

# **Review of health services for Children Looked After and Safeguarding in Kingston upon Thames**

# Children Looked After and Safeguarding The role of health services in Kinston upon Thames

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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 Kingston upon Thames. 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 Kingston upon Thames, 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.
- Where we found areas for improvement in services provided by NHS but commissioned by the local authority then we will bring these issues to the attention of the local public health team in a separate letter.

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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 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 67 children and young people.

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## Context of the review

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*Children and young people make up 24% of Kingston upon Thames's population with 49% of school age children being from a black or minority ethnic group.*

*On the whole, the health and well-being of children in Kingston upon Thames is generally better than the England average. Both the infant mortality rate and the child mortality rate in Kingston upon Thames are similar to the England average.*

*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 Kingston upon Thames was significantly better when compared to the England average. The percentage of teenage mothers in the area and breastfeeding indicators (breastfeeding initiation and breast feeding prevalence at 6-8 weeks after birth) in 2012/13 was also significantly better to the England average.*

*A strengths and difficulties questionnaire (SDQ) was used to assess the emotional and behavioural health of looked after children within Kingston upon Thames. The average score per child in 2013 was 15. This score is considered to be a borderline cause for concern. The average score over the last two years has slightly been increasing which maybe an indication that the emotional wellbeing of children is starting to deteriorate.*

*In 2013, the Department of Education (DfE) reported that Kingston upon Thames had 75 looked after children that had been continuously looked after for at least 12 months as at 31st March, (excluding those children in respite care, note that the Kingston LSCB report 134 children looked after (CLA) including children in respite care during this period). The DfE reported that 73% of children had their immunisations up to date. All CLA received their annual health assessment and 93% of LAC had their teeth checked by a dentist. As at 31 March 2013, there were 15 CLA who were aged five or younger, all of these children had up to date development assessments.*

*Commissioning and planning of most health services for children is carried out by Kingston CCG*

*Acute hospital services are provided by Kingston Hospital NHS Foundation Trust*

*School nurse services are commissioned by Royal Borough of Kingston (RBK) Public Health through the CCG and provided by Your HealthCare Community Interest Group (CIC).*

*Health Visitor services are commissioned by NHS England and provided by Your HealthCare Community Interest Group (CIC).*

*Contraception and sexual health services (as the school nurse KU19 and CASH) are commissioned by Public Health England (Kingston) and provided by Your HealthCare Community Interest Group (CIC).*

*Child and Adolescent Mental Health Services (CAMHS) are provided at Tier 3 and Tier 4 by South West London and St George's Mental Health NHS Trust.*

*The last inspection of health services for Kingston on Thames' children took place in June 2012 as a joint inspection, with Ofsted, of safeguarding and looked after children's services. Recommendations from that inspection are covered in this review.*

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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

Foster carers who told us:

*"What helped most was the bereavement counselling for the child to help them deal with their losses when they came into care. I wish this was more widely available. All looked-after children should have this."*

*"We have had good dental support at home from the community service."*

*"The nurse who does the health reviews tries to engage the children and has a full discussion with them as much as she can. She has known these children for a long time and knows them very well."*

*"The Looked-after children's nurse is very effective. Review health assessments were a bit chaotic and a mess but she has organised these to work better."*

*"It's been a mixed bag of experience with health support for the children we have looked after. I'm cross about the lack of help for child's emotional issues."*

*"CAMHS will not consider a foster care placement as settled even though the child may have been placed with me for 2 years or more, only if the child is placed permanently. I have been trying to get CAMHS help for our current child and banging my head in frustration. Now the behaviour is entrenched."*

*"We do get a health plan from the health review but the information on these is so basic and vague. If a child then moved placement, it would be of no help to the new foster carer."*

*"Health assessments are always discussed at the looked-after child review. The review officer makes sure this happens."*

A mother of a young child who said *“Health services are excellent in Kingston. We moved here from another borough and the services are so much better here. The health visitors are especially good. They are friendly and help my child, giving us as much time as we need. We don’t feel rushed at all. They give good advice and guidance and make sure things happen. They will chase things up”*

A new mother who had previously delivered a baby some years ago at Kingston Hospital said *“the staff are so nice, caring and careful. It has been so much better than before.”*

Another new mother told us *“support from midwives has been excellent, you just press the button and they come, they really are happy to help.”*

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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 Children and young people up to 18 years of age can access effective care from the paediatric emergency department (ED) at Kingston Hospital. The department is open 24 hours a day throughout the year and is staffed with appropriately qualified nurses and doctors. Young people between 16 and 18 years can choose whether to attend the paediatric ED or the adult ED, however, the risk assessment of young people treated in the adult environment has an adult focus and therefore the vulnerability of a young person may be missed. (**Recommendation 6.5**)

1.2 All children and young people book into the department through a shared reception with adult ED. Reception staff record the full demographic details, including which General Practitioner a patient is registered with and in the case of a school child, which school they attend. A printed identity bracelet is then given to each patient. This helps to avoid error in treatment and in dispensing medication.

1.3 Children are directed through to the dedicated paediatric ED waiting area where they remain under observation by staff until they are called for treatment. The reception area is next to the main desk which nursing and medical staff work from and this ensures that children remain visible to practitioners at all times.

1.4 Good arrangements are in place to highlight to staff those children that have a child protection plan in place or who are looked after by Royal Borough of Kingston. An electronic flag shows up on the electronic patient record to highlight to practitioners that there is a known vulnerability with the child. On one file we reviewed the child's mother had not declared any social care involvement when the electronic record identified that a child protection plan had been in place. This prompted the practitioner to make further enquiries with children's social care, thereby protecting the child well.

1.5 Both adult and paediatric EDs have very recently moved to a paperless electronic patient record and all attendances are now inputted onto the trust's IT system. The electronic prompts for triaging attendances of children and young people for non-accidental injury are now not available unless the practitioner first identifies a child protection concern. This anomaly means that practitioners are not routinely documenting that they have considered the key questions recommended in the NICE guidance and this may lead to concerns being missed.

**(Recommendation 6.6)**

1.6 The new electronic ED record has appropriate safeguards built in with regard to safe discharge of children and young people to make sure that, for those most vulnerable children, a consultant review has to take place before a child is discharged from the department.

