of risk, her emotional well-being or her mental health.

There has been escalation of concerns and professional challenge over a considerable period, with mixed messages and limited articulation of the outcomes to be achieved.

The systemic failures across agencies mean that her and her family's vulnerabilities and risks were not recognised.

The ineffectiveness of plans had never been challenged to address these significant and growing concerns, resulting in the child being left at harm.

Key Strengths

- Senior leaders across the partnership recognise the importance of supporting children to be resilient, and they share a commitment to multi-agency working. Children's emotional health and well-being have been priorities for leaders in Sefton for several years and have resulted in the commissioning of a range of services to help support children and their families. The HWBB has appropriate links with the local safeguarding partnership arrangements and receives regular information on children's needs and services from the children's emotional health and well-being steering group and the children's integrated commissioning group (CICG).
- As a result of this commitment to supporting children's emotional well-being, a number of pilot projects were agreed through a series of collaborative meetings that incorporated Public Health, South Sefton and Southport & Formby clinical commissioning groups (CCGs), headteachers and members of the local community and voluntary services. The key aim of the pilots, that began in 2017 and ended in 2019, was to explore the various approaches in schools to enabling children to build resilience and improve their emotional well-being. The final report 'Supporting young people's emotional health and well-being' was completed by the Public Health Institute, Liverpool John Moores University in August 2019. The research is comprehensive and provides leaders with clear recommendations on those services that are effective in supporting children to be resilient. An example of positive support that promotes children's resilience, emotional health and well-being is the 'Big Love Little Sista' project which shows

positive outcomes for 20 students with anxiety, by supporting them to express their emotions.

- The strategic plans are being informed by children's voices and children are provided with the opportunity to express their views to senior leaders on what is important to them. For example, the Camhelions group helps to capture the voices of children, and this has informed the May 2019 refresh of the Local Transformation Plan 2015–2020. Another example is the 'SYMBOL' meeting, which includes Sefton Young Advisors and Sefton Youth Voice, where children meet with senior leaders to discuss issues that they are worried about. Some recent examples have included their views about emotional health and well-being, as well as knife crime, and what they consider will help to support them.
- The recently implemented and revised multi-agency safeguarding arrangements have maintained an independent chair. Members of the LSCB are very proud to have a wide representation of partners that is broader than the expectations of key statutory agencies, and this now includes representation from schools. There have been recent challenges in progressing the work of the LSCB due to capacity within the board's business unit. Positively, partners have taken responsibility to rectify this and have invested in the recruitment of two new posts to progress the work of the LSCB.
- Despite these challenges, the LSCB has appropriately prioritised the dissemination of learning from recent serious case and learning reviews. A particular strength is the development and publication of '7-minute' briefings. The briefings identify key learning from serious case and learning reviews and they are distributed across the partnership, providing key information for staff in an easily accessible and concise format. Staff report that they read the briefings and find them useful to their practice. To correlate and support the briefings, the safeguarding board commissioned an organisation to use drama to deliver the messages learned from serious case reviews. The sessions were performed from the child's perspective and had a powerful impact on staff.
- In addition to the recent launch of a free online counselling and emotional well-being platform known as Kooth, the local authority has supported the development of an emotional well-being toolkit for schools. This includes training for school staff to be mental health first aiders, and the 'Bully Busters' scheme. Information on all these projects and individual children's needs is appropriately shared with wider education support services, including those for admissions, elective home education and children missing education. It is too soon to demonstrate the impact for children.
- Inspectors identified some strong examples of quality assurance and management oversight by individual agencies within the partnership that help to support their safeguarding practice and identify children with emotional and mental health needs. School nurses undergo effective safeguarding and risk-

based supervision sessions with their specially trained supervisors. This enables them to be clear about risks to children for the families that they are supporting.

