

Review of health services for Children Looked After and Safeguarding in Thurrock

Children Looked After and Safeguarding

The role of health services in Thurrock

Date of review:	19 th October – 23 rd October 2015
Date of publication:	24 th December 2015
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Provider services included:	Basildon and Thurrock University Hospitals NHS Foundation Trust North East London NHS Foundation Trust South Essex Partnership University NHS Foundation Trust Addaction Visions
CCGs included:	NHS Thurrock CCG NHS Basildon & Brentwood CCG (only as lead commissioner for Basildon and Thurrock University Hospitals NHS Foundation Trust)
NHS England area:	Midlands and East Region
CQC region:	Central
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Summary of the review

This report records the findings of the review of health services in safeguarding and looked after children services in Thurrock. 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 Thurrock, cross-boundary arrangements have been considered and commented on. Arrangements for the health-related needs and risks for children placed out of area are also included.

About the review

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

- The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.
- The focus was on the experiences of looked after children and children and their families who receive safeguarding services.
- We looked at:
 - the role of healthcare providers and commissioners.
 - the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
 - the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.
- We also checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, *Working Together to Safeguard Children 2015*.
- 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.

How we carried out the review

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

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

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

In total, we took into account the experiences of 130 children and young people.

Context of the review

Thurrock lies to the east of London on the north bank of the River Thames and within the Thames Gateway, the UK's largest economic development programme. Thurrock has a strong manufacturing and retail focused economy. There is a very significant regeneration programme centred on five growth hubs: Purfleet, Lakeside, Grays, Tilbury and London Gateway. Thurrock has a resident population of approximately 40,200 children and young people aged 0 to 18, representing 25% of the total population of the area. In 2012, 25.7% of the school population was classified as belonging to an ethnic group other than White British compared with 22.5% in England overall. Some 12% of pupils speak English as an additional language. Deprivation levels in Thurrock are consistent with the national average, but there are significant pockets of deprivation and inequality, with several areas falling within the 20% most deprived areas in England and 20.0% of children in Thurrock are living in low income families, which is greater than the national average.

*Most of Thurrock residents 99.2% (159,402 residents) are registered with GP practices that are part of the **NHS Thurrock Clinical Commissioning Group**. Thurrock has a higher proportion of children and young people aged 0-19 years (26.84%) than the national average (23.9%). The number of 0-19 year olds is set to increase to 50,500 by 2037.*

14.1% of the population are from minority ethnic groups, with 7.8% identifying themselves as Black/Black British. Thurrock's younger population is more ethnically diverse than the all-age population, with areas to the west of the borough seeing the highest proportion of school-children from minority ethnic groups.

Current data indicates that 8.9% of reception-aged children and 22.8% of Year 6-aged children in Thurrock are obese, which is similar to the national average but higher than the regional average.

Child oral health in Thurrock is fairly poor, and it is estimated that about 30% of children and young people in Thurrock have experience of tooth decay that can lead to pain and costly NHS procedures.

South West Essex has the highest number of children with sickle cell disorders in Essex, with an estimated 66.5% of all children with these disorders living in the South West of the county. Work is underway to review the existing sickle cell service to ensure needs are appropriately met.

Commissioning and planning of universal health services for children are carried out by Public Health (within Thurrock Council). The CCG commissions specialist services for children, acute and community services and safeguarding functions. Children and young people's continuing health care is hosted by Mid Essex CCG and child and adolescent mental health services/emotional health and wellbeing are hosted by West Essex CCG..

Commissioning arrangements for looked-after children's health are the responsibility of Thurrock CCG and Thurrock CCG's designated LAC Nurse and the looked-after children's health team and operational looked-after children's nurse/s, are provided by North East London NHS Foundation Trust looked after children's team.

Acute hospital services are provided by Basildon and Thurrock University Hospitals NHS Foundation Trust. The lead commissioner is Basildon & Brentwood CCG with Thurrock CCG as an associate to the contract. There is a minor injury unit (MIU) at Orsett Hospital. Thurrock Walk-in Centre (WIC) is due to close in March 2016.

Health visitor services are commissioned by Public Health (within Thurrock Council) and provided by North East London NHS Foundation Trust (Community provider).

Specialist health visitor services are commissioned by Thurrock CCG and provided by North East London NHS Foundation Trust. Family Nurse Partnership is commissioned by Public Health, Thurrock Council and provided by South Essex Partnership University NHS Foundation Trust.