1.7 We saw examples of Paediatric ED staff checking on the capacity and understanding of young people to consent to treatment and also speaking to parents and carers to obtain consent to share information. CQC considers this good practice.

1.8 Young people attending the ED, where there are concerns around alcohol or substance misuse, are not being routinely referred to the local substance misuse service. Some of these attendances are being identified following paediatric liaison, however, such failures to refer to specialist services can result in missed opportunities to offer support early to young people and their families.

**(Recommendation 6.7)**

1.9 Most mothers to be are referred to maternity services by GPs. Many GPs are not using the template referral and important information is often missing. The quality of referrals seen varied considerably with some GPs providing only the minimum of detail. Other GPs provided appropriate and important information which supported an informed triage into the specialist midwifery team Isis. The failure to use the template and provide a full health and social history, in one case seen, led to delay in allocating a vulnerable expectant mother to the Isis team.

**(Recommendation 1.2)**

1.10 Midwifery services manage well any non-attendance by expectant mothers during the ante natal period. If two consecutive appointments are missed then the GP is contacted and if the mother to be is cared for by the Isis team then these are followed up urgently. This process means that vulnerable expectant mothers are closely monitored to ensure that they, and their unborn baby, receive appropriate and timely ante natal care.

1.11 The trust has introduced new paperwork to prompt midwives to make repeated routine enquiry about the presence of domestic violence in their relationship. However, there is some confusion about the version of notes being used within the trust and how and where this information is stored. It is important that domestic violence is discussed and the outcome recorded as research shows that pregnancy is a time when domestic violence can happen for the first time or escalate. (**Recommendation 6.3**)

1.12 Pregnant teenagers and young expectant mothers under 22 years of age are offered the option of attending a programme of ante natal classes. There has been no formal evaluation or consultation with the local community to find out if the timing of this service meets their needs. However, the content of the sessions is evaluated at the end of each course and feedback is positive with many young women saying how much they have benefited from the practical skills taught.

1.13 Whilst numbers of expectant mothers attending the ante natal class are low, most of the young expectant mothers complete the sessions. We saw evidence of how teenage mothers to be were encouraged to attend the ante natal classes and how close monitoring and information sharing between midwives, health visitors and school nursing around the care of one vulnerable pregnant teenager provided good and well co-ordinated support.

*Child B was known to the school nurse since her early teens when concerns were expressed about a violent incident in school. The school nurse met regularly with Child B in school and also at the family home alongside her mother. However, late in Autumn 2013 Child B was referred to the Isis midwifery team by her GP as she had a positive pregnancy test. At the booking, a full risk assessment was carried out and her care was discussed at the midwifery concerns meeting. It was agreed that a referral would be made to the Single Point of Access team to arrange for family support once the baby was born. B was offered the ante natal classes which she attended regularly along with her partner. Records seen demonstrate that the health visitor, school nurse and midwife were in regular discussion to support B throughout her pregnancy and to address any concerns in a consistent and co-ordinated way. A birth plan was created and shared with professionals involved in B's care and once the baby was born they were both discharged home to live with B.s parents. The school nurse and CASH service visited B soon after discharge to provide follow up contraceptive advice and treatment. Records seen indicate that B is enjoying her baby with good attachment noted and that the baby is thriving well.*

1.14 We heard about good early help support services which are achieving good outcomes for children and vulnerable parents. There is an effective feeding support team which operates drop-in clinics in children's centres over a seven day period so that mothers have good access to feeding support as needed.

1.15 School nurses effectively support children and young people who attend school in the Royal Borough of Kingston. All secondary schools in the borough have access to a named school nurse who provides a drop in service at which young people can either access routine or enhanced services. Enhanced drop in clinics offer contraception advice, condom distribution, chlamydia testing and access to emergency contraception. The clinics are well used and popular with young people.

1.16 Relationships with local schools are good and school nurses receive notification on children and young people who either transfer in or out of schools to ensure that appropriate health checks have been, or will be, carried out in line with the healthy child programme. The school nurses provide the local immunisation and enuresis services. However, the school nursing service is not commissioned to provide a service to those children and young people who do not access education or are home educated, unless they are identified as needing protection as part of a child protection plan. This gap is a common feature of serious case reviews.

1.17 Good arrangements are in place to transfer children from the health visitor to the school nurse; for those children with complex health need or social vulnerability, face to face conversations are supplemented by case summaries and chronologies to ensure continuity of support.

1.18 Young people are able to access a specialist youth contraception and sexual health (CASH) service provided by school nurses known locally as the KU19; in addition to the enhanced drop in consultations available in some secondary schools, dedicated young people's clinics are held across the borough. KU19 can now provide young people with a range of CASH services, including the fitting of long acting reversible contraceptives. Well established and popular innovations include a texting and email service providing young people with a confidential opportunity to access advice and support.

1.19 The paper pro forma used to assess young people who access the enhanced drop in service within school does not sufficiently explore vulnerability. Currently, when school nurses use the paper proforma as opposed to the electronic record, they are only expected to record capacity to consent as part of the Fraser competency assessment. The paper proforma does not prompt the practitioner to discuss with young people the age of partners, the number of partners and whether there is any violence or coercion within the relationship. Practitioners are trained to explore vulnerability as part of every consultation, however, without a full and detailed proforma to capture this information to transfer into the electronic record there is the potential for this information not to be gathered. This then provides missed opportunities to identify potential exploitation and to strengthen data collection within CASH services to help professionals identify locations and potential, existing or emerging perpetrators. (**Recommendation 5.1**)

1.20 A specialist young people's CASH nurse provides enhanced support to those young people who need additional help or advice including outreach support. She works closely with the children looked after health team to provide targeted support as requested by either the young person or the children looked after nurse.

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## 2. Children in need

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2.1 Paediatric liaison carried out by the named nurse for child protection effectively reviews all attendances of children and young people who attend the emergency department. Notifications of attendance are sent to GPs, health visitors and school nurses. ED practitioners complete health visitor liaison forms where they identify a need for more targeted intervention by public health nurses. For example, one liaison form identified that a child had taken a second accidental overdose of his mother's travel sickness medication and ED staff asked the health visitor to follow this up with the family to provide education to avoid any recurrence.