- Leaders in children's social care have used the learning from repeat audits to support investment for all team managers to attend a five-day supervision training course to help raise awareness and improve the quality of recording and reflection. Half the cohort of managers have completed the course, although it is too soon to see a positive impact on children in practice.
- Emergency department staff at both Alder Hey and Ormskirk hospitals appropriately seek ad hoc guidance and support from their safeguarding teams in order to support their decision-making. Furthermore, staff at Ormskirk Hospital benefit from proactive case discussions with the safeguarding team that reflect on the clinicians' practice and appropriately identify whether additional actions are required to meet the child's needs.
- A police superintendent, who is the force mental health lead, chairs the Crisis Care Concordat (CCC) oversight group, which includes partners from Sefton and other local authorities. This group coordinates the Merseyside response and provides governance for all the CCC groups across Merseyside. In addition, senior leaders have created a detective post jointly funded by Merseycare NHS Trust, which acts as the force's mental health specialist liaison officer. The force's knowledge, awareness and understanding of children with mental ill health is developing.
- Challenges from the designated nurse for children in care regarding the timeliness and quality of initial and review health assessments have influenced commissioning decisions relating to the looked after children's health teams. This has resulted in improved quality assurance arrangements and new business processes for tracking and monitoring looked after children's health needs to ensure that they are more thoroughly identified and that children are seen with fewer delays. Very good use is made of children's voices in health assessments for looked after children carried out by Alder Hey and North West Boroughs, particularly in relation to identifying emotional health and well-being needs. There is good evidence that consideration of the impact of adverse childhood experiences is helping to inform planning to meet children's needs.
- Following a recommendation made by the HMI Probation Single Inspection in February 2019, the YOT is making more effective use of its management information by using it to understand the needs of children and young people known to the service. The plan is for this information to help support and influence future commissioning of emotional health and well-being provision.
- Inspectors identified some good practice within individual partner organisations. For example, staff from the police vulnerable persons referral unit (VPRU) and police staff within the MASH have received multi-agency training that has provided vital insight into safeguarding and associated joint working. In addition, 75% of call handlers and dispatchers within the joint police and fire command and

control centre have completed threat, harm, risk, investigation, vulnerability and engagement (THRIVE) training which has a focus on the mental health of children and adults.

- When partners refer concerns about children to the front door, these initial contacts are prioritised and responded to in a timely way. The quality of recording on contacts is good, and the work undertaken and rationale for decision-making is easy to understand. When children are identified to be at risk of immediate harm and are referred to the MASH, there is evidence of thorough information-gathering from partners to inform decision-making.
- When the police within the MASH are asked for information about children who it is clear may be at risk of harm, staff are able to quickly provide this information to help inform strategy meetings. The detective sergeant in the MASH ensures that links are created between the relevant social worker and an officer in the Police Vulnerable People's Unit (PVPU) to undertake joint working.
- The quality of YOT referrals to the MASH about children and young people is good and they clearly identify their safeguarding and mental ill-health needs. All children who receive an out-of-court disposal are offered an assessment by the liaison and diversion worker, and a nurse from the enhanced team attends the YOT weekly multi-agency risk and welfare management meeting.
- Information-sharing from the MASH to health services about children's needs is effective. For example, information about children's outcomes discussed in the MASH is routinely shared with all health practitioners from whom information was requested. There is a 70% return of information requests to the MASH from GPs, and this is continuing to improve. In addition, there is effective routine and consistent child protection information system checks at both Alder Hey and Ormskirk hospitals. There is also consistent oversight of children's attendances at Ormskirk hospital by paediatric liaison.
- It is positive that the police have made changes to the command and control system with a view to capturing the voice of the child more effectively. When a log is created with the opening codes that identify, for example, a domestic abuse incident or concern for safety, this now triggers a set of questions through which callers are asked if any children are involved, if there are safeguarding concerns and if the family need specific support.
- In addition, frontline officers can access information and guidance on their handheld devices though the relevant software. This provides officers with step-by-step guidance when using powers under section 136 of the Mental Health Act. It gives officers access to relevant legislation and useful internal and external contact numbers in order to help support children. For some children, police investigations are recorded clearly and appropriate steps are taken to respond to crimes involving children with mental health concerns.
- All children brought into police custody are screened by the criminal justice mental health liaison team (CJMHT) for mental health and vulnerability issues.

Children are appropriately seen out of hours by the nurse. This screening enables those staff to advise the police on pre-existing history to assist in the assessment of risk and help manage their welfare while in custody, as well as signposting to appropriate services. Inspectors reviewed a sample of detained children. Risk markers are clear and most of these children were offered the option to see the CJMHT while in custody. This is good practice and provides rapid intervention opportunities for children affected by poor mental health at a time of crisis.

