

Review of health services for Children Looked After and Safeguarding in London Borough of Newham

Children Looked After and Safeguarding

The role of health services in London Borough of Newham

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Contents

Summary of the review	3
About the review	3
How we carried out the review	4
Context of the review	4
The report	6
What people told us	6
The child's journey	7
Early help	7
Children in need	11
Child protection	14
Looked after children	15
Management	18
Leadership & management	18
Governance	19
Training and supervision	20
Recommendations	22
Next steps	23

Summary of the review

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

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

About the review

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

- The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.
- The focus was on the experiences of looked after children and children and their families who receive safeguarding services.
- We looked at:
 - the role of healthcare providers and commissioners.
 - the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
 - the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.
- We also checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, Working Together to Safeguard Children 2013.

How we carried out the review

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

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

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

In total, we took into account the experiences of 41 children and young people.

Context of the review

Newham has a young, diverse, mobile and rapidly growing population of 318,000 rising to 340,000 by 2016 and to 382,000 by 2021. It has an unusually young age profile in comparison to the age profile for England, has the highest birth rate and high population churn. The 2014/15 funding for Newham Clinical Commissioning Group is £391m. The population will grow and demand for NHS services is expected to continue to rise and the CCGs challenge is therefore to improve the quality of services, meet the needs of its local population and reduce health inequalities.

Commissioning and planning of most health services for children are carried out by Newham CCG, with specialist commissioning of the health visiting services, Sexual Assault Referral Centre (SARAC) at Paddington and Tier 4 children and adolescent mental health services being carried out by NHS England. Primary care, delivered by General Practitioners, is also commissioned by NHS England. School nursing and contraception and sexual health services are commissioned by the local authority.

Acute hospital services are provided by Barts Health NHS Trust at Newham Hospital. The Urgent Care Centre (UCC) on the Newham Hospital site is provided by East London Foundation NHS Trust.

Community based services are provided by East London NHS Foundation Trust. Child and Adolescent Mental Health Services (CAMHS) and adult mental health services are also provided by East London NHS Foundation Trust. The adult substance misuse service has recently been decommissioned and reference to adult substance misuse service in this report refers to those services provided by East London Foundation NHS Trust.

The last inspection of health services for Newham's children took place in November and December 2011 as a joint inspection, with Ofsted, of safeguarding and looked after children's services. Recommendations from that inspection are covered in this review.

Children and young people make up 28% of Newham's with 93% of school age children being from a black or minority ethnic group.

On the whole the health and well-being of children in Newham is mixed when compared with the England average. Both the infant mortality rate and the child mortality rate in Newham are not significantly different to the England average.

The rate of children looked after (CLA) under age 18 per 10,000 children as at March 2013, was significantly better when compared against the England average. The annual CLA report states that the number of CLA has steadily decreased since 2010 and as at March 2013 was at an all-time low. In terms of up to date immunisations for this group, ChiMat reported that in 2013, the percentage of children in care within Newham with up to date immunisations was also significantly better than the English average. However, overall the percentage of all Newham's children having MMR immunisations and other immunisations such as diphtheria, tetanus and polio by aged two was significantly worse when compared with the England average.

The indicator for the rate of emergency department attendances for children under four years of age in 2011/12 was significantly worse than the England average. In terms of hospital admissions the rate of hospital admissions caused by injuries in children for two different age cohorts (0-14 years and 15-24 years) was significantly better than the England average in 2012/13. With regards to mental health, the rate of hospital admissions for mental health conditions and the rate of hospital admissions as a result of self-harm in 2012/13 were both significantly better than the England average.

In 2011, the conception rate for under 18 year olds per 1000 females in Newham was not significantly different to the England average. The percentage of teenage mothers in the area in 2012/13 was significantly better than the England average. Breastfeeding indicators for both breastfeeding initiation and breast feeding prevalence at 6-8 weeks after birth were also significantly better than the England average. ChiMat does indicate that there is an issue with child obesity in Newham between the ages of four and 11.

The report

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

What people told us

We heard from a new mother who was waiting for a discharge planning meeting with social care and told us *"I felt really looked after. I had lots of appointments for me and the baby and it was perfect."* However, she also said that she would have benefitted from staff on the post natal ward checking how she was coping with all the feeding and bathing as well as her emotional health.