2.2 There are no regular opportunities within the ED to share learning from missed opportunities to identify and refer families to children's social care or celebrate good practice. Instead, the named nurse provides feedback to individual practitioners where issues or incidents occur. This does not promote or support a culture of continuous improvement. (**Recommendation 6.8**)

2.3 Young people attending ED following self-harm, overdose or deterioration in their mental health are supported well. CAMHS respond promptly during normal working hours and arrangements to provide support "out of hours" are effective. Young people are assessed and are either discharged home with follow up CAMHS appointments or are admitted to the paediatric ward with appropriate support.

2.4 The CAMHS liaison nurse plays a key role in ensuring effective communication with primary care and community services following a young person undergoing a CAMHS assessment at the acute trust. They provide feedback to schools for out of area children and young people.

2.5 A recent audit showed that all young people who attended ED who were identified as needing a follow up CAMHS appointment were seen by the team. This demonstrates that those young people who need access to immediate support for their emotional health are seen quickly.

*A is a 17 year old female with past substance misuse history. She became unwell with mental health problems and was taken into police custody under Section 136 of the Mental Health Act 1983. A was immediately transferred to the CAMHS in patient unit at Springfield where she was assessed as not well enough to be discharged into independent accommodation. After spending a short time in hospital, due to the intervention of the Adolescent Assertive Outreach Team she was able to go into supported living with floating support with daily visits from the AA OT. A is now doing well with the floating support in supported living accommodation and has gained independence. A transition pathway and plan is in place for her transfer into adult mental health service so ongoing support is assured.*

2.6 Effective protocols are in place to ensure that young people taken into police custody under Section 136 of the Mental Health Act 1983 are diverted from custody into the identified beds at Springfield which is a dedicated in-patient CAMHS unit covering the 5 boroughs in South West London. This means that those young people are receiving care in a therapeutic and age appropriate environment which is considered best practice.

2.7 Young people access into CAMHS services is a long standing challenge with lengthy waiting times for initial assessment appointments, although cases identified as urgent are expected to be seen within a week. Earlier in 2014, most young people needing CAMHS support would wait for 4-5 months for an initial CAMHS assessment and we saw a case example. Currently waiting time has been reduced to approximately 6 weeks through the short-term provision of locum clinicians and agency staff.

2.8 In order to manage capacity with the CAMHS service, the trust operates a “zoning” meeting in CAMHS where the highest risk cases are rated “red” and all these are discussed weekly. This includes risk of serious self-harm and includes consideration of safeguarding issues. All “red” cases are expected to have a crisis plan in place. Most young people requiring tier 4 in-patient mental health provision are placed in a bed at Springfield Hospital. There are occasions when a young person has had to be placed at distance away from home. The adolescent assertive outreach team at Springfield Hospital works effectively to deflect young people from requiring in-patient treatment through intensive home support and effect seamless transfers of young person back into the community, facilitating early discharge.

2.9 The identification of potentially vulnerable children in households of adults who attend ED at Kingston Hospital is underdeveloped and therefore likely to be unidentified and unreported. The newly introduced IT system does not facilitate the recording of children in households and is not part of the mandatory recording at triage. The number of health liaison forms completed by practitioners in this very busy department are low as are the number of referrals to children’s social care. There has been no monitoring, analysis or audit on the voice of the child within families where adults present at ED through self-harm, mental illness, substance or alcohol misuse or domestic violence. The opportunity to safeguard these children is being missed. **(Recommendation 3.1)**

2.10 The Isis team are a small team of midwives and a midwifery assistant who support the most complex socially vulnerable women who are pregnant, including teenagers under 18. The team provide direct care to a small number of women and a consultation service to community midwives who deliver care to vulnerable women as part of their caseload. This approach supports community midwives in delivering care to those women who have additional need and offers intensive support to very vulnerable mothers to be.

2.11 Dedicated safeguarding ante natal clinics and mental health ante natal clinics are held at the hospital where the expectant mother can benefit from longer appointments and depending on risk, more frequent ante natal contacts.

2.12 A perinatal mental health pathway exists to provide care and support for women with medium to high perinatal mental health needs, although this does not specify the support for women with mild to moderate mental health needs in pregnancy. The current perinatal mental health service does not currently include a perinatal consultant psychiatrist. However, the team can access the local psychiatric liaison service for support and advice. **(Recommendation 3.4)**

2.13 Additional support for mothers with mental health problems with children under 5 is also available from a specialist health visitor. We saw many examples of good, effective liaison between adult mental health and midwifery services. Joint visits are undertaken as necessary and are routine practice, particularly with the specialist mental health midwife.

2.14 There are regular opportunities to discuss and plan support for vulnerable mothers to be at the trust's monthly multi agency midwifery concern meetings. These are well attended by partner agencies, including children's social care. However, the recommendations from the meeting are not transferred into the individual patient notes and therefore are not immediately available to any midwife providing care. **(Recommendation 6.9)**

2.15 The Isis team work with professionals involved in supporting a mother to be with comprehensive and sensitive ante natal, labour and post natal plans. However, these do not currently include relapse indicators for those women with known mental health problems which would help labour and post natal staff to identify if the woman's mental health started to deteriorate. **(Recommendation 6.2)**

2.16 The midwifery plans are not shared with the mother to be and copies of the plans are not kept in their patient held record. This does not promote involvement of the woman in the planning of her care and participating as an equal partner in the decision making. **(Recommendation 6.2)**

2.17 We saw many cases of how health visitors and school nursing are working effectively to support families, to increase resilience and reduce risks to children and young people. Joint visits between public health nurses, midwives and children's social workers are a feature of partnership working in Royal Borough of Kingston. These visits support families well as they provide a consistent and shared approach by professionals.

2.18 Health visitors and school nurses routinely observe home environments and use their observations as part of their day to day risk assessment. We saw a number of safeguarding referrals where chaotic home environments were cited as risk indicators of harm to the child. However, there is no clear proforma to ensure a systematic and consistent approach to assessment, risk evaluation and analysis. Your Healthcare recognised that risk analysis, case recording, evidencing good needs and risk analysis are areas for development in the service and are reviewing a number of established recording models in other areas.

