

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

# Children Looked After and Safeguarding

## The role of health services in London Borough of Brent

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<b>Provider services included:</b>	Central and North West London NHS Foundation Trust (CNWL) Ealing Hospital Integrated Care Organisation North West London Hospital NHS Trust (NWHT) Care UK (Urgent Care Centre)
<b>CCGs included:</b>	Brent CCG
<b>NHS England area:</b>	London
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## Summary of the review

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This report records the findings of the review of health services in safeguarding and looked after children services in Brent. 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 Brent, 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.

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## About the review

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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.

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## How we carried out the review

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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 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 60 children and young people.

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## Context of the review

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Commissioning and planning of most health services for children are carried out by Brent Clinical Commissioning Group (CCG). Acute hospital services and accident and emergency services for children are provided by Northwick Park, part of the North West London Hospital NHS Trust. The hospital also provides acute paediatrics; maternity and neo-natal unit services. Children and families access primary care services through one of 67 GP practices, walk in centres and the Urgent Care Centres (UCC) at Northwick Park Hospital and Central Middlesex Hospital.

The Urgent Care Centre at Central Middlesex Hospital is commissioned by Brent CCG and is provided by Care UK. Care UK has its own governance structures. Greenbrook Healthcare are responsible for the UCC at Northwick Park Hospital site and employ the GPs.

Community services such as school nursing (but not school based immunisations), substance misuse and sexual health services are commissioned by the local authority through public health department. The children looked after nursing service is delivered through Ealing Integrated Care Organisation (ICO) which covers Ealing, Harrow and Brent and is commissioned by Brent CCG.

Child and adolescent mental health services (CAMHS) are provided by Central and North West London NHS Foundation Trust (CNWL) mainly delivered in the community. The trust does have a child mental health in-patient service for children aged under 13 with complex emotional, behavioural and psychological difficulties. The service is located at the Collingham Child & Family Centre in the Kensington and Chelsea local authority area. The mother and baby inpatient unit is based at Park Royal Centre for Mental Health (local authority of Brent) along with the specialist perinatal community service that operates across Brent and Harrow.

The last inspection of health services for Brent's children took place in September 2011 as a joint inspection, with Ofsted, of safeguarding and looked after children's services. Recommendations from that inspection are covered in this review. Northwick Park Hospital was visited as part of the Harrow Children and Looked After Review earlier this year and this report makes reference to the progress that North West London NHS Trust has made since that time.

Children and young people make up a quarter of Brent's population with 92% of school age children being from a black or minority ethnic group.

On the whole the health and well-being of children in Brent is mixed when compared to the England average. The infant mortality rate in Brent is not significantly different to the England average however the child mortality rate is significantly worse than average.

The rate of children looked after under age 18 per 10,000 children as at March 2013, was significantly better when compared against the England average. However, ChiMat reported that in 2013, the percentage of children in care within Brent with up to date immunisations was significantly worse than the English average. Overall, the percentage of all Brent's children having MMR immunisations and other immunisations such as diphtheria, tetanus and polio by aged two was not significantly different 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 both age group cohorts - children under 14 years of age and children between the ages of 15 and 24 years in 2012/13 were both significantly better when compared to the average. With regards to mental health, the rate of hospital admissions for mental health conditions in 2012/13 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 Brent and the percentage of teenage mothers in 2012/13 were significantly better when compared to 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 Brent Child Health Profile Chart of March 2014 reports significant childhood obesity. In all births in Brent low birth weight is worse than the England average.

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## The report

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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.

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## What people told us

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We heard from

One woman who was using maternity services who told us. *"My midwife is easy to relate to, she is easy to understand and she explains things and so I don't worry."*

One young person told us about the GUM service, *"It's the best, it does everything and young people should know you can get everything done there and the people are nice."*

A foster carer who looks after young people and prepares them for independence who told us *"CAMHS are really good, even if the children don't want to go, I can go and their advice really helps."* She told us how even though one of her young people refuses to attend his health review, that the support offered by the children looked after nurses and the administrator in trying to engage him is consistent and *"that they haven't given up."*

Young people in care or who were care leavers told us that they "don't see the point of the health reviews, same routine and don't see any difference. *They just give me information and leaflets."*

We asked how the health review process could be improved for them and they told us that *"it would be good to stick to the same person so that they know you"*. They also said *"speak to you by yourself for at least part of the session."*

Health passports for young people leaving care were thought to be a good idea but young people wanted flexibility on when they would be given to the young person as some young people made the point that if they were living in semi independence then they should be able to hold their own passport. They thought it useful to help them when registering with doctors or at other health clinics.

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## The child's journey

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

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### 1 Early help

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1.1 Improved arrangements to identify vulnerability and safeguard children and young people accessing emergency care in Brent are now in place. Young people aged 16 and over who are not in education are seen in the adult emergency department. The urgent care centre, operated by Care UK, see, treat and discharge the majority of children who present at the UCC. Those with life threatening illnesses are referred to Northwick Park Hospital paediatric team or ED. All young people under 16 attending the emergency department at Northwick Park Hospital who require admission to hospital are admitted to Jack's Place, the paediatric ward. This ensures that these children are treated by the most appropriately qualified and experienced medical and nursing staff.