Another new mother who had just had her baby on the midwifery led unit told us *"the midwives were professional and very nice. They helped me and came whenever I called. This is my first baby and I was scared."*

A 15 year old child was describing the local CAMHS and told us *" I felt listened to.....for the service to stay open for a long time because it helps a lot.....All staff really helpful and kind and they answer the phones really quickly.... I now feel more confident..... my self-esteem is more high"*

A client of the adult substance misuse service who had recently given birth told us *"here it's not all your fault people try to help you, support you and give you help"*

The child's journey

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

1. Early help

1.1 Newham CCG worked with local provider services and fourteen years ago commissioned East London Foundation Trust to provide a specialist GP Transition practice to help provide a primary care service to those patients who have been unable to register with a local GP practice or for migrants with no supporting documentation. This service helps to ensure that children and young people are allocated a public health nurse, their immunisation and vaccination programme is up to date and their health needs are co-ordinated by a general practitioner. The scheme is very successful and is now at capacity because families do not want to transfer into main stream GP provision.

1.2 Children and young people up to the age of sixteen are seen in a dedicated paediatric emergency department which is open 24 hours a day, seven days a week. The department is staffed by specialist paediatric trained nurses and sees many very young transient families, many are not registered with a GP and do not speak English. With the exception of ambulance emergencies, all families attending the department are triaged by urgent care. If they are not registered with a GP they are directed to the local transitional primary care practice. However, no agency is commissioned to check if these families then do go on to register with primary care and resolve the issue for future ongoing health support. All walking children will see a GP streamer between 8.00am to 11.00pm to determine whether they are treated in paediatric emergency department, UCC or seen and discharged by a GP. All other times children up to the age of 16 are seen directly in paediatric emergency department. Within the UCC there is a nurse who "walks the floor" to observe patients waiting for treatment in case their health deteriorates and they need immediate treatment.

1.3 The paediatric liaison health visitor attends the unit twice weekly and attends weekly psychosocial meetings. We were assured that to mitigate the risk of her lack of ongoing presence within the unit that all attendances are inputted onto the East London Foundation Trust's IT system and then screened electronically by her for any potential issues that may have been overlooked by emergency department staff.

1.4 There had been a historical issue of routine attendances not being inputted onto the East London Foundation NHS Trust's Child Health Information System in a timely manner. We observed the impact of this legacy with delayed notifications from attendance at emergency department to community staff. We were assured that this is being effectively addressed and the backlog has significantly reduced with robust contingency arrangements in place to avoid a recurrence.

1.5 A flagging system is in place to identify children who attend the emergency department and have had involvement with children's social care or have a child protection plan in place. This enables practitioners to escalate concerns where appropriate and share information with other agencies involved in the child or family's life.

1.6 Young people who attend the emergency department either through self-harm or needing urgent care for their mental health are able to access an improved service. There is an increased presence of CAMHS in the department and the rapid assessment interface and discharge team is available to provide mental health support to those young people aged 16 and over. These initiatives are helping to assess young people's mental health and sometimes avoid unnecessary admission.

1.7 We were, however, concerned at the number of young people between 16 and 18 who were admitted to Newham University Hospital on adult wards. It is not always in the interests of young people to be cared for in an adult environment and we saw no evidence of any risk assessment informing the decision to admit to an adult bed.

1.8 We noted the need for increased vigilance around the identification and recording of a young person's next of kin and who accompanied them to the department. There is nowhere on the electronic form for this to be documented for this age group. We saw how this was not always assessed and considered and could leave this group of young people in potential vulnerable situations.
(recommendation 3.1 & 5.1)

1.9 A psycho-social meeting is held weekly within the emergency department where children and young people about whom there are concerns are discussed. There is good attendance from health care professionals who jointly develop plans of action to help safeguard vulnerable children.

1.10 Newham is a diverse population with over 132 dialects and languages with one of the country's highest birth rates. Newham Hospital has a centralised delivery suite with a co-located birth centre and a free standing birth centre in a different part of the borough. The maternity department at Newham Hospital is decorated in zone colours to aid families who do not speak English as their first language and helps them to identify in which area they need to access services. Women can self-refer to midwifery services though most referrals are made by GPs.

1.11 The quality of information provided by GPs on the maternity referral varies considerably. On some referrals even basic essential information was missing, for example, in the case of Woman A, the referral did not identify that the mother had a child with a genetic disorder or that she had a history of female genital mutilation. In contrast, a referral for a woman with a complex social history, completed by a GP working in the transitional practice, gave a most detailed history of substance misuse, domestic violence and prior mental health problems. This early information is crucial in informing midwifery services about which team to allocate women to and for midwives to have a more informed view when booking the pregnancy.