School nurse services are commissioned by Public Health (within Thurrock Council) and provided by North East London NHS Foundation Trust.

Specialist school nurse services are commissioned by Thurrock CCG and provided by North East London Foundation Trust.

Contraception and sexual health services (CASH) are commissioned by Public Health (within Thurrock Council) and provided by North East London NHS Foundation Trust.

Child substance misuse services are commissioned by Public Health (within Thurrock Council) and provided by CRI (Crime Reduction Initiative) Wize Up.

Adult substance misuse services are commissioned by Public Health (Thurrock Council) and provided by Addaction Visions. This followed a national merger between KCA Visions, the previous provider since April 2014 and Addaction in July 2015.

Child and adolescent mental health services (CAMHS) are provided by South Essex Partnership University NHS Foundation Trust until 31 October 2015. From 1 November 2015, this will be provided by North East London NHS Foundation Trust. This is a collaborative commissioning arrangement across greater Essex with 7 CCGs & 3 LAs. Recommendations relating to residents of Thurrock have been targeted to Thurrock CCG so that they may influence the main commissioner of these services.

Adult mental health services are provided by South Essex Partnership University NHS Foundation Trust for primary care (until 31.03.2016) and secondary care services. South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSSFT) for primary care from 01/04/2016. The CCG has also commissioned Thurrock Mind to provide peer mentoring, social inclusion and employment services.

Specialist facilities are provided in a Sexual Assault Referral Centre commissioned by NHS England. Tier 4 in –patient child and adolescent mental health service is commissioned by NHS England.

*The last inspection of health services for Thurrock's children took place in June 2012 (published July 2012) as a joint inspection, with Ofsted, of safeguarding and looked after children's services. The contribution of health agencies to keeping children and young people safe was found to be **adequate**. The Being Healthy outcome for looked-after children was also found to be **adequate**. Recommendations from that inspection are covered in this review.*

The report

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

What people told us

We heard from a number of foster parents about their experience of health assessments;

"My experience has been generally very good although getting in to get the health assessments done seems to take longer than it should. For the child I am currently looking after, the initial assessment was due in April 2014 but it was not actually done until June. Then we have had to wait until August this year, 14 ½ months, instead of 12 to get the review assessment done. I think this is because I am looking after a Thurrock child who is placed in another part of the county."

"Sometimes if they have called to offer an appointment they are flexible if I am unable to make that time and are happy to give me another slot."

"I see a paediatrician every six months; even though sometimes getting an appointment can be delayed the service is otherwise very good."

"My experience has been highly variable and I have learned that appointments are not always readily available. However, when you do get access the staff are very good. The LAC nurses are very good."

"I am looking after a child with complex needs and the LAC nurses have been very patient and creative in ensuring they get the child's wishes and feelings even when the child is difficult to engage. They are very good at that. For example, they changed my child's medication at her request so she could see what it would be like and then reinstated it later when she decided she would like to continue to take it."
"The children had their health review today. Two ladies came. They were lovely and put the children at ease. It was so good that they did the health review here in our home. When it was done in school last year, he was only seven so some of his answers weren't correct or were misunderstood."

"We have had good support from the looked-after children's nurse as well as the social worker."

“The young person’s voice must be heard. It is so important in their health review”.

Foster parents also told us about their involvement with health plans and looked-after children’s health service development;

“I have a health background and so I find my contribution to the health plans is always valued.”

“I always feel involved in the health plans of the children I have looked after and have always been asked to contribute.”

“I am part of the LAC health steering group and contribute my views there as well as the views of other foster carers I speak with. For example, I had an idea that all LAC should have a medication booklet for all prescribed and non-prescribed medicines to help carers to manage their medicines – also to help the children themselves when they are learning to administer their own medicines as they get older. This idea was adopted and now all children are supplied with a medication booklet when they go to a carer.”

We heard from young people who are looked-after;

“I had a health review today and had my height and weight checked. I hadn’t met the nurse before. She was friendly and I liked her.”

“She asked me what I wanted to talk about and got my consent for the assessment. I liked that. The nurse explained everything to me.”

A young mother in a mother and baby placement told us;

“I feel safer and able to look after my baby in my own way. I see the health visitor regularly and she and the foster mother help and support me.”