2.19 The planning of support to families who do not meet the threshold of child protection but need extra help is not always effective. We saw examples of how health visitors and school nurses work closely with families under partnership plus and enhanced services but the planning often consisted of a list of tasks rather than being outcome focussed and SMART. This lack of SMART planning means that practitioners and families are unable to articulate and share common goals, evaluate progress and minimise drift.

2.20 Families where parents have mental health problems are often referred by health visitors to Welcare who offer an eight week course in small groups. The course has evaluated well with positive outcomes for mothers reported. We heard how some women reported being free of depression after finishing the course, some were planning to return to work and because of increased involvement with group activities they also thought their children were less socially isolated

2.21 Practitioners we spoke to demonstrated a low level of awareness of the “Think Family” model in the adult mental health service and little operational awareness of the “See The Adult, See The Child” policy which has recently been refreshed and the new updated version is with the local safeguarding children safeguarding board (LSCB) for their approval.

2.22 Assessments of adults with mental health problems or substance misuse accessing services provided by the trust do identify children within the household but do not fully explore other children the adult may have regular contact with. Also, the assessment does not include how the adult considers how their substance misuse impacts on the child or could present risk to the child or how the adult prioritises their needs in relation to the child’s need. This approach means that the child’s voice is not heard and their needs are not being assessed or met. (**Recommendation 4.5**)

2.23 Adult mental health practitioners told us that they will share collaborative crisis plans setting out relapse risk indicators to other services but we did not see examples of these in health visitor services. Direct liaison between health visitors and adult mental health and adult substance misuse service practitioners is under developed. We found that professionals are over reliant on formal meetings as part of child in need or child protection processes to engage in direct dialogue with other health professionals. This is not facilitating a strong team around the child/family approach to ensure children are effectively safeguarded. (**Recommendation 4.1**)

2.24 The adult substance misuse service does not routinely share relapse indicators with health visitors. This may be of particular importance where an unborn or infant is subject to a child protection plan and the health visitor and adult worker are the key health professionals involved. (**Recommendation 4.1**)

2.25 Where adult mental health service users are difficult to engage, adult mental health practitioners make concerted efforts to get engagement. However there is no “did not attend” (DNA) policy in the South West London & St George’s Mental Health Trust. We heard how practitioners respond to DNA’s on a case by case basis based on their clinical judgement. Without an effective and collaborative DNA policy, practitioners lack guidance to ensure consistent practice in minimising risks to children as a result of adult DNA; especially as early sign of disengagement from service could be a cause for concern. The potential lack of compliance with local multi-agency DNA arrangements as set out by the LSCB is a gap which could impede a child on a child protection plan being safeguarded effectively.  
**(Recommendation 4.4)**

2.26 We saw evidence of how information sharing between GPs and health visitors is improving and helping to identify vulnerable families and provide a co-ordinated approach to their support. Some GP practices have formal meetings with health visitors to discuss vulnerable families and other GP practices host health visitor clinics. However, this integrated approach to support does not include the school nurse and GPs are not always aware of the valuable and in-depth work with vulnerable children and families registered with their practice.

2.27 There is an effective process in place whereby the Your Healthcare safeguarding team receive all Police notifications of domestic incidents involving families with children. The safeguarding team review these and disseminate them to the appropriate school nurse or health visitor for follow-up action. The safeguarding lead follows up with the practitioner in supervision or as appropriate to monitor what, if any, action has taken place. Families can access support for domestic violence from the local “one stop” which has health visitor involvement. The local multi-agency risk assessment conference (MARAC) is well attended by health agencies, however, the involvement of GPs in the domestic violence agenda is underdeveloped. GPs we spoke to were unaware of how to share information with MARAC and did not electronically flag families that were discussed.  
**(Recommendation 1.1)**

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### 3. Child protection

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3.1 There is an increasing level of awareness of female genital mutilation (FGM) in adult women and the risk of young children becoming victims of FGM across the multi-agency partnership. We heard a case example where agencies across a number of local boroughs liaised closely and effectively to ensure a young child at high risk of FGM and her mother were protected.

3.2 Kingston Hospitals NHS Foundation Trust and Your Welcome Trust are both developing a policy on FGM however these will need to integrate with the wider health and social care's approach to protecting women and children from this illegal practice.

3.3 There is a multi-agency child sex exploitation (CSE) policy in place with health representation on both the strategic and operational groups. CASH services are not routinely represented on the operational group and this is a gap. Many young people will access CASH, including the KU19 service, who are often not in contact with other services and will be engaged in risk taking behaviours

3.4 In a number of services including CAMHS, health visitor, midwifery, adult mental health and substance misuse, we have seen written safeguarding referrals which do not clearly set out the risks of significant harm to the young person and did not include all requested information such as significant members of households, siblings or language spoken. This is an area for development across all healthcare providers. (**Recommendation 3.2**)

*Child C was a two year female brought to the paediatric ED by her parent with a significant burn. The ED nurse triaged the child and alerted her senior nurse of concerns at the delayed presentation and the lack of intervention by the parent to provide basic treatment. During the course of further medical consultation it became evident that there were inconsistencies in the version of the events that the parent then described to the doctors. The senior nurse escalated to children's social care who attended the department within 2 hours and a multi-agency strategy meeting took place at the hospital with hospital staff, social care and the police. A child protection medical was arranged immediately and the records seen indicate that this was comprehensive and met all guidelines, photographs were taken and a body map completed with the report reviewed by a consultant. The paediatrician came to a conclusion that the injury was not suspicious but that the family needed additional support. This is now being arranged.*

3.5 All referrals to children's social care are now sent to the single point of access (SPA). Health is represented in the SPA through a part time health visitor liaison role. There are plans to increase this to a full time post as the multi-agency safeguarding hub (MASH) is developed. Health practitioners we spoke with were positive about the improved access to advice and support since the SPA was introduced. Most health practitioners are receiving written acknowledgements to safeguarding referrals and in some cases we have seen, the rationale underpinning the decision taken at the SPA about intervention.