1.12 Midwifery services use the widely used perinatal institute records for maternity care and in those records seen there were gaps in the recording of family name at birth, ethnicity and religion. This lack of information can lead to services not responding to the individual faith and cultural needs of their patients. Currently Newham midwives do not generate midwifery birth plans for all women. This is part of an improvement agenda and is due to be resolved by Autumn 2014 (**recommendation 5.2**)

1.13 We saw evidence of comprehensive risk assessments carried out at booking pregnancies, though it was often unclear when and if these are repeated throughout the pregnancy. It is important that risk is continuously assessed throughout pregnancy as this can be a vulnerable time and midwives need to be aware of any significant change in circumstance that may impact on the safety of a newborn baby or the support a pregnant woman and family may need (**recommendation 5.2**)

1.14 Health visitors do not routinely carry out ante natal visits and they are often not aware of concerns identified in pregnancy as the health visitor and midwifery liaison forms are not routinely completed by midwives or received by health visitors. Although practitioners spoke about the use of the health and midwifery liaison forms there is no formal process for a standardised routine referral to health visitors from midwives to enable early contact with the family. We saw some cases where health visitors would have clearly benefitted from information held by midwives and which only became known to them as a consequence of this CQC review. In some instances this lack of information sharing meant that opportunities to safeguard children were being delayed or missed (**recommendation 4.1**)

1.15 Health visitors are commissioned to deliver the Healthy Child Programme, however, this does not currently include ante natal contact. There is close monitoring of performance and the lack of capacity to deliver some key visits, in particular the two and a half year development check, is recognised and is being addressed through a concerted recruitment initiative. This is now having a positive impact on the workload of health visitors and is most welcomed by this group of staff.

1.16 A new school nursing service model was introduced in April of this year with an increased rostered and presence of the school nurse in maintained, academies and free schools. Early feedback from head teachers, school staff and school nurses is positive.

1.17 We heard about how close working relationships between the school nurse safeguarding lead and the local authority attendance management team ensure that those children who are not in school or who have poor attendance are not disadvantaged in their access to a school nursing service. The community safeguarding lead has responsibility for these children and young people as part of her caseload. Those children who are home educated are allocated to a school nurse based on their postcode.

1.18 School nursing recognise the public health need to address the high levels of childhood obesity in Newham. Families with children identified as at risk through the national child measurement programme are offered support from the school nurse and the dietician as well as an opportunity for referral to the Development Advisory Clinic. It is too early to comment on the impact of this renewed effort to address the problem.

1.19 Overall, information sharing with public health nurses and other professionals remains an area for development. This has been a common feature throughout the review and means that assessment to identify risk and subsequent planning to support vulnerable families is not always based on all known facts. One barrier to the identification and sharing of information in Newham is the number of transient families that move in and out of the Borough and the high number of families that are not registered with a local GP. Local health partners have introduced a number of initiatives to identify these families and support them in registering with a GP, however, this work has not yet been formally evaluated.

Child H had moved between two different health visiting teams in his early years and the transfer paperwork had not taken place. When Child H moved into primary school he did not transfer into the school nursing service. Child H was receiving CAMHS support for an eating disorder; CAMHS did not communicate with the school nurse and the headteacher, although aware of paediatric and CAMHS involvement, had also not shared this information with the school nurse. This meant that the professional opinion from a qualified school nurse was not considered or used to inform future planning of his care.

1.20 Major issues faced by community health nurses include a highly mobile population and the lack of GP registration by families. Whilst there are protocols and guidance on transferring children between teams, receiving families into the area and transferring their care out of the area, the effectiveness of these has not been audited and assurance is not sufficiently robust (**recommendation 1.1**)

1.21 Children and young people in Newham who need additional support for their emotional health and wellbeing are able to access a wide range of support groups. The local CAMHS offer a hub and spoke model which signposts and allocates children and young people to the most appropriate service and care pathway. Waiting times to access CAMHS continue to reduce. This means that children and young people are increasingly accessing care at their most vulnerable time. CAMHS value service user involvement and have a parent support group and a young people's group 'Young team' who meet monthly who are consulted on services.