“The health visitor seems really nice. She has given me her phone number and I have been able to ask her questions when I am not sure or worried about something.”

“My baby recently had immunisations. A lovely nurse ran the clinic. She told me all the likely effects from the immunisations; what to look for if my baby is getting poorly and where to go for help if I am worried.”

We spoke with new mothers in the maternity ward who told us;

“The only problem I had during my pregnancy was getting hold of my community midwife; she sometimes took a few days to return my calls. The maternity assessment unit was brilliant, and they explained everything to me very thoroughly”

“In theatre everyone was lovely; it was weirdly quite a nice experience”

We spoke to a parent and child who were waiting for treatment in the paediatric assessment unit. They told us;

“The nurses are really good and they treat you nice here. Everyone is lovely, overall; the children’s department is fantastic. The nurses are compassionate and they let you know what’s going on, and don’t keep you waiting for long”.

We spoke with one young person aged fifteen who was approaching their sixteenth birthday. When asked how they felt about having to wait in the adult waiting area once they reach 16 and then receiving care and support from adult services they told us;

“I would rather be given the choice of being seen here (in the children’s ED) than out there (in adult ED). It’s nicer here and I like the feel of the place.”

We spoke with the young person’s mother who told us;

“We have been here several times now. It can get really busy out there (adult waiting area) and at the end of the day even though she will soon be 16, technically she is still a child. She should at least be given a choice. Kids get a great service here.”

The young person went on to tell us;

“It’s nice here. They (the staff) always treat me nicely and ask me the questions. I like that.”

We spoke to the mother of another young person who told us;

“I have been trying to get an appointment for my daughter with her GP for weeks. I work and it’s really difficult. They told me that I should go to Gray’s in Thurrock. That’s half an hour away but I did. When we got there I was told the wait would be over three hours and that is why we are here again. We have been waiting here for over an hour but at least I feel comfortable here with my other children but that’s not the point. There is just nowhere else to go sometimes.”

The child's journey

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

1. Early help

- 1.1 There is a good range of early help support services available to children and families living in Thurrock operating in partnerships involving health, social care and the voluntary sector. We heard and saw a number of good examples. Health visitors are in the process of rolling out antenatal visits as part of the universal health visiting offer as a result of increased capacity in the service created by *Call to Action*. Community Mums and Dad's practitioners run parenting groups, and support the breast feeding initiative in Thurrock. In records reviewed, we saw evidence of good breastfeeding support and advice being offered to new mothers.
- 1.2 Pregnant women access maternity services at Basildon & Thurrock University Hospitals NHS Foundation Trust (BTUHT) either through their GP practice or self-referral. Midwives have a flexible approach to conducting antenatal appointments in a variety of settings including the woman's home address, although home visits are generally only conducted if concerns are identified rather than part of the universal offer.
- 1.3 All universal plus families are seen at home or in clinic for a development review. Parents are also encouraged and invited to attend universal clinics or baby massage groups, which are available to all families. This helps to engage families with children's centres and facilitates families in having opportunities to access early support and advice.
- 1.4 Families of children under five benefit from a good delivery of the Healthy Child Programme. These families receive a new birth visit, a six week check, and a development review using the ages and stages questionnaire at 9-12 months and then again at two – two and a half years. Three sites across Thurrock are piloting the new integrated two-two and a half years' development reviews working in partnership with the children's centre team. It is envisaged that the integrated reviews will be rolled out by April 2016. This is a positive development as it is important that professionals are working together to review development needs of this age group; a key time when specific issues may begin to become a problem. Thus, a good opportunity for targeting families that require early help and support.

Case Example: *Three year old male. Concerns about the child's school readiness identified by the health visiting team. The community nursery nurse completed 2 - 2.6 month development review in January 2015. The nursery nurse felt the child did not have the appropriate level of speech and language. The nursery nurse agreed to continue to monitor the child and review progress in discussion with the health visitor.*

The mother stopped engaging with the nursery nurse and there were several failed contact visits between March-April. The case was discussed at safeguarding supervision by health visitor. Risk factors were discussed and an action plan identified, however no time frames were specified which would have facilitated effective monitoring of progress.

Following further failed contact, the health visitor sent a completed CAF referral to children's social care in June. In July the health visitor did a joint visit with the social worker and a plan was agreed at the visit with the mother.