1.2 There can be long waits of up to two hours to be seen at the urgent care centre at Central Middlesex Hospital. Young people who leave the department before being seen are automatically referred to the paediatric liaison health visitor which acts as a safety net and follow up mechanism for families. In addition, the shift lead makes a decision on whether to follow up by phone directly to the family and contact the GP to share information more immediately.

1.3 Since the previous Ofsted and CQC Safeguarding and Looked After Children's inspection in 2011, electronic flagging systems are now in place within the paediatric emergency department, populated on a fortnightly basis on information received from local children's social care teams. This ensures that staff are aware of additional needs or concerns about a child or young person, including if they are looked after. We heard from one young person who was looked after that the emergency department had sought their consent to share information about the attendance with their social worker and foster carer.

1.4 However, there is a lack of pre-emptive electronic flagging alerts. in place within the urgent care centre at Central Middlesex Hospital, to ensure staff are aware of additional needs or concerns about a child or young person. Currently, information on children at risk is contained within the comments section of the last presentation. We were told that if the receptionist identifies a child on a child protection plan they will inform and alert the shift lead. The shift lead is then responsible for ensuring that the appropriate paperwork is completed and that all clinicians who have seen the child are also aware that the child in on a plan.

1.5 Robust systems within the paediatric emergency department ensure children and young people's safety. The review of all under 18 presentations in the paediatric emergency department by both the paediatric liaison health visitor and senior nurse contributes to quality assurance and acts as an additional safety net, meaning that children and young people are followed up after discharge. However, we did see some delay in notifications being received by health visitors and school nurses and this means that some families will not be receiving support or intervention at the earliest opportunity. **(Recommendation 3.4)**

1.6 Paediatric liaison do not review those attendances of young people aged between 16 and 18 who attend the adult emergency department and more work is still required to ensure that 16-18 year old young people are assessed for potential safeguarding risk. The current arrangements of using adult based paperwork does not prompt or provide health practitioners with any triggers to highlight potential risk and may lead to vulnerabilities being missed. **(Recommendation 7.3)**

1.7 The implementation of safeguarding stamps and sticker systems on paperwork since the last review, along with discussion of vulnerable children and families at the weekly psycho-social meeting is a positive development, and is leading to early identification of those children, young people and families that require additional support. The psycho-social meeting is still developing and there are some challenges to attendance of partner agencies and also timely follow up of actions due to capacity. Currently the recording of minutes and follow up is the responsibility of the named doctor for safeguarding. In some cases recorded, it was unclear if all actions had been completed in a timely manner.

1.8 Timely and detailed referrals to maternity services made by GPs included relevant history around vulnerability. Improvements in assessments in midwifery services demonstrated increased awareness and recording of the women's partner or father of the baby and a minimum of three risk assessments carried out during and after pregnancy to identify and monitor vulnerability especially for incidence of domestic violence. This is important as there is considerable research to evidence that domestic violence either begins or increases during pregnancy.

1.9 The trust are in the process of implementing a system for women to alert midwives of domestic violence, however, there remains no routine scheduling for a woman to spend time with the midwife alone where she would be safe to make disclosures of domestic violence or other concerns that she may not wish to share with other people present. This is a missed opportunity to identify and act upon potential disclosures such as domestic violence, mental health history and previous obstetric history. **(Recommendation 7.1)**

1.10 Good arrangements are in place to monitor attendance at ante natal appointments and any woman who misses three appointments is seen at home by a midwife.

1.11 The healthy child programme is currently delivered through targeted ante natal contacts with good compliance around the new birth visit and work is ongoing with the local authority to develop a partnership approach to completing the 2 and a half year review. Interpreters are currently routinely used to ensure equal access to health visiting services, however this will be an area of challenge with the planned introduction of drop in style clinics rather than appointments system.

**(Recommendation 3.2)**

1.12 These planned changes to the service delivery model may carry an inherent risk that children who do not attend for visits will not be tracked. Practitioners we spoke to could not tell us how the tracking systems would work to ensure children are seen regularly. **(Recommendation 3.3)**

1.13 The Family Nurse Partnership programme is currently being established and there is much enthusiasm about its benefits to the most vulnerable young people who are pregnant. However, practitioners expressed some concern that the strict criteria around early booking is unlikely to meet the needs of some of the BME groups in Brent who traditionally book pregnancy late. Consideration of complementary early support offers to meet the needs of the diverse cultural population would be beneficial.

1.14 Young people have access to effective contraceptive and sexual health (CASH) and genito urinary medicine (GUM) services across Brent, with some centres offering dedicated young people clinics. One young person told us that the GUM clinics “were the business, brilliant.” In all cases seen, comprehensive risk assessments were carried out with all young people aged under 16 years of age to help identify any exploitation or other vulnerability and we saw how in one case this had led to appropriate referral to Children’s Social Care. However, the existing protocol for under 13 year attendance requires immediate revision. This was brought to the attention of the designated doctor who has taken action.