3.6 Most health care providers, including GP practices have electronic flags on their electronic patient record to indicate where a child is identified as having a child protection plan or is looked after. This supports a holistic assessment of a service user by the professional involved in their care. However, the adult substance misuse service has no flagging of identified vulnerabilities or risks to child including children on child protection plans on its IT system. This could mean that the voice of the child is not heard or their vulnerability appropriately assessed. **(Recommendation 4.5)**

3.7 All health providers set a clear expectation that where practitioners are engaged with a case where there are child in need or child protection plans in place, then the practitioner should be a member of the core group, attend child in need meetings and child protection conferences.

3.8 Performance on the attendance of health visitors and school nurses at child protection case conference is good and all conferences have a community health representative as required. This could be a member of the Your Healthcare safeguarding team if the health visitor /school nurse was not available.

3.9 However, we have heard from a number of practitioners across services that there is inconsistent attendance by adult service practitioners at child protection conferences and it is clear that the process by which adult service practitioners are alerted and invited to key meetings and how these invitations are channelled within the providers is not robust. In one case example, the invitation to the adult substance misuse practitioner had gone directly to the practitioner who was on leave. And in another example, the practitioner had not been invited to a recent child in need meeting despite holding information essential to ensure a safe decision was made. **(Recommendation 4.3)**

3.10 In all files reviewed we saw evidence of attendance by health professionals at child protection conferences and of submitted reports. Most health practitioners complete the multi-agency report template and in Your Healthcare these are regularly quality assured. Reports for child protection conferences completed by midwives are not routinely shared with families prior to the conference taking place and this is a mandatory requirement of the LSCB. **(Recommendation 6.1)**

3.11 We heard that a small number of GPs do regularly attend child protection case conferences involving children from their practice. However, this is not routine practice.

3.12 GPs with whom we met, place a high priority on attending child protection case conferences when they can, and submit reports to conference in the form of a letter or complete a template report in most cases. Conferences are often scheduled at times when it is very difficult for the GP to attend. Little exploration of alternative ways of GPs participating in the case conference have been explored, such as teleconferencing, Skype etc. GPs told us that they would welcome more use of technology in this way. One GP had teleconferenced into a case conference in the past and had been able to participate constructively and actively in the conference information sharing and decision making on that occasion.

3.13 Where health practitioners have not received minutes of meetings or child in need plans from children's social care, we have seen a lack of follow-up by health practitioners to ensure that they obtain copies and place them on the patient record. These are important documents and are necessary to inform and steer the practitioner's intervention and practice. **(Recommendation 3.3)**

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## 4. Looked after children

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4.1 Performance on timeliness of initial health assessments (IHA) is particularly weak. The health and social care partnership face a significant challenge in ensuring that children entering care have their health needs identified in a timely manner in line with national timescales. The newly introduced "Process for referring a child for an Initial Health Assessment" guidance within children's social care is not yet embedded in practice; although delayed notifications from children's social workers is only part of the picture. It is not clear that there is a whole systems approach to the delivery of the health of looked-after children. Currently, there is a risk that some children will be entering and leaving the care system without a full assessment of their health needs. **(Recommendation 5.2)**

4.2 Recent IHA's show an improvement in quality, however, parental health histories are still often incomplete even when it is clear that a baby will be coming into care at birth and the reason for the child coming into the care is often missing. The absence of this key information, potentially only really available at the time child first becomes looked after, can have a profound and lasting impact on the child as they make their journey through the care system and into young adulthood. Many young people tell us that the absence of this health history has a long-term detrimental impact on them. **(Recommendation 5.2)**

4.3 The interim named doctor undertakes most IHAs for unaccompanied asylum seeking children (UASC). He is enthusiastic about this work and is able to describe key factors he considers within the assessment, receiving coaching and regular supervision from the designated doctor. However, the named doctor has not had any formal training courses on how to undertake these or health issues relating to UASC. The named doctor was able to demonstrate that he understands the important role of the interpreter and identified a case example where the presence of a female interpreter, made it culturally impossible for a full discussion of a young male's sexual health.

4.4 Most review health assessments (RHA) are undertaken by the looked-after children's nurse even for those children and young people placed out of area. This helps to give the young people continuity of health assessment and support. The CLA nurse knows some of the young people very well, facilitating a trusting relationship and providing some stability for the young person where there may be a high degree of instability in many areas of their life. In one case seen the young person who has smoked since a very early age has been able to cut down to 5 a day from 20 as a result of a consistent message from professionals and the nurse helping her to see the detrimental effect of smoking on her health over time.

4.5 Not all RHAs are carried out by the CLA nurse; some are undertaken by a school nurse and practitioners we spoke to did not recall attending training provided either on the health needs of children looked after or the review health assessment and planning process. There is, however, support offered to practitioners by the children looked after nurse who attends their team meetings on a termly basis to provide advice and guidance. **(Recommendation 5.5)**

4.6 GPs are not being routinely asked to contribute to initial or review health assessments. GPs may have additional information to support an assessment and this is also a missed opportunity to involve them in the care of this vulnerable group of children. **(Recommendation 5.3)**

4.7 Review health assessments seen were not always holistic and did not consider information from CASH, substance misuse or CAMHS as part of the process. The establishment of care pathways for young people and care leavers remains an area for development since the previous SLAC multi agency inspection. **(Recommendation 5.3)**

4.8 Strength and difficulty questionnaires (SDQs) are not being used to inform review or discussion with the child or young person. The potential for the SDQ to be used by the young person to track their own personal emotional growth as part of the assessment has not been explored.

4.9 A single community NHS dentist sees most children looked after requiring dental care and offers a very personalised and sensitive service to the young people who may have had little or no dental treatment previously.

4.10 There remains a perception by some practitioners and foster carers that Tier 3 CAMHS is only being offered to children looked after in stable placements even though the intervention and support of CAMHS may be instrumental in sustaining fragile placements. CQC received assurance from CAMHS managers that no child is excluded from the CAMHS Service, including those who are not in a permanent placement. This is dependent on a referral from the named social worker for the child or the child's G.P. The CLA therapist routinely sees children and foster carers through placement breakdown.

4.11 Cases demonstrate some good inter-professional liaison about looked-after child where there is a high level of concern about the health and wellbeing of a young person.