Outcomes:

Mum is now engaging well with the health visiting team.

The child is now in nursery and accessing support from a speech and language therapist.

- 1.5 We saw good, supportive work with children and young parents in the family nurse partnership although no service user has yet completed the full programme. FNP liaises well with the teenage pregnancy community midwives and has good working relationships with health visitors, social workers and mental health workers. Joint visits, although not routine practice, are conducted where appropriate.
- 1.6 The health needs of the 5-19 population which are supported by the school health service (SHS) include self-harm, obesity and sexual activity. Health needs of school aged children are assessed at staged contacts using questionnaires. This is currently offered on school entry, transition from year 6 -7 and to movements within the service. We were told that further contact for mid-teens was in development at the time of this inspection. The planned addition of a staged contact for mid –teens is best practice guidance as recommended in the healthy child programme (5-19).
- 1.7 As part of the universal offer, the SHS has taken steps to be more visible and accessible to children, young people, parents and carers and schools. School nurse practitioners provide weekly drop-ins at all secondary schools and termly drop-ins at primary schools. These are often themed around national or more local public health campaigns.

- 1.8 Young people at secondary schools have good access to sexual health advice and support. This includes assessment for c-card, pregnancy testing, Chlamydia screening and emergency hormonal contraception. The SHS has set up a Twitter account to engage with the population and deliver further key public health messages. Examples being; information about the health risks associated with sugary drinks and Stoptober. The SHS secondary school drop-ins are also promoted via Twitter. Uptake of PSHE as part of the commissioned targeted offer was described by managers as variable. We were told that the SHS had identified that young carers was an area for further development. We saw that there is a location on SystmOne to hold those known to be young carers. This caseload was empty on examination and ***we have drawn this issue to the attention of Public Health, Thurrock Council as the commissioner of the SHS.***
- 1.9 There are not strong information sharing links between adult health services and the school health service. The SHS does not receive any routine notification from adult mental health or adult substance misuse services that an adult with caring responsibilities for children is accessing their service. Good information sharing by services working with adults where there may commonly be vulnerabilities to the health and wellbeing of children within those households by virtue of the adult's ill health or risk taking behaviour would support the early identification of vulnerable children and young people. This would facilitate early support for the young person to be offered by health visitors and school nurse practitioners (***Recommendation 1.1***). ***This issue has been drawn to the attention of Public Health, Thurrock Council as the commissioner of the adult substance misuse service.***
- 1.10 When adults and children attend the minor injury unit (MIU) at Orsett Hospital, where age appropriate, history is taken directly from the child. This is good practice and in cases we saw, this was clearly documented. A child's interaction with the accompanying adult was recorded occasionally. We also saw in some cases that the clinician noted no safeguarding concerns, but this was not recorded routinely. It was not clear that sufficient attention is given to the assessment of safeguarding risks and the risks of potential hidden harm as a result of the behaviours of adults (***Recommendation 2.1***).
- 1.11 In both the MIU, provided by NELFT and Thurrock's GP led walk-in centre (WIC), there are no safeguarding children proforma or prompts within the IT systems. We were told in both locations that staff do consider safeguarding issues as part of their assessment but as there is no standard proforma in either provider, the recording of this was inconsistent and we could not be assured that safeguarding is routinely considered fully, and that safeguarding practice is subject to good managerial oversight. At the MIU, there is no robust method of quickly identifying children who are frequently attending different urgent care providers which can be a helpful risk indicator (***Recommendations 2.2 and 4.1***).