- Joint working between Addaction Stars young person's substance misuse service and the YOT is improving and, as a result, referrals from the YOT are increasing. This ensures that young people who misuse substances receive the support that they need in a timely manner. The joint working agreement is being reviewed to strengthen the governance and performance monitoring arrangements. There are also strong partnerships with Catch 22, which delivers services to support those who are affected by serious youth violence. There is a clear referral pathway in place to enable the YOT to access its services swiftly to ensure that children and young people receive the support they need.
- There is a range of provision to support children identified to be in need of early help and intervention with their emotional health and well-being needs. When children are identified with lower level emotional well-being and mental health needs, they can access support from services such as the Star Centre, which is operated by Venus. The Star Centre accepts referrals from CAMHS, schools, GPs and the YOT, and 40% of the children and young people who are currently using the service have referred themselves.
- A comprehensive school nursing offer, including an enhanced service and a specialist emotional health and well-being nurse, supports early identification of children's needs. The service also provides a range of work in schools to increase children's awareness of emotional well-being, including for those who are not in school or who are home educated. Some of the children within the deep dive sample are looked after children, and they receive a high standard of support with their emotional health and well-being needs. This is evident in the work of school nurses. For example, they use the HAPPY questionnaire (health awareness, prevention and intervention) to encourage children to rate their own emotional well-being.
- Children identified as having higher levels of emotional health and well-being needs, and who have a social worker, can quickly access support from the local authority specialist therapeutic team. The team provides children and their families with specialist therapeutic intervention and assessments. Workers in the therapeutic team continue their interventions for children referred to CAMHS while they wait for an initial assessment. Feedback from children and young people is sought to test that the service is delivering and meeting their needs. Children are positive about the relationships they have with staff, and the service appropriately prioritises and supports children looked after.

- Most social workers in locality teams demonstrate a good understanding of the impact of childhood trauma and the child's lived experiences on their emotional health and well-being. Most children who have a plan coordinated by a social worker are being provided with some services to support their mental health needs. This includes access to counselling and family therapy via Venus, support to help reduce the impact of domestic abuse, and specialist support for those who have experienced sexual abuse.
- The deep dive analysis of children identified that when children who are looked after received a service from CAMHS, they are provided with flexible and responsive support that is tailored to meet their individual needs. This includes more frequent visiting and support in line with the wishes of the child and their care staff, alongside re-offering specialist interventions at a time when children are ready to engage. CAMHS has provided additional guidance and training for care home staff in response to their concerns, and this helps to provide children with a consistent response when they need help and interventions.

Case study: Effective practice

When children have a clear plan that is understood, progressed and shared between partners, they experience improved outcomes and positive emotional well-being.

Multi-agency partners developed a good understanding of a child's experience when he became looked after following concerns that he was exhibiting harmful sexualised behaviour.

Professionals working together have ensured that he is happy in his residential care home and when at school. His wishes, worries and feelings are well understood by the people who look after him.

He has been helped to establish an open and trusting relationship with his CAMHS psychologist. His review health assessment, collated by the looked after children's nurse, provides a holistic picture of his needs and his health requirements.

Next steps

Sefton MBC should prepare a written statement of proposed action responding to the findings outlined in this letter. This should be a multi-agency response involving key partner agencies. The response should set out the actions for the partnership and, where appropriate, individual agencies.[2]

Sefton should send the written statement of action to ProtectionOfChildren@ofsted.gov.uk by 30 March 2020. This statement will inform the lines of enquiry at any future joint or single agency activity by the inspectorates.

Yours sincerely

Ofsted	**Care Quality Commission**
Yvette Stanley National Director, Social Care	Ursula Gallagher Deputy Chief Inspector
HMI Constabulary and Fire & Rescue Services	**HMI Probation**
Wendy Williams HMI Constabulary and Fire & Rescue Services	Helen Davies Assistant Chief Inspector

[2] The Children Act 2004 (Joint Area Reviews) Regulations 2015 www.legislation.gov.uk/uksi/2015/1792/contents/made enable Ofsted's chief inspector to determine which agency should make the written statement and which other agencies should cooperate in its writing.