Child M was brought to the CASH clinic by a teacher who had seen her accessing online advice on how to carry out a pregnancy test. The CASH nurse saw the young person and during the consultation appropriately assessed her competency and completed the risk assessment. During the discussion Child M disclosed that she was involved in a casual relationship with an older man and that she had a history of self-harm. The nurse provided Child M with appropriate health care and advice and referred the case to children’s social care so that she could be assessed and offered additional support.

1.15 Resources within school nursing service are stretched and the majority of their work is concentrated on supporting children and families who have a child protection plan in place. Currently school nursing do not support health promotion in schools or hold any drop in clinics for children and young people. The population in Brent is very mobile and arrangements between schools and the school nursing service to share information about new entrants to schools are underdeveloped. In addition, children and young people who are not in school or who are home educated are not supported by the school nursing service. There is a school nurse allocated to work with homeless families and who reports to a dedicated team in the local authority any children identified who are not in school. However, these children are not part of her caseload. This lack of support is often identified in serious case reviews.

1.16 Positively, there is increased awareness of the common assessment framework (CAF) within Brent with health providers making good progress in training practitioners. However, the local offer for early help and intervention is not well understood by health practitioners. For example, we heard from practitioners working in substance misuse, how they have a limited awareness of early help options available in the local area, and are unable to be proactive in their approach to signposting parents who would benefit from parenting support. We also saw evidence of early analysis of the paediatric liaison referrals which indicate that many of the families attending the emergency departments and urgent care centres have a limited social and support network. The named safeguarding team at the hospital are discussing innovative ways to try and meet this need and reduce its impact on acute services.

1.17 There is a lack in clarity about the purpose of the multi-agency safeguarding hub (MASH) with some professionals using the service to access only child protection advice. Feedback from the MASH on what decision has been made and on any action taken is not routinely available and has left practitioners confused about what to do next.

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## 2 Children in need

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2.1 Awareness on the impact of parental health and behaviours on the safety and wellbeing of children is good. Practitioners working in adult emergency care demonstrate appropriate professional curiosity and routinely obtain information around adults who may have contact with children at home, especially in cases where the adult has attended following domestic violence, mental health or substance misuse. Despite there not being a keyworker for domestic violence in the emergency department, cases we saw highlighted a high level of awareness and comprehensive recording of information and risk to children living in the household, including detailed referrals to the paediatric liaison health visitor completed by practitioners working in adult emergency care. This ensures that those children who are at risk because of their parents or carer's health or behaviours are identified early and referred for assessment and support.

2.2 The continued arrangement with the psychiatric liaison team and Harrow CAMHS team attending at the request of emergency department staff is working well to meet the immediate needs of children and young people who present at Northwick Park hospital with mental health concerns. Brent CAMHS team were seen to be responsive in their ability to meet the needs of children and young people on their caseload within a day of admission to "Jack's place" with rapid community follow-up appointments if appropriate. Ongoing concerns in cases seen highlighted issues with timely access to CAMHS inpatient beds, and in one case, a young person waited four days until a bed could be found in Bristol. An acute paediatric ward is not a therapeutic environment and is not the best place to care for these vulnerable young people. (**Recommendation 2.1**)

2.3 Community CAMHS are working hard to maintain waiting lists with rapid access appointments available for emergency cases within 24 hours and wait times of up to eight weeks for core services. The skill mix of the CAMHS team ensures family needs are supported if the child or young person will not engage with direct intervention and we saw good examples of parent and sibling work being completed. Currently school nurses can still refer children and young people direct to CAMHS and this is much appreciated, especially as the school nurses perceive a reducing provision within schools to support children and young people's emotional health and wellbeing. There is work ongoing to start a formal forum for CAMHS and school nurses to meet to improve communication and explore how the services can work closely together to support families.

2.4 The CCG have appointed a named nurse for safeguarding children in primary care. It is anticipated that the post holder will work with NHS England, the CCG and GPs in Brent to support and improve on existing practice which is too variable. In some primary care practices we visited the knowledge and flagging systems for children looked after, families who had been discussed at MARAC and those in child protection or on child in need plans were either missing, inconsistent or not understood. This means that the GP is not fully informed of the family situation or any associated vulnerability during a consultation. (**Recommendation 1.1**)

2.5 The Jade Team are a specialist group of midwives who support well those women who are pregnant and have significant and high risk social vulnerability. The team case work directly with a small number of women risk assessed as highest need and provide a consultation service or shared care with community midwives to many others. This allows more women to benefit from specialist help and advice.

2.6 We saw how the newly introduced perinatal mental health pathway is positively supporting women with identified and newly emerging mental health concerns during pregnancy. This includes continuity of care with good communication between the specialist midwife and the perinatal mental health team and earlier referrals from midwifery to the specialist team. Care plans are available to support women in labour and during the post natal period, however, these were sometimes generic and did not contain descriptions of relapse indicators. This meant that labour ward staff and post natal ward staff may not be able to recognise and respond to the individual signs that a woman was becoming unwell.  
**(Recommendation 7.2)**

2.7 All services users who become pregnant in the course of substance misuse and alcohol treatment in Brent, are automatically transferred to The Junction, to enable a pregnancy lead with additional expertise, to share their specialist substance misuse knowledge, and liaise with relevant ante and post natal professionals involved in their care. Cases seen highlighted the impact of this as the unborn baby is at the centre of effective care planning.