1.22 We visited the Coborn Unit and found it to be an attractive, well designed therapeutic place for young people to receive care as an in- patient. Staff demonstrated a good understanding of the many different cultures of the young people who utilise the service. A broad range of support is provided to meet the requirements of these young people. We recognise the difficulties faced in trying to plan discharges for those young people who have received care there and are ready for return back into their originating local authority area and the ongoing work being carried out by the trust and local authorities to return these vulnerable children to their local areas. We felt that the messages left on a 'Hope wall' by young people who leave the service are a source of inspiration to other young persons within the unit.

1.23 Young people have good access to an effective young people's contraception and sexual health services (CASH) and genito urinary medicine (GUM). The young people's CASH service is known locally as Shine and is based in the community. We read files that demonstrated compliance with policy on assessing young people's capacity against the Fraser competencies and also saw robust risk assessments. Both services made regular referrals to children's social care where there were concerns about a young person's vulnerability and possible exploitation and practitioners routinely attended professionals meetings and other key child protection meetings.

1.24 The CASH Nurse for Vulnerable People is a highly valued resource who offers an outreach service to work with those young people who need additional support to access CASH, including CLA. From cases we reviewed, she demonstrated a personalised and flexible approach to delivering services and supporting young people working across neighbouring borough's to keep young people safe.

2. Children in need

2.1 The newly introduced triage service is effective in providing practitioners with a quick response to referrals for child protection or requests for additional support for vulnerable families. Where health practitioners identify families or children that require additional support, contact is made with the children's triage service which includes representatives from children's social care, community health, youth offending team and the police. Each service contributes to the decision making about which service is best placed to respond and delay in providing support or services is minimised.

2.2 Pregnant women with complex social risks are supported well by the specialist vulnerable pregnancy team known locally as Acorn. The midwives in the Acorn Team deliver a midwifery service to women under 20 years of age and any woman identified as vulnerable, eg. those women where domestic violence has been identified, women who have a history of current substance misuse or learning disability. The team have recently started to take on responsibility for women with established perinatal mental health concerns. Women who are cared for by the Acorn Team access an enhanced care pathway with increased number of ante natal visits and a more flexible approach to the scheduling of appointments. This helps to increase their engagement and attendance during the critical ante natal period.

2.3 A well established and effective perinatal mental health service supports those pregnant women who have moderate to severe mental illness or who are at risk of relapse post delivery. We saw evidence of good co-ordination of complex care packages that reflected the individual needs of the woman. However, the pathway of care for those women who have mild to moderate risk is less well developed and relies on custom and practice and informal networks rather than a formal process. One pregnant woman was referred to the perinatal mental health service and after assessment was deemed to be low risk so referred back to the GP with a suggestion that she access a more local Tier 2 service. Later in the pregnancy the GP referred the woman back to the team who again declined the referral as they felt that she still not meet the threshold for secondary care input. The woman did not receive any mental health support by the time she delivered the baby and this information was never shared with the health visitor
(recommendation 1.3)

2.4 Female Genital Mutilation (FGM) is part of ongoing work led by NHS England and lead professionals within Newham recognise the need to design local pathways across services to reflect a whole system approach. We saw how information on women with identified FGM was not being shared appropriately to protect young females in families.

2.5 Midwives in Newham face particular difficulties in managing complex social vulnerability; in particular women presenting late in pregnancy, women often leaving the country after booking to spend their pregnancy abroad. We saw evidence of how some of these issues are now so common place that incidences around late or concealed pregnancy are not always escalated appropriately and midwives do not always demonstrate inquisitive enquiry into disclosures made by women. A new safeguarding algorithm developed by the Barts Health NHS Trust clearly highlights these as significant risks and is due to be implemented across midwifery services by Autumn 2014 when it will be accompanied by some targeted training.

2.6 Midwifery services are introducing processes to mitigate some of the risks by introducing a centralised booking system where the initial booking appointment incorporates the taking of blood for tests and plans are well advanced to also introduce carrying out the initial scan of the pregnancy at the same time. This will allow midwives and the pregnant woman an opportunity to carry out a more comprehensive initial assessment at the earliest opportunity.

2.7 We identified a gap in identifying and arranging for early support for some pregnant women who did not meet the threshold for child protection. Whilst the midwifery team can refer to the family nurse partnership and to the early years midwifery team, (both offer evidence based interventions to support vulnerable pregnancies and families), they do not use the children's triage service to access the local offer and this means that some families may not be offered a full package of support that is available to vulnerable families residing in Newham
(recommendation 1.1)

2.8 We saw evidence of how the family nurse partnership had worked flexibly and extensively to keep a challenging teenage mother engaged with the service and of how the early years midwifery team were successful in educating new and young fathers on some key principles around caring for and communicating with their new baby.