4.12 Although there is some evidence of CLA health practitioners trying to reflect the voice of the child, there is scope to strengthen this further to more fully capture a sense of the child as an individual personality.

4.13 Children are routinely seen alone for at least part of the RHAs, without their foster carer, when this is age and competency appropriate. Cases reviewed indicate a commitment from the children looked after health team to gaining the young people signed consent for IHAs and RHAs where appropriate. This is helping young people to engage with their health assessment.

4.14 Young people are offered a choice of venue for their RHAs and the CLA child nurse is creative and determined in trying to engage older teens in reviews of their health needs. As a result, only three young people have declined their RHA this year, although the nurse is still trying to actively engage with them.

4.15 The CLA nurse and named doctor develop a separate health plan. However none of the health plans we saw were SMART. No overarching and measurable objectives were set and timescales were vague and not sufficiently specific in order to ensure delivery of actions was timely and responsible individuals can be held to account. Despite the recent positive influence of substantive independent reviewing officers now being in post and the increased scrutiny and challenge they have brought, we found evidence of actions identified in health plans not always being actioned. In one case, a young child had suffered a delay of one year in a referral being actioned to ophthalmology to correct a squint. (**Recommendation 5.4**)

4.16 The CCG acknowledges that health support to care leavers is an area for development since the previous SLAC inspection in 2012. The designated nurse has developed a business case for the appointment of a dedicated looked-after children's nurse for care leavers in order to give appropriate support to this vulnerable cohort. However the authorisation for the recruitment process has not yet been finalised.

4.17 The children looked after service is committed to involving young people in the development of the service. We saw some examples of their influence, such as in the introduction of Healthy Living Certificates given to young people after RHAs in recognition of individual looked-after children's awareness of their own health and wellbeing and healthy eating. Another example is the new child friendly and age appropriate front sheets being added to the child's copy of their health plan which is routinely sent to them after their RHA.

4.18 Additional developments and initiatives that are being discussed with young people include the development of an "app" about sexual health. Work is also ongoing on the introduction of health passports for care leavers, looking at a number of different models used across the country.

4.19 Quality assurance of IHAs and RHAs is not robust. Where local clinicians are undertaking RHAs on behalf of Royal Borough of Kingston for young people placed out of borough, the quality assurance of these assessments is undertaken by the designated doctor and CLA nurse. However, the team is currently quality assuring its own work as the designated doctor and CLA nurse audit the teams assessments. There is some consideration of developing peer review with a neighbouring authority but no clear plan is currently in place. (**Recommendation 5.6**)

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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 Healthwatch report that they feel valued as a member of the CCG Board and told us about the unannounced monitoring visits earlier in 2014 to look at the emergency department, paediatrics and maternity services. Findings were good, with most service users reporting satisfaction with services.

5.1.2 Kingston on Thames CCG acknowledges the significant capacity pressures on the designated nurse in undertaking this role for both safeguarding and looked-after children. It is difficult for the designated nurse undertake a full leadership and quality assurance role in respect of the looked-after children service. (**Recommendation 2.1**)

5.1.3 Informal cover arrangements for the designated nurses in the five boroughs are in place and work well.

5.1.4 The named GP works effectively to promote safeguarding children practice across the CCG. She is well supported by the NHS England named GP network which she attends regularly. All GP practices across Kingston have a named GP safeguarding children lead and there are regular meetings between health professionals and children social care, including with the named GP.

5.1.5 Safeguarding resource within the Kingston Hospital NHS Foundation trust does not reflect the “*Safeguarding Children & Young People: roles and competencies for health care staff. Intercollegiate guidance March 2014.*” The named doctor for Kingston Hospital NHS Trust is employed for one session per week and supports and promotes safeguarding practice through a programme of informing and enabling colleagues to develop, implement and demonstrate safeguarding children practice. He receives supervision from the Kingston CCG designated doctor and attends safeguarding children training at Level 4 on an annual basis. The named nurse for the trust is employed full time but also provides paediatric liaison for the trust and is supported by a full time administrator. There is insufficient resource within the role to fulfil the duties of the named nurse role and there are no robust arrangements to provide support during annual leave or sickness. (**Recommendation 6.10**)

5.1.6 The named midwife for Kingston Hospital NHS Trust is the head of midwifery and is supported in the role by a safeguarding midwife who works as part of the specialist safeguarding midwifery team. The named midwife does not have a job or role description that reflects the intercollegiate guidance 2014. Midwifery is represented at the trust’s internal safeguarding committee by the safeguarding midwife. (**Recommendation 6.10**)

5.1.7 The new safeguarding advisor role created in Your Healthcare two months ago has built capacity in the provider’s safeguarding team, ensuring that staff are well supported through effective safeguarding supervision arrangements and strengthened practice governance.

5.1.8 The reorganisation of CLA support service in April into two multi-agency teams focused on Royal Borough of Kingston and Richmond CLA respectively under the virtual head, has positively influenced a higher level of focus on the needs and voice of the young people. We heard about a case example where there had been identifiable beneficial outcomes for a young person from the stronger partnership approach, even at this early stage.

5.1.9 The CCG and local authority have jointly commissioned an interim named doctor for looked-after children for 12 hours per week from the acute hospital trust. This doctor undertakes IHAs and is keen to develop the role under the guidance of the designated doctor.

5.1.10 The CAMHS service offered by the mental health trust is currently under review in all 5 boroughs. Management posts are being reduced to enable resources to be re-invested into frontline service development. This will include the development of a more robust eating disorder service to support young people with higher levels of need for this specialist support.

5.1.11 The CCG identify a need to work with local communities, particularly those more recently moved into the borough from Eastern European countries, to help them access the most appropriate level of health support for their needs. The most significant of this is to link new arrivals into the borough register and access primary care to reduce pressures on urgent care.

5.1.12 A multi-agency policy exists for the resolution of professional disagreement and is endorsed by the LSCB. However, we saw an example of how a safeguarding concern was escalated through the midwifery clinical escalation policy when clearly the correct process would have been through the multi-agency protocol. This shows a lack of understanding about the safeguarding risk within the case and also a lack of awareness about the multi-agency policy on escalation.  
**(Recommendation 6.4)**

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## 5.2 Governance

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5.2.1 The recently appointed chair of the LSCB also chairs the LSCB in a neighbouring authority. This facilitates safeguarding performance benchmarking and sharing/resolving of common themes and issues and dissemination of good practice.