2.8 Within health visiting, we saw good understanding of potential risk and thorough completion of family health assessment, including detailed picture of the father of the baby or the woman's partner and other adults supporting a new mother. Assessments demonstrated learning from serious case reviews, including maintaining emphasis on the "voice of the child." Health records seen in health visiting and also school nursing indicate that whilst assessments of families and children are comprehensive, the care planning is not as robust; it is not SMART or outcome focussed. This means that it is difficult for practitioners and families to know when they have achieved success and avoid drift. This echoes a recent finding and recommendation in the recent Ofsted Report "In the Child's Time: professional response to neglect." ..... **(Recommendation 3.1)**

2.9 In some cases seen the "did not attend" (DNA) follow up policy within health visiting was not robustly adhered to, with DNA's sometimes not logged on records and on other cases, lack of follow up leading to significant gaps in appointments being offered. In one case seen this delay was 4 months. Such delays can negatively impact on the health visitors' ability to ensure children's safety, and that families' support needs are being met in a timely way. Assertive follow up following DNA's is being established however this practice requires more management oversight to ensure best outcomes and to ensure consistent information exchange with other disciplines e.g. GP's. **(Recommendation 3.3)**

2.10 Effective arrangements are in place to ensure that vulnerable families who move out of Brent continue to be safeguarded. A verbal handover between professionals takes place and records are transferred using secure mail and receipt confirmed.

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## 3 Child protection

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3.1 Cases of pregnant women with increased vulnerability are discussed at regular psychosocial meetings and although the children's social workers from Brent are invited, attendance is variable. The LSCB has a pre-birth protocol which is currently being updated and needs to be disseminated across front line services to increase its use. Currently children's social care do not action referrals until a woman's pregnancy is at 24 weeks gestation. This leaves limited time to plan a co-ordinated approach to supporting women who may often deliver early notwithstanding that the London Child Protection Procedures indicate that a child protection conference cannot be held before 30 weeks gestation. A memorandum of understanding between the Trust and Brent Children's Social Care is in place around how best to care for babies who are born without an unborn plan in place and are not to leave hospital with the parents. These incidences are rare and are always raised and discussed as serious incidents. This is good practice as it increases opportunity to learn from such incidents and avoid or mitigate risk in the future.

3.2 Sharing of information on vulnerable families between midwives and health visitors is weak other than in the most complex of cases. We saw significant variation in the communication and recording of information in families that were supported through early help and child in need, in comparison to those formalised under child protection plans. Often midwives are not sharing concerns about vulnerable families early and instead rely on liaison arising from the psychosocial meetings; this means that health visitors are not being alerted to those families below the threshold of child protection, therefore help is not always targeted appropriately and opportunities are being missed to support families in a co-ordinated way. (**Recommendation 5.1**)

3.3 In recognition of the need to strengthen the liaison between health visitors and GP practices, some GP practices have introduced liaison meetings. In one GP practice we visited we saw evidence of the liaison meeting taking place bi-weekly, to discuss families of concern with all GPs in the practice, which also included the attendance of the substance misuse worker. GP's found this regular communication particularly beneficial and it contributes to a more holistic approach to case management, allowing vulnerable families to access appropriate support. However, there is reported to be no similar information sharing opportunities with the school nursing teams and this is a gap where there are families with only school aged children and young people.

3.4 The population in Brent would indicate that there are large numbers of cultural groups at risk of Female Genital Mutilation (FGM). The maternity services offer two clinics at both Northwick Park Hospital and Central Middlesex for reversals and where women and their families can access counselling and follow up support. The Head of Midwifery is passionate about this cause and contributes to national and local discussion on how best health services can eradicate and support women and children on FGM. The Head of Midwifery plans to work with the local population and other key stakeholders recognising the sensitivities around this practice and the need to engage communities.

3.5 Since the local London service alert network disbanded there is now no formal process to share information of vulnerable pregnant women across London. This is of concern as some pregnant women who attempt to avoid engaging with children's social care do often travel around London to avoid detection and intervention.

3.6 Referral to children's social care, by some health practitioners, often did not articulate or assess risk. This meant that sometimes social workers were making decisions on requests for help or child protection without fully understanding the implication of the information contained in the referral. Some practitioners expressed frustration at the decision making of the multi-agency safeguarding hub (MASH) and described a level of inconsistency in the application of thresholds. The MASH does not currently advise practitioners of the rationale behind their decision making, especially when declining requests for intervention.

3.7 Attendance at child protection conferences and core groups by health practitioners is good. In the Integrated Care Organisation all child protection reports are checked to ensure that they reflect a comprehensive and holistic assessment of need. There has been a particular focus on learning around the voice of the child and the role of fathers. A copy of any referral to children's social care is sent to the safeguarding team to ensure that risk is assessed and articulated. An Inter-Agency Escalation Policy endorsed by the LSCB is in place and practitioners we spoke to were aware of its existence and how to invoke it.