- 1.12 If a child or young person is referred to Basildon and Thurrock University NHS Foundations Hospitals Trust (BTUHT) emergency department (ED) or paediatrics, MIU staff liaise directly with BTUHT practitioners to ensure the child or young person arrives safely. If the referral is due to safeguarding concerns then to ensure arrival, transfer by ambulance is arranged and this is good practice in safeguarding the child.
- 1.13 At BTUHT, the relationship between the adult and the child being brought in for treatment is quickly established through good registration practices. Information is collected from the accompanying adult and is then checked on the IT system by the booking in receptionist. If any information is missing or appears different to the information on the IT system then this is followed up with the parent or carers. This means that not only are children's emergency practitioners quickly establishing the relationship between the adult and child, but they are also identifying any anomalies and acting upon them promptly.
- 1.14 Children and young people attending BTUHT ED are triaged quickly using a dedicated under 16 admission paperwork and then wait for treatment in children's waiting area, which is bright and child friendly. Children's ED practitioners are able to maintain good supervision of the waiting area to ensure that children and young people are kept safe at all times, and monitored for any signs of deterioration. Where a child leaves the ED before treatment, there is a clear protocol in place for staff to follow-up. We saw a case example of this although not all the follow-up actions had been fully documented.
- 1.15 All children that are under the age of one year, have been referred by the GP or midwife, have a learning disability or have a known medical condition are sent straight through to the dedicated paediatric assessment unit, attached to the children's ED. All children aged under two years who attend with a head injury are seen by a consultant paediatrician in line with best practice. The paediatric assessment unit has access to a designated paediatric consultant, Monday-Friday 9-5pm. Outside normal office hours, there is access to paediatric on-call consultant cover. The current pathway is working well, which means that children who are most vulnerable are seen in promptly and assessed by an appropriate clinician.
- 1.16 Young people aged between 16 and 18 who attend the ED are treated in the adult ED but are not subject to specific paediatric admission documentation; instead the adult documentation is used. This is not in accordance with guidance and there is a risk that clinicians may not be immediately aware that the patient notes are for a child and that they need to assess for any child safeguarding issues (**Recommendation 3.1**).

- 1.17 Children and young people who attend the children's ED following an incident of alcohol or substance misuse are referred to the local substance misuse team in accordance with the service protocol which states the referral process for a child or young person is only for those consent and who are therefore willing to engage with the service. Relationships with the children's substance misuse team are reported to be well established.
- 1.18 BTUHT routinely send out notifications to key professionals that a child or young person has attended the ED and this is good practice, facilitating prompt follow-up by health visitors and other health professionals. However, although we saw some notifications containing good detail surrounding the child's attendance, these did not always contain sufficient useful information to support good follow-up care and we saw a number of examples of this in different services, including the school health service where practitioners routinely went back to the ED for more information. This is time consuming for both the community health provider and the ED and we saw case examples which did not then require any further follow-up from the school nurse, although unnecessary time had been spent ascertaining this. In one case of an unaccompanied asylum seeking child, we saw a notification of his attendance at the ED sent to his GP. This contained insufficient information on which the GP could base an effective decision about the need for primary care support or intervention in the case of a highly vulnerable young person (**Recommendation 3.2**).
- 1.19 Young people who have lower levels of emotional health needs are not currently sufficiently well supported and this is a known gap in the Early Help offer. Children who might meet the threshold for support at tier two are managed within other services such as school nursing or the community paediatric service currently. Additionally, GPs told us that they were frustrated at difficulties in accessing specialist diagnoses for children who have behaviours indicating ADHD or ASD. The lack of tier two services is well understood locally and we noted the plans to address this through the imminent re-provision of the CAMHS service from 1 November 2015.

2. Children in need

- 2.1 We saw case examples of good communication and joint working between professionals in order to improve outcomes for children and families where there are known vulnerabilities.
- 2.2 In the antenatal appointment care plan there is no identified visit where women can expect to be seen alone and know that they will have the opportunity to discuss possible domestic violence or exploitation issues. This does take place on an ad hoc basis during the pregnancy when opportunity presents. Police notifications of domestic violence incidents were seen within notes sampled and we were advised that maternity services routinely receive all police reports where women are pregnant. Midwifery is expected to follow up high risk cases within 5 days, when there is a confirmed pregnancy and the woman has no other children. This is monitored by the trust's safeguarding team. In the case notes sampled, we saw that enquiries around domestic violence issues were consistently asked when it was safe to do so. Practice could be strengthened further by informing women and their partners in the antenatal appointment care plan that on at least one visit the woman will be seen on her own. This would reduce the reliance on professional confidence in asking an accompanying adult to leave a consultation and the potential for variable practice. **(Recommendation 3.3).**
- 2.3 Specialist midwives and midwives with special interests at BTUHT are available to support midwifery colleagues with complex cases and we saw good evidence of their role in intra and multi-agency liaison. Specialisms include; women with mental health issues /substance misuse, two community midwives with an interest in teenage pregnancies holding caseloads consisting of teenage women only and the named midwife acting as the specialist midwife for domestic violence as an area of interest, not included in her job description. Additional support offered to women with identified vulnerabilities include; additional visits (ante and postnatal), joint/specific clinic appointments, and dedicated antenatal classes for pregnant teenagers. These help to ensure that vulnerable women are well supported and receive co-ordinated services throughout their period of care. The specialist midwives and midwives with special interests are flexible and proactive in engaging women with their services and we saw evidence of them having good oversight of cases held and conducting joint clinics where possible; for example with the community drug and alcohol service (CDAS).