5.2.2 Governance of children's safeguarding arrangements in health is becoming more rigorous. The CCG has retained safeguarding and health of looked after children on the risk register to ensure these activities maintain a high profile across the community. The CCG decision to move the designated nurse role from the provider into the CCG at the earliest opportunity clarified the role as being part of the commissioning and governance arrangements in line with statutory guidance. CCG and senior managers in provider agencies identify this change as having strengthened governance arrangements across the health economy. There are regular contract quality review meetings chaired by the CCG and involving health providers including GPs.

5.2.3 Co-location of the director of public health in the same building as CCG facilitates development of partnership approaches and strategic communication.

5.2.4 Safeguarding for young people has a high profile in Your Healthcare community health trust with the safeguarding lead routinely attending the trust's Board meetings. As a result in part of the move of the designated nurse to the CCG, Your Healthcare have re-invested resources into their safeguarding team, making their internal governance stronger. The trust uses internal audits to quality assure performance. The most recent resulting in a "green" rating. Exploration of the establishment of a cross authorities' peer review model is in the early stages of discussion.

5.2.5 There is, however, a lack of clarity in the community health service on how key documents such as child in need and child protection plans should be stored and included within the child or mother's case record. Some practitioners are holding key documents in hard copy in separate files or storing them on their computer hard drives. This includes health visitor reports to child protection conferences in some instances. This means that other practitioner or managers needing to work with the case may not have ready access to key documents which should be informing the work with the child. **(Recommendation 3.3)**

5.2.6 We found that often case recording does not always accurately reflect practitioner activity, including the voice of the child. A new practitioner who may start to work with a family is then not able to accurately assess and evaluate previous interventions and could lead to delay.

5.2.7 Performance governance on the health of looked after children by the partnership is underdeveloped with a lack of outcome focused performance measurement. There is no analysis or quantifiable data produced to evidence any improvement in the health of children once they become looked after. The looked-after child nurse has no input into and does not see the annual children's social care independent reviewing officers' (IRO) report and therefore an opportunity for this to be used as an effective part of performance improvement across the partnership is being lost. **(Recommendation 5.6)**

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## 5.3 Training and supervision

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5.3.1 The interim named doctor for looked-after children is being well supported in this role by the designated doctor who gives 1:1 supervision routinely. A training package has been put into place to support the clinician's identified developmental and learning needs and he feels positive. However, to date this has not included specific training on undertaking IHAs for unaccompanied asylum seekers. The clinician demonstrates an understanding of issues which may impact on the health and wellbeing of this cohort, given the high numbers of UASC becoming the responsibility of Royal Borough of Kingston currently and the complexity of their needs.

5.3.2 The named GP continues to develop mini teaching/information sessions which are available on the intranet for GPs and practice based staff to access and learn from; recently these have included guidance on how best to write reports for conference, the health of children looked after and how to use flagging on IT systems to identify families of concern. Evaluation and reflection of learning arising from the sessions is encouraged and GPs use this as part of their preparation for appraisal.

5.3.3 The Kingston Hospital NHS Foundation Trust Board undertake safeguarding training annually to maintain a good level of understanding of current children's safeguarding issues.

5.3.4 Training data within the trust is being cleansed and the trust is working with the CCG to ensure that reported figures are accurate.

5.3.5 There can be a difficulty of releasing paediatric staff to attend Level 3 multi-agency training although this is being given priority. To provide additional support to acute trust staff, the safeguarding designated nurse delivers topic based training on a regular (annual) basis. Recent topics include FGM and CSE.

5.3.6 In response to the previous safeguarding and looked after children multi agency inspection, midwifery staff now attend Level 3 safeguarding children training and mandatory compliance in excess of 80% is reported within the service.

5.3.7 The majority of adult mental health practitioners complete the Trust Level 2 training as detailed in the Intercollegiate Document. This training includes a detailed focus on the impacts of parental and adult mental health on children and the trust feel is appropriate and commensurate for the majority of adult mental health practitioners. Level 3 training is provided within the Trust for all CAMHS practitioners and team and borough leads. This training is also specifically provided to teams and services where there is greater direct work with children and families. Staff can access LSCB multi-agency training at all Levels. Additional training at Level 3 is provided where it is identified that there is increased focus and work with families and children.

5.3.8 During the inspection we spoke to some teams working in adult mental health and substance misuse services who would benefit from Level 3 training in line with intercollegiate guidance to help develop their expertise in identifying and responding to child protection concerns. (**Recommendation 4.2**)

5.3.9 The adult mental health database of staff's mandatory training profiles does not include children's safeguarding although staff and managers understand this to be mandatory. This has two potential consequences; firstly, staff may not regard it as a priority to undertake this training even to level 2 as the trust currently requires. Secondly, as it does not appear on the training dashboard, team managers are not being equipped with the information they need in order to monitor uptake effectively. The Named Nurse for Safeguarding Children for the Trust has access to the data for all teams and services and can identify and highlight gaps in compliance, although practitioners we spoke to were not aware of this process. (**Recommendation 4.2**)

5.3.10 CAMHS practitioners are currently trained to "level 3" but this is only training delivered by the trust's own named nurse with no multi-agency component.

5.3.11 Some adult substance misuse practitioners are trained to Level 3 but they told us that this is e-learning with only one hour's additional face to face training and again there is no multi agency component. The trust, however, has confirmed that all Level 3 training is provided face to face.

5.3.12 It was clear from our discussions with managers and practitioners in the service that the lack of opportunity to undertake safeguarding training in a multi-agency environment was detrimental to practitioners' practice.

5.3.13 Supervisory staff in Your Healthcare have received safeguarding supervision training and the supervision arrangements in the community health services are robust. Health visitors and school nurses receive 1:1 supervision on a 3 monthly basis and group supervision sessions enable shared reflective practice and learning. Group supervision is being introduced for nursery nurses and speech and language therapist practitioners. Discussion of cases at supervision is routinely recorded on the child or mother's case record in line with best practice; as is the level of risk the case has been assessed at.