2.9 Information sharing between midwifery services and other health partners is weak (GPs, health visitors and school nurses). We saw too many examples of where midwives providing care would have benefited from information held by health partners.; Examples included GPs making initial referrals and not including full health and social histories, health visitors already working with a family and not informing maternity staff when the mother became pregnant again, missing updates from other health professionals who are working with the families such as perinatal mental health **(recommendation 1.1)**

2.10 Information sharing was also a feature in adult substance misuse services where the team did not always share information in a timely way with other professionals. In some cases seen, the delays in sharing information by the substance misuse team delayed the opportunity for midwives to contact and offer services to very vulnerable women. In addition, in one case practitioners within substance misuse services whilst challenging children's social care about decisions, did not consider escalating concerns at an earlier enough stage to the trust safeguarding lead for support and advice.

2.11 Appropriate representation and involvement of health partners in the Multi Agency Child Exploitation Forum (MACE) is contributing to the effectiveness of this panel which started in April 2014 to bring together key partners across Newham to share information about young people who are at significant risk. We saw evidence of how this panel is pro-active in alerting services to young people who would benefit from targeted support.

3. Child protection

3.1 The local sexual assault referral centres have been rationalised and children and young people in Newham now travel to Paddington Haven for examination when sexual abuse has been alleged or suspected. The CCG recognise the lengthy travel that this involves, often late at night but the numbers are low however from our discussions and review of files there are good arrangements in place to offer follow up support from either the Haven, from the community paediatricians or Newham sexual health services.

3.2 Robust arrangements exist to refer cases where midwives identify potential and significant safeguarding risks to the unborn child. Midwives refer direct to the hospital social work team and copy the referral to the trust's safeguarding team. Weekly psychosocial meetings take place and these are well attended by partner agencies, including health visitor, perinatal mental health team and children's social care. Cases of concern are discussed and progress monitored closely.

Child C was known to the specialist contraception and sexual health nurse for vulnerable young people and when Child C disclosed she was pregnant the CASH worker completed a comprehensive referral to the specialist midwifery team, Acorn. The referral clearly articulated risk and enabled the Acorn team to allocate the case to an appropriate midwife. The midwifery services referred Child C to children's social care and also referred her on to the Family Nurse Partnership Programme. Child C has attended all her FNP, ante natal and medical appointments and has made good progress. When Child C delivered her baby, they went to a specialist mother and baby foster placement where they continue to thrive.

3.3 Good arrangements are in place to ensure midwifery attendance at child protection conferences and core groups. However, key documents were missing in some of the health files we reviewed, including email correspondence, records of minutes and child protection reports for conference. This means that records can be incomplete, is potentially unsafe and is poor practice (**recommendation 5.2**)

3.4 The local London service alert maternity network has recently disbanded and there is now no formal process in place to alert and share information on pregnant women with identified vulnerability who have moved out of their area. In one case we read, we saw how a neighbouring midwife had contacted a midwife in the Acorn Team, via an informal email, to outline her concerns about a pregnant woman and thought she may have moved into Newham. In this case the midwife had contacted Woman X and invited her to book with the Acorn Team. The woman booked her pregnancy late and during the risk assessment disclosed previous social work involvement with her family and a referral was made to children's social care. The named midwife network is developing a process to formalise this process as they recognise the risks involved in not sharing this information formally but balancing the need for appropriate governance around information sharing.

3.5 Referrals to children's social care made by health professionals are not always complete and do not always contain details of previous children in the household or of other significant households. Risk is often not assessed or articulated. This means that the social worker considering the referral does not have access to a full holistic assessment on which to base their decision making (**recommendation 1.2**)

3.6 We saw some good practice by one health visitor who, since taking over a case from a colleague, had made regular visits to a family and had documented well her risk assessments and plans of care. This facilitated open and challenging dialogue with the family's social worker as she was able to articulate and evidence her ongoing concerns which were then acted upon and the child was protected well by a robust child protection plan.

3.7 Good systems ensure health visitor and school nurse representation at child protection conferences; there are discussions between health visitors and school nurses to avoid duplication and over-representation where more than one public health nurse is working with the family.

3.8 Some GP practices across Newham have introduced regular communication meetings with named health visitor representation. In one practice we heard how, in order to gain the most benefit from these meetings, the health visitor is sent a list of the children who will be discussed and the concerns the practice has about them a few days prior to the meeting. This allows the health visitor to bring information relating to these cases, enabling a full informed review of the cases and develop actions to take forward. This supports a co-ordinated approach to the support of vulnerable and complex families.