3.8 From cases seen and in discussion with health practitioners it appears that GPs are not attending child protection conferences. We saw evidence of GP contribution to child protection conferences through written reports, with evidence of use of standard templates provided by Brent Local Authority for GP completion in some locality areas and the use of a letter format in others. There was significant and unacceptable variability in the style, quality and quantity of information contained in these reports. (**Recommendation 1.1**)

3.9 “Think Family” is well embedded in both the adult mental health team and substance misuse teams. Communication between these disciplines and lead child health professionals is very strong and many practitioners highlighted the strength of the liaison and information sharing from the adult mental health team. Cases seen were exemplary and were safeguarding children in vulnerable families well. Care plans and relapse indicators routinely recorded the needs of the child and parenting goals were consistently actioned in recovery plans. Service development particularly in the substance misuse team has not yet given consideration to the needs of parents who need to access specialist intervention and currently some service users find it challenging to attend appointments and engage with treatment plan because of the constraints of attending with children.

3.10 The Junction staff employ a robust risk assessment and “Think Family” approach to the safeguarding needs of children involved with service users. Safe storage boxes are provided to all adults accessing the service who have any contact with children. Service users are not routinely offered home visits due to capacity pressures and there are some challenges around parents accessing some aspects of the service due to location and availability of childcare. Work on service user consultation has recently started however there is not a specific focus on the needs of adults with parental responsibility with regard to service development.

GP referred Woman E to midwifery services to book her pregnancy, there were no known risk factors at the time of the referral and the maternity plan was for Women E to be looked after under a “shared care” arrangement between the hospital and her GP supported by a low risk care plan. During the pregnancy Woman E was admitted to hospital following an incidence of domestic violence. There was good information sharing between the hospital, the police and midwifery services. Concerns were escalated to the trust safeguarding team and the case discussed at the midwifery psychosocial meeting. The specialist safeguarding midwife made contact with Woman E and made an appointment to see her. During that appointment Woman E made a full disclosure as to the extent of the domestic violence and a referral was made to the MASH with a subsequent referral into MARAC. Woman E was supported to relocate to a safe address and children’s social care put a safety plan in place. The Midwife developed a care plan for delivery and postnatally to safeguard Women E and her baby which worked well.

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## 4 Looked after children

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4.1 A quality assurance group for children looked after services has responsibility for monitoring provision of care and is jointly chaired by Brent CCG and LBB of Brent. There has been substantial improvement in the quality of initial and review health assessments for children looked after although it is recognised that there needs to be consistency in the timeliness of initial health assessments which is still too variable. That said, some of the more recent health reviews carried out by the recently appointed children looked after nurses are of an exceptional quality and evidence a holistic and well informed assessment with a SMART health action plan and are to be commended.

4.2 Initial health assessments are carried out by the Associate Specialist for community paediatrics for complex cases or the trainee paediatricians who are on rotation. Supervision to trainees and quality assurance of all initial health assessment and health plans is provided by the consultant community paediatrician who is covering the vacant role of designated doctor for children looked after. There is an improvement in the quality of initial health assessments since the last safeguarding and looked after children inspection in 2011, with more emphasis in the collection of parental health information. However, it is of concern that there are still too many initial health assessments not completed within the statutory timescale and therefore not available to inform the child's statutory review. (**Recommendation 6.3**)

4.3 The LAC health team carry out the majority of review health assessments for children and young people looked after by London Borough of Brent. Where this is not possible because of capacity or if a young person is out of borough and the review will be late, then individual arrangements are made. This can lead to the continuation of episodic reviews which do not reflect the child's health journey and has been a feature of the past few years. It was originally anticipated that with the recruitment of an additional children looked after nurse, all health reviews would be carried out by the children looked after health team and any issues in quality or consistency in reviews for those children placed out of area would be resolved. However, the team resource will again be depleted when the lead nurse leaves in a few weeks. We were not given any assurance as to the robustness of any contingency arrangements to address this issue. (**Recommendation 6.1**)

4.4 Health plans seen during this review were comprehensive and the majority had clear timescales for actions and were outcome focussed. In review health assessments we saw good examples of information sharing between the children looked after CAMHS and health team so that practitioners had access to the most up to date situation.

4.5 There remains a need to clarify responsibility around the monitoring of actions identified in health plans between the local authority and the children looked after health team. (**Recommendation 6.2**)

4.6 The newly appointed children looked after nurses have made significant progress in engaging young people who had previously refused to attend for their health assessment through a concerted programme of assertive outreach. We saw how they had successfully persuaded a number of young people to take part in their health review; often for the first time in a number of years. This meant that for those young people getting ready to leave care there had been a good opportunity to identify and plan for their health needs as they made this important transition into adulthood.

4.7 We saw evidence of how young people were being asked to sign their consent for the health review, therefore improving their engagement in the process, and starting to help them take responsibility for their health. We heard from one young person how they had contributed to their health plan by writing some of the actions. However, we also heard from young people that they did not find the health reviews of any benefit and that historically they did not always receive copies of their assessment and plans which they would have found useful.