5.3.14 We heard from one new staff nurse working in the school nursing service who was still in her preceptorship and she told us how well she had been supported in gaining experience and demonstrating competency in safeguarding children practice.

5.3.15 Supervision is not fully established in the adult substance misuse service. 1:1 sessions are in place for some practitioners. Group supervision has been introduced in Wellbeing, but only very recently and only one session so far. Practitioners received this session well and had found it very valuable in reflecting on practice. (**Recommendation 4.6**)

5.3.16 The named midwife meets regularly with the safeguarding midwife to discuss cases of concern and the midwives from the Isis team access informal supervision from the named and designated nurse. However, this supervision is not formally documented and recommendations and planning arising from the discussion are not entered in the patient notes. (**Recommendation 6.11**)

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# Recommendations

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## **1. NHS England & Kingston CCG**

- 1.1 Work with GPs to develop their understanding and participation in the local MARAC, to include the introduction of flagging for families identified and discussed at the Conference.
- 1.2 GPs to be trained and encouraged to use the standard referral form when referring pregnant women to book with maternity services. Referrals should be supported with complete and relevant health and social history to assist maternity services in allocating appointments to the most appropriate team.

## **2. Kingston CCG**

- 2.1 To review the arrangements for the designated nurse and designated nurse for looked after children to ensure that there is sufficient capacity for the responsibilities as outlined in the Intercollegiate Guidance March 2014 to be fully discharged.

## **3. Kingston CCG, Kingston Hospitals NHS Foundation Trust, South West London & St George's Mental Health NHS Trust & Your Healthcare Community Interest Company.**

- 3.1 Ensure that robust arrangements are in place to identify and respond to vulnerable children in households where adults with mental health needs, substance or alcohol abuse, domestic violence or other risk taking behaviours are engaged with health services.
- 3.2 Ensure that health practitioners are trained appropriately to complete comprehensive referrals to children's social care that includes a clear assessment and articulation of risk to the child and document what action and support is being sought.
- 3.3 Ensure that health practitioners are trained in and can demonstrate compliance with local and national record keeping guidance and policies so that key patient records are stored safely and appropriately.
- 3.4 Review the perinatal mental health pathway to ensure that it reflects the care available to pregnant women with mild to moderate mental health needs.

#### **4. Kingston CCG & South West London & St George's Mental Health NHS Trust**

- 4.1 Ensure that there is effective liaison and sharing of expertise with other health professionals in child in need and child protection cases including the undertaking of joint visits as appropriate.
- 4.2 Ensure that practitioners working routinely with adults who have close and frequent contact with children undertake multi-agency level 3 safeguarding in line with statutory guidance and that uptake of training is monitored effectively
- 4.3 Ensure that there is an effective pathway in place by which practitioners are invited to multi-agency meetings for vulnerable children including child in need and child protection conferences as appropriate.
- 4.4 Ensure that there is an effective non-attendance policy in place commensurate with that operated by the LSCB in order that children are safeguarded.
- 4.5 Ensure that all children with whom service users are in regular contact with are recorded on the patient record and that a flagging system is introduced to identify those families where there is a child protection plan in place, along with an assessment of the impact of parental mental health or substance misuse on the emotional health and wellbeing of any children involved.
- 4.6 Ensure that the outcomes of supervision in safeguarding children are entered onto the service user's patient record.

#### **5. Kingston CCG & Your Healthcare Community Interest Company**

- 5.1 To ensure that the consultation with young people and data collection requirements seen as part of the enhanced drop in service provided within schools facilitate the identification, recording and appropriate sharing of information of vulnerability and potential exploitation.
- 5.2 Work with partners to urgently review the process for initial health assessments for children looked after, to include how health providers can support colleagues in obtaining parental health histories.
- 5.3 Ensure that initial health assessments and health reviews include all relevant information from health agencies who may be involved in working with the child or young person, including the child's GP.
- 5.4 Ensure that health plans developed from initial health assessments and health review assessments are outcome focussed and SMART.

- 5.5 All health practitioners carrying out initial health assessments and health review assessments should be appropriately trained to understand the specific health needs of the vulnerable cohort of children and young people and the assessment process.
- 5.6 Implement a robust and challenging quality assurance process with clearly defined performance indicators to ensure that the effectiveness of the health assessment and review process to improve the health of children looked after can be demonstrated.

## **6. Kingston Hospitals NHS Foundation Trust**

- 6.1 All reports prepared for child protection conferences and core groups are shared with families prior to the conference as required by the local LSCB.
- 6.2 Ensure that midwives include descriptions of an individual woman's relapse indicators on ante natal, labour and post natal birth plans so that midwives and other practitioners working with the woman are able to identify and respond to any early emerging concerns. These plans should be shared with the mother to be and a copy provided to her if she chooses.
- 6.3 Ensure that the new arrangements for the domestic violence routine question are understood and embedded into practice by all practitioners working in maternity services.
- 6.4 Ensure that the multi-agency escalation policy to resolve professional disagreement on child protection is well understood within midwifery services and that the maternity policy on clinical escalation clearly references the existence of this policy and when it should be used.
- 6.5 Ensure that all young people attending the adult emergency department receive an age appropriate risk assessment of their vulnerability to identify any safeguarding or child protection concerns.
- 6.6 Amend the electronic triage process for identifying child protection concerns so that completion is mandatory for all attendances of children and young people to the Emergency Department.
- 6.7 Ensure that the process for identifying and referring any young person who attends the ED following substance or alcohol misuse is referred to the local support service in accordance with local policy and guidance.
- 6.8 Implement a programme of child safeguarding supervision and learning opportunities for ED staff to capture the learning from referrals to children's social care and paediatric liaison.
- 6.9 Ensure that the outcome and any planning arising from discussion at the multi-agency midwifery concern meeting is entered onto the patient record.

- 6.10 Review the arrangements for the named professionals within the trust to ensure that these are compliant with Working Together 2013 and the Intercollegiate Guidance 2014.
- 6.11 Formalise the supervision arrangements within midwifery service and ensure that the outcome of any discussion and plans are recorded in the patient record.

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## Next steps

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An action plan addressing the recommendations above is required from Kingston upon Thames 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.