4. Children Looked After (CLA)

4.1 The designated nurse for CLA is also one of two specialist CLA nurses who carry out review health assessments for all children who are looked after by London Borough of Newham and are placed either within the Borough or out of the area but within two and a half hours of driving time. This means that the majority of CLA are not disadvantaged by their out of area placement and receive the same quality of service.

4.2 When commissioning external initial and review health assessments, the CCG use the national quality checklist to ensure that the quality of reviews is consistently high and these are monitored by the CLA nurses.

4.3 The process for arranging and reporting on the outcome of initial health assessments is fundamentally flawed and leads to unnecessary delay and means that sometimes the initial health plans are not available for the first statutory review. The CLA health team are currently monitoring performance on the timeliness of the initial health assessment based on the date of the completed request for assessment rather than the statutory timescale of 28 days from the child entering the care system, so reports on timeliness are inaccurate. Delays in completing initial health assessments are compounded by an unwieldy and lengthy process starting with delays in receipt of completed requests for assessments by children's social care. Further delays occur between the community paediatrician completing the assessment, passing on the paperwork to the designated doctor who handwrites the health summary, and then this being forwarded to the CLA nurse for completion of the health plan. We saw a number of health files where the completed assessments and health plans were not on the team's database. This was unacceptable and was resolved during the inspection period (**recommendation 2.2**)

4.4 CLA nurses attend the initial health assessments to provide informal consultation to foster carers and to meet the child or young person. This promotes early contact and an opportunity to discuss with foster carers and young people any health issues and how the CLA health team can support the new family.

4.5 The relationship between the CLA nurses and the children is often continuous and enduring. CLA nurses spoke positively and knowledgeably about the children they supported, however, this detail and passion did not translate into the written assessments and health plans which were often generic and not SMART. Health assessments we saw did not routinely include consideration of Strengths & Difficulties Questionnaire (SDQ) scores or reference to the Drug Use Screening Tool (DUST) (**recommendation 2.2**)

4.6 There is no system in place to monitor completion of actions identified in health planning; instead practitioners rely on their own personal working practices. Review health assessments were often episodic in nature and did not reflect the child's health journey. In most initial health assessments and health reviews we read, we noted that the birth family and health history were not recorded. These are missed opportunities to provide context around a child's future health needs. GPs are not routinely contacted to ask for their input into either initial or review health assessments though they are copied into the health plans (**recommendation 2.2**)

4.7 Good efforts are made in ensuring that looked after children are registered with a GP and dentist and that they are up to date with their immunisation and vaccinations. Children and young people looked after who need additional support around their emotional health and wellbeing can access specialist CAMHS support. Although the service does not routinely extend past a young person's 18th birthday, the active local Children's Rights Service does provide a counselling service for care leavers up until their 25th birthday. This is an issue that has been raised by the Children in Care council and is being progressed with commissioners.

4.8 We were told that young people were offered choice in the location of their health reviewed and, where competent, were asked to sign their consent to the health review process. This helps to engage young people with the health review process and to start to take responsibility for their own health care.

4.9 There are nominated health professionals working in CASH and substance misuse services providing consistency of support to young people by professionals who understand the challenges faced by young people in the care system. Those young people that become pregnant are prioritised for the Borough's Family Nurse Partnership if they meet the criteria.

Child G was a looked after child referred to the CASH nurse for vulnerable people. She identified Child G as taking part in risk taking behaviours and referred her to a group who were working with some of her school peers who had also been identified as presenting with similar concerns. Child G attended the sessions and at a later date shared some information that raised concerns about possible sexual exploitation. Partners in children's social care and the police were diligent in following up the issues. The CASH nurse maintained contact with Child G during some very challenging circumstances and was able to advocate well for her during her time in care. Child G is now in supported living, is well supported and is thriving.

4.10 Care leavers are provided with a health passport, however, whilst this contains a printed copy of their immunisation and vaccination history it does not contain a full health summary including details of childhood illness and birth details. This is a missed opportunity to give young people a fully personalised passport that they can retain and refer to throughout their adult life. CLA nurses try, wherever possible, to give young people their health passport personally and make sure that the public health information is tailored to their local area as well as giving national advice telephone numbers (**recommendation 2.3**)

4.11 There are no formal quality assurance or audit programmes in place to provide evidence of ongoing improvement in practice for either initial health assessments or health reviews. Because of the dual role of the designated nurse there is a lack of independence and challenge in monitoring and reporting on service quality (**recommendation 2.2**)

Management

This section records our findings about how well led the health services are in relation to safeguarding and looked after children.