4.8 Young people in care access generic CASH and substance misuse services and there are no dedicated workers allocated to working with this vulnerable group of young people who understand the particular needs and the issues they face. An outcome from the improved review health assessment is the significant increase in the number of young people looked after who have now disclosed substance misuse and who have accepted an offer for intervention. Although there is a teenage pregnancy midwife working as part of the Jade Team there are no specific care pathways for children looked after or care leavers; though we were assured that these young people would now be prioritised for the new Family Nurse Partnership service. We did speak to one young person who was pregnant and was frustrated at the lack of early support and was not aware of the FNP programme. This was resolved during the week of the review.

4.9 The specialist Children Looked After CAMHS team has been decommissioned and those young people who are in the midst of a treatment plan are being carefully managed to ensure continuity of their care. One young person we spoke to told us that he was aware of what was happening but that he had been reassured he would still be working with the same practitioner. However, current arrangements mean that children looked after will no longer have access to a dedicated CAMH service and that these vulnerable children and young people will not be prioritised within the generic CAMHS service. Children looked after nurses have been told that they will no longer be able to refer to CAMHS and that future referrals will now be made by the child's social worker.

4.10 The impact of the recent decision by the local authority to decommission the existing CAMHS children looked after and learning disability service is being closely monitored by the CCG. Brent CCG recognise the need for flexibility in supporting these vulnerable children and young people whilst new care pathways are developed and the wider provision of CAMHS across North West London is planned. Inspectors were assured that through a combination of dialogue and collection of hard data that the CCG will discharge their responsibility in ensuring that these children will continue to receive a timely, quality service and that the impact on the generic CAMHS will be monitored and any emerging risk responded to.

4.11 Arrangements are well advanced to provide young people leaving care with a health passport. The format has been agreed and supplier sourced and we are assured that the order has been placed. Young people we spoke to were enthusiastic about the benefits of the health passport and were keen to influence the roll out across the service. This includes when a young person should be given responsibility of holding the passport and how information should be collated. One young person who had left care asked if a passport would be offered to young people who had already left care as she would find it personally useful.

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## Management

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

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### 5.1 Leadership and management

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5.1.1 Appropriate arrangements are in place to provide Brent CCG with assurance on safeguarding practice across health services provided to the population of Brent. The quality, safety, clinical risk and research committee is a formal sub-committee of the Brent CCG Governing Body and receives regular reports from the safeguarding and children and looked after group, the provider assurance group and provider clinical quality groups.

5.1.2 The Brent, Harrow and Hillingdon Federation of CCGs share key posts, including the Director of Quality and Safety who has safeguarding as part of her portfolio. There is increased joint working across the Federation on standardising safeguarding practice to ensure a consistent approach in the quality of support to vulnerable families who often cross boundaries across the three local authority areas.

5.1.3 The CCG is well represented on the Brent Local Children Safeguarding Board with the CCG Chief Operating Officer attending the LSCB Executive Group and other key individuals from the CCG and provider trusts attending other key sub groups such as the quality, audit and outcomes, vulnerable groups and the voice of the child. Brent is a pilot site for data collection looking at FGM. There is significant activity across the Borough and recently there has been consolidation of action plans held across different constituents of the LSCB to work towards a whole systems approach to tackling this issue along with other high level concerns prevalent in Brent such as forced marriage and honour violence.

5.1.4 The designated doctor has a full time contract with the CCG and is able to retain some clinical practice within the role. The designated nurse has line management responsibility for the newly appointed named nurse for primary care. Both designated professionals have access to appropriate training and supervision.

5.1.5 A safeguarding patch forum exists across North West London chaired by the NHS England Area Team safeguarding lead. The quarterly peer forum for named and designated safeguarding professionals across the six boroughs alongside attendance at the London named nurse network meetings provides a platform for peer support, case discussion, and identify training issues.

5.1.6 There is recognition that there is significant work to do around implementing the safeguarding assurance framework. Brent CCG continues to support NHS England in the commissioning and monitoring of some specialist services, including health visiting, which is due to transfer to public health in October 2015.

5.1.7 The demographic profile of Brent is changing, with increasing mobility of very vulnerable families and this is impacting on health practitioners as they are experiencing higher level of demand for service without additional resource.

5.1.8 Efforts are being made to recruit to vacancies within health visiting and school nursing but the impact is not yet evident and case loads are high.

5.1.9 The CCG has approved three sessions for a designated doctor for children looked after and to date has been unsuccessful in appointing to the vacancy. A community paediatrician is currently covering the designated post; however, they are also the medical advisor for fostering and adoption and well as the clinical lead for community services. This is unsustainable.

5.1.10 The CCG has appointed full time interim designated nurse for children looked after in recognition that strategic planning for this vulnerable group of children and young people was an area that needed considerable development. Good progress has been made however there is still no decision made across the CCG or the Federation about the permanent configuration of designated nurse for children looked after. We have been given assurance that this will be resolved by August 2014.

5.1.11 Part of the work plan for the designated nurses has been the quality assurance visits to residential care homes and schools where children looked after by London Borough of Brent are placed. This work has been delayed because of the postholders' waiting for DBR clearance which has only recently been received.

5.1.12 The designated nurses for children looked after are now making key strategic links with the multi-agency sexual exploitation group, however, there is currently a gap in representation at an operational level by the named nurse for children looked after. It is well recognised that children looked after are some of the most vulnerable children that are recognised as being targeted for exploitation. The designated nurses for children looked after have recently been invited to attend the “missing from care group” and the voice of the child sub group. This is good progress as whilst there have been significant improvements in the quality of the health assessments and health planning for these children, the recognition and planning of local services to address their vulnerability is less well developed. Historically, some work took place by public health in the past to identify and benchmark the health needs of the children looked after population in Brent but this was never progressed.

5.1.13 The Children looked after lead nurse is based in the integrated care organisation and she is supported by a full time specialist children looked after nurse. The CCG have recognised the need for additional resource and have recently approved the funding for a further full time nursing post within the team. However, the current lead nurse has recently resigned and as yet there are no confirmed arrangements to recruit to the imminent vacancy.

5.1.14 The specialist children looked after nurse is co-located with colleagues from the London Borough of Brent part time; however, the full benefits of co-location are not realised because of logistical issues around providing her with supporting IT. We were advised that this issue was addressed during the week of the review. The specialist nurse for LAC told inspectors that early benefits of co-location include better relationships with social care and facilitating planned and opportunistic discussion on individual children and young people.

5.1.15 The delays in initial health assessments remain of concern and all breaches are reported to the quality assurance group for children looked after. Close attention is paid by this group on the provider’s meeting their key performance indicators and this has led to the current emphasis on timeliness; there is now a need to focus on a providing children and young people with a more holistic and supportive service.

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## 5.2 Governance

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5.2.1 Practice in primary care has been audited to cover key areas of concern including domestic violence, obtaining children’s details for those adults who register and have mental health or substance misuse concerns, health records for children, availability of appropriate safeguarding policies and protocols and leads in safeguarding children. However, completion of the audit was at an individual GP practice and during the review we saw significant variation in the quality and robustness of approach to this key area of work.

5.2.2 Governance of safeguarding within CNWLT is high, with annual safeguarding audits to ensure consistency in practice and survey monkeys completed to monitor safeguarding supervision and make changes based on practitioners' needs. The safeguarding champions also complete a case note sampling audit of safeguarding documentation across the CNWLT provider to identify issues and develop best practice models in keeping children and young people safe.

5.2.3 We saw good evidence of significant and early improvement to practice in midwifery services following learning from serious case reviews, peer review of the service and the CQC Review of Children Looked After and Safeguarding carried out earlier in 2014. However, the changes to practice are not yet fully embedded. The named midwife for safeguarding children post remains vacant for Northwick Park Hospital and this has an impact on the ability of the management to promote, embed and audit new processes and systems to better safeguard vulnerable women and their unborn babies.

5.2.4 A comprehensive audit programme on evaluating safeguarding children practice helps drive improvement within the ICO. We looked at the findings from one recent audit on safeguarding children record keeping and how these were influencing training, for example with greater emphasis being made on including the "voice of the child."

5.2.5 The children looked after health team are currently in transition between paper held records and electronic records and there are no appropriate safeguards in place to alert practitioners on the status of the electronic records where these are incomplete and waiting for old records to be uploaded. This is unsafe. **(Recommendation 3.5)**

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## 5.3 Training and supervision

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5.3.1 Brent CCG monitor closely provider's performance in meeting statutory training needs on safeguarding children and overall compliance is good.

5.3.2 The designated nurse has devised a training programme to deliver information to GPs on learning from serious case reviews. However, the uptake and impact of safeguarding children training within primary care is variable. The CCG has a high number of single handed or small GP practices and whilst the CCG continue to offer and support safeguarding training, some practices have elected to access on-line training without any additional face to face input. In an area of such high need and the disparate practice we saw in primary care during this review, there is a clear need for GPs to understand and embed good safeguarding children practice in their day to day interactions with the families they support and the practitioners they work closely with. **(Recommendation 1.1)**

5.3.3 The designated nurses have developed a training strategy for improving awareness on the needs of children looked after and this now needs to be ratified by the LSCB and supported by an implementation programme. This will help health practitioners understand the vulnerability and needs of this group of children and young people. We saw how the impact of training undertaken with the adult emergency department nursing team by the named nurse for safeguarding has developed practitioner awareness of “Think family” and resulted in a higher number of referrals being made to the paediatric liaison health visiting service.

5.3.4 During the review we were told how there had been a recent change in how the training for midwives across the North West London Hospital NHS Trust would be recorded. It is unclear as to how the proposed revisions for Level 3 safeguarding children training, to include annual updates with full training every three years, will be effectively implemented and monitored. This could lead to potential gaps in training and inadequate assurance by the trust. (**Recommendation 2.2**)

5.3.5 North West London NHS Trust is committed to improving the midwifery service and recognise well the impact of a woman’s mental health during pregnancy. The trust supports four midwives per year to attend the local university mental health module. The perinatal mental health midwife has attended specialist training on mental health and told us how this had increased her understanding on the issues faced by women in pregnancy and helped her to become more effective in working closely with women on her caseload.