5.1 Leadership and management

5.1.1 Newham CCG, East London Foundation Trust and Barts Health NHS Trust are represented on the Newham LSCB. A Joint Health Safeguarding Group is a formal sub group of the LSCB which also reports in to the CCG Quality Committee. Membership includes named and designated professionals, executive safeguarding leads and representation from the local authority. The designated nurses from Tower Hamlets and Newham represent the local CCGs on the provider internal safeguarding committees.

5.1.2 The CCG is making good progress in reporting against the Quality Outcomes Framework but recognises that the formal assurance to NHS England as part of the National Performance Framework is still in its infancy and requires strengthening.

5.1.3 There is evidence of commissioners working to identify and commission services to promote and maintain the health of children and support vulnerable families. However, there is a gap in the knowledge of the health needs of the children who are looked after by the London Borough of Newham. This means that it is not possible to identify and report on the impact of health services provided to this vulnerable group of children and young people.

5.1.4 The newly introduced safeguarding children dashboard will include questions for children around “feeling safe”. The questions are being piloted and reviewed by existing children consultation groups and will be further refined. CQC consider this is good practice and demonstrates a commitment to listening and involving children in their own care.

5.1.5 Adequate arrangements are in place for the designated professionals in safeguarding children who access supervision and training appropriate to their roles. There is, however, some concern at the capacity of the designated doctor for the CCG who is employed by the local NHS trust under a service level agreement but also undertakes the role of designated doctor for looked after children as well as the medical advisor for fostering and adoption. This also provides a challenge for the postholder in maintaining his independence in both roles (**recommendation 2.1**)

5.1.6 The East London Foundation Trust's safeguarding team is adequately resourced to support community health and mental health staff working across Newham and has good representation and involvement on the local sub groups of the LSCB. Barts Health NHS Trust also has an adequately resourced team and is represented on appropriate LSCB subgroups and full board.

5.1.7 The CCG have access to the named GP resource who is a good and passionate advocate for safeguarding children. There are ongoing discussions with NHS England area teams as to how named GPs across London can best be resourced and utilised; the designated nurse is working effectively to support the named GP and promote safeguarding children practice within GP practices.

5.1.8 Good progress is being made to recruit to health visitors and a recent recruitment drive in Denmark has resulted in some posts already filled. Within Barts Health NHS Trust good progress has been made in recruiting to midwifery posts and the trust has a weekly reporting system to monitor and reduce reliance on agency staff.

5.2 Governance

5.2.1 The CCG have strong arrangements in place to monitor and drive improvement in safeguarding practice across Newham. The revised governance arrangements provide clear lines of accountability to provide the CCG with robust assurance. The CCG reviewed its governance structures in the summer of 2013 and there are clear lines of accountability to provide the CCG with robust assurance. One example of a recent success is the CCG working closely with the provider trusts to improve the quality and attendance at safeguarding children training. Another is the close scrutiny around the outcomes of the 2013 Section 11 audits carried out by providers for the LSCB and the performance against subsequent action plans.

5.2.2 The designated nurse has recently completed joint work with colleagues in Waltham Forest, City and Hackney and Tower Hamlets to design a safeguarding dashboard that facilitates a more proactive approach in provider trust's reporting on safeguarding activity within their organisations;. The dashboard now includes a more rigorous set of key performance indicators reflecting the recommendations in recent national reports. The designated nurse has received approval to take part in the CCG Assurance Visits and these will commence in the near future and will ensure that a focus on safeguarding children practice is maintained across all provider services.

5.2.3 Barts Health NHS Trust have responded well to the recent CQC inspection and have strengthened their governance arrangements within the women and children's clinical academic group.

5.2.4 Barts Health NHS Trust recognise the need for continuous improvement in safeguarding practice within midwifery services. A new maternity safeguarding pathway has been devised and along with templates to record discussion at key child protection meetings, should strengthen and improve risk assessment and information sharing. This pathway is due for dissemination across the trust's midwifery services by Autumn 2014.