5.3.6 We heard about ongoing training and development of health visiting teams to update their knowledge of safeguarding including a “set list” of LSCB training to be attended, that is agreed in conjunction with supervision advisor in their individual session. This individualised training programme ensures practitioners receive regular updates on areas that are pertinent to local Brent issues.

5.3.7 Positively, the health visitor team leads are accessing a leadership in safeguarding programme run by NHS London which aims to provide effective support for all staff.

5.3.8 Newly qualified health visitors and school nurses employed by the ICO benefit from a structured preceptorship that supports their development in competent safeguarding children practice. Newly qualified practitioners are accompanied to child protection conferences by either the safeguarding advisor or a senior practitioner.

5.3.9 Adult mental health services and the substance misuse team are accessing Level 2 safeguarding training; this level is below that recommended by the intercollegiate guidance and needs review to ensure that practitioners working with vulnerable families are trained appropriately. (**Recommendation 2.2**)

5.3.10 All practitioners who work in the urgent care centres receive safeguarding training up to level 3

5.3.11 Supervision arrangements within the integrated care organisation are robust, with clear links arising from discussion around practice to identification of training needs, learning from serious case reviews and other serious incidents. There are regular opportunities for formal safeguarding supervision and uptake is carefully monitored to ensure that health practitioners regularly participate and discuss all cases. However, currently safeguarding records are saved by the practitioner rather than recorded in patient notes. This means that the safeguarding plan is not always visible to the team working corporately and can lead to uncertainty if the actions had been followed up and what the outcome was for the child.

**(Recommendation 6.4)**

5.3.12 Robust supervision is in place within the substance misuse service to ensure all safeguarding issues have been considered. High levels of management oversight are in place for all cases involving children which are discussed weekly at the multi-disciplinary team meeting.

5.3.13 Practitioners working in the urgent care centre provided by Care UK are not accessing supervision support and as they see a high number of children and vulnerable families this is an area that needs addressing. **(Recommendation 8.1)**

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## Recommendations

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- 1. NHS England and Brent CCG should:**
  - 1.1 Assure themselves on the quality of contribution by General Practitioners to keeping children and vulnerable families safe within the London Borough of Brent.
  
- 2. NHS England, Brent CCG, Central & North West London NHS Trust, Ealing ICO (Community Services Brent) and North West London NHS Trust should:**
  - 2.1 Ensure that young people who require emergency in-patient mental health care are not disadvantaged by delay in accessing an appropriate therapeutic environment.
  - 2.2 Ensure that all practitioners working with vulnerable families undertake children's safeguarding training commensurate with their roles and responsibilities and in line with intercollegiate guidance.
  
- 3. NHS England, Brent CCG and the Ealing Integrated Care Organisation should:**
  - 3.1 Ensure that public health nurses are working effectively with vulnerable families by ensuring assessments for child protection and child in need are supported by health plans that are outcome focussed and SMART to monitor progress and avoid delay and potential drift.
  - 3.2 Ensure that the new offer for families accessing health visiting services does not disadvantage those families from black and minority ethnic communities and access to translation and interpreting services remain available.
  - 3.3 Ensure that robust arrangements are in place to ensure that those families who do not access the health visiting service are identified and followed up quickly.
  - 3.4 Ensure that paediatric liaison referrals and notifications are being processed without delay and appropriate action is being taken.
  - 3.5 Ensure that appropriate and immediate action is taken to mitigate the risk of dual recording of patient notes on IT and paper records.

**4. Brent CCG, Central & North West London NHS Trust and North West London NHS Trust should:**

- 4.1 Ensure that practitioners making referrals to children's social care include a full assessment of the perceived risks and are clear about their reason for the request for intervention.

**5. Brent CCG, Ealing Integrated Care Organisation and North West London NHS Trust should:**

- 5.1 Ensure that information sharing pathways are effective in order that information is always shared in a timely, appropriate and secure manner enabling practitioners to respond to the needs of vulnerable families at the earliest opportunity.

**6. Brent CCG and Ealing Integrated Care Organisation should:**

- 6.1 Implement a robust contingency plan to ensure the continuation of children looked after health service in light of the current and impending vacancies within the specialist health team.
- 6.2 Work with the Brent Children Social Care Team to agree the pathway for monitoring of actions identified in the health plans of children looked after by the London Borough of Brent.
- 6.3 Ensure that initial health assessments for children looked after are carried out within the statutory timescale and that the assessments and health plans are available to inform the child's first Local Authority statutory review.
- 6.4 Ensure that health plans arising from supervision with public health nurses are kept on the client's notes so that these can be referred to and shared with colleagues who may also work corporately with a vulnerable family.

**7. Brent CCG and North West London NHS Trust should:**

- 7.1 Ensure that all women accessing maternity services are routinely offered "time alone" during the booking process to provide a safe opportunity for discussion on sensitive and confidential issues.
- 7.2 Ensure that maternity plans for those women with perinatal mental health concerns holistically reflect a woman's individual needs, including relapse indicators.
- 7.3 Ensure that the paperwork used in the adult emergency department for 16 to 18 year old young people facilitates a full safeguarding assessment of vulnerability.

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## Next steps

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

Please submit your action plan to CQC through [childrens-services-inspection@cqc.org.uk](mailto: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.