5.2.5 East London Foundation trust demonstrated robust arrangements to monitor safeguarding children activity within community services and to ensure representation of public health nurses at key child protection conferences. A recent decision has been made to look at the contribution of school nurses to initial child protection conferences and transfer-in child protection conferences to explore a more targeted approach. Audit has shown a need for health visitors and school nurses to be more proactive in sharing conference reports with families prior to the date of the conference and for reports to be always uploaded on the IT system.

5.3 Training and supervision

5.3.1 There is a recognised gap in the recording and reporting of training safeguarding children attendance at GP practice level. Work is ongoing with NHS England to see how this deficit can be addressed. The CCG designated nurse has developed and is now delivering a practice development programme for GP safeguarding leads which is being well received. Recent topics include domestic violence, report writing for child protection conferences and female genital mutilation.

5.3.2 Looked after children nurses are actively engaged in the training of foster carers. This helps to ensure that foster carers are aware of the importance of health reviews and how they can access support to maintain and improve on the health of their foster children.

5.3.3 We heard of the good progress made to recruit to vacancies in midwifery and how newly qualified midwives follow a year-long preceptorship programme. Newly qualified midwives are supported in their safeguarding and child protection practice by more experienced colleagues. However, the competency framework on child protection is underdeveloped. The trust recognise this and will be addressed as part of ongoing dialogue with the midwifery practice facilitator.

5.3.4 Both East London Foundation NHS Trust and Barts Health NHS Trust have identified deficits in performance on the numbers of staff attending Level 2 and Level 3 safeguarding children training. They are working closely with the CCG and are well supported by the designated nurse in ensuring that training content complies with the newly issued intercollegiate guidance. Both trusts have submitted a recovery plan. East London Foundation NHS Trust is meeting their trajectory to achieve compliance. Barts Health NHS Trust is compliant at all levels of safeguarding since October 2013

5.3.5 Supervision in safeguarding children practice has also been identified as an area for improvement in both organisations and plans are well advanced to implement improved processes and reporting.

5.3.6 Community based health staff employed by East London Foundation Trust have access to high quality supervision in safeguarding children practice. All cases that are subject to child protection or child in need plans, along with other cases of concern, are discussed in supervision using the “Strengthening Families” model. Staff report that this has a positive impact on their practice and helps to identify and resolve issues of concern, share some of the stress in working with complex families and identify potential training needs for the individual practitioner.

Recommendations

1. Newham CCG, East London Foundation Trust and Barts Health NHS Trust should:-

- 1.1 Review the current information sharing protocols and guidance across health practitioners in Newham to ensure that practitioners are trained and supported in providing co-ordinated and informed packages of care to families living in Newham and those that have recently moved into or out of the Borough or between geographic teams.
- 1.2 Assure themselves that referrals to children's social care by health practitioners contain all relevant information, including full risk assessments and articulate the risk well so that children's social care are making informed decisions on how best to respond to requests for support and intervention.
- 1.3 Develop an integrated referral and care pathway to support women who have mild to moderate perinatal mental health concerns.

2. Newham CCG & East London Foundation Trust should:

- 2.1 Review the capacity and governance arrangements of the postholder currently undertaking the roles of Designated Doctor, Designated Doctor for CLA and Medical Advisor for Fostering and Adoption to ensure that there is sufficient resource and accountability allocated to these important statutory posts.
- 2.2 Review and improve the arrangements for the initial health assessments and review health assessments for looked after children to ensure that these are timely and holistic and lead to completion of SMART health plans which are subject to a formal quality assurance process.
- 2.3 Ensure that the care leaver health passport includes a young person's full health history so that they can refer to this through their adult life.

3. Newham CCG and Barts Health NHS Trust should:-

- 3.1 Review the arrangements on admitting young people between the age of 16 to 18 to adult wards to ensure that where this has been agreed it is in the best interests of those young people and that appropriate safeguards are in place to protect them.

4. Barts Health NHS Trust and East London Foundation NHS Trust should:

- 4.1 Review and improve on information sharing between midwives and health visitors to ensure that key information is shared early to maximise opportunities to support vulnerable families

5. Barts Health NHS Trust should:

- 5.1 Ensure that the arrangements to safeguard young people aged between sixteen and eighteen attending the emergency department are robust and that risk assessments routinely include details of their next of kin and who has accompanied them.
- 5.2 Assure themselves on the quality of record keeping within midwifery services provided at Newham Hospital to ensure that maternity notes are complete, with documented repeat risk assessments, and include all key essential information such as child protection reports and minutes from child protection conference meetings.

Next steps

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

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