Case Example: *A woman having her first baby disclosed at booking that she had long term mental health issues and was under the care of the Community mental health team. With consent, the Basildon & Thurrock University Hospitals NHS Foundation Trust community midwife ensured that the woman was appropriately referred for additional support, including to the specialist midwife for perinatal mental health.*

The midwives regularly communicated with health visitors, children's social care and mental health colleagues throughout pregnancy and through to postnatal discharge from maternity services. This ensured that the woman and her family were supported, received co-ordinated multi-agency care and all professionals involved worked together to ensure the best possible outcome for this family.

The mother was discharged home with her baby; children's social care assessed the case but did not feel they needed to be involved as sufficient support was being provided by the agencies already involved.

- 2.4 There are two independent domestic violence advocates (IDVAs) funded by the voluntary sector working within the hospital. The IDVAs attend multi-agency risk assessment conferences (MARAC) which focus on families where there are known to be issues of domestic violence and ensure relevant information is shared with the trust.
- 2.5 Midwives ensure identified concerns are widely shared not only with the BTUHT maternity department but also throughout the hospital. As a result, staff are quickly alerted if women attend services such as the ED or gynaecology for example. There is a structured handover sheet used to inform community midwives of up to date safeguarding information when a woman's is discharged from hospital. This helps ensure community colleagues are fully aware of all safeguarding issues and also that their safety is considered as they are lone workers entering home environments and are therefore themselves potentially vulnerable to abuse.
- 2.6 The effectiveness of liaison between midwifery and health visiting services varies. In some areas monthly inter-service meetings are in place which facilitate information sharing and enable families needing additional support to be identified and engaged with promptly. However, we were informed that the midwifery service in some areas within Thurrock has experienced significant changes in staffing. As a result, communication and partnership working between some midwives and health visitors' teams is known to be less good (**Recommendation 3.4**). ***This issue has been drawn to the attention of Public Health, Thurrock Council as the commissioner of the health visitor service.***

- 2.7 There are no regular meetings between GPs and midwives, although community midwives can access SystmOne to view patient records in primary care services operating this records system. We also saw evidence of the named midwife contacting a GP for information in a case where there were significant safeguarding concerns. We were told that some GPs on SystmOne have closed access to other professionals, which undermines the effectiveness of having an almost universal health information system. GPs hold essential information about patients current and historical health and social issues which may impact on parenting capacity so accessing this information is an essential part of risk assessing potential harm to an unborn. We were told that the CCG and NHS England expect all GP practices to share safeguarding information with other professionals and relevant agencies when there are concerns for the welfare of a child. An information sharing agreement has been signed pan-Essex
(Recommendation 4.2).
- 2.8 Where new mothers have identified mental health needs, we saw good support from the specialist perinatal maternal mental health visitors leading to improved outcomes for the child and family. NELFT has a lead for domestic abuse and harmful practices whose role includes ensuring that all frontline practitioners have the required knowledge, skills and competencies to manage domestic violence within their caseloads. There are no specialist health visitors for travelling families or substance misuse however, although these are known to be contributing factors locally to the increased numbers of children subject to child in need (CIN) or child protection plans
(Recommendation 2.3).

Case Example: 42 week old baby diagnosed with complex health needs. Mother has a border line personality disorder. The case was referred to the health visiting team by the community midwifery service at the monthly inter-service liaison meeting.

A specialist health visitor for perinatal maternal mental health worked in close partnership with the community mental health team and other professionals including the mental health support worker and psychiatrist, community children's nurse and Great Ormond Street Hospital.

The specialist health visitor offered the mother regular contact through home visits and text messages. The practitioner also attended Great Ormond Street Hospital (GOSH) with the mother, so that she could support her when the doctors informed her of her baby's diagnosis.

The health visitor also supported the mother to have an initial attachment assessment. The practitioner appropriately accessed advice and guidance from the North East London NHS Foundation Trust (NELFT) safeguarding children's duty team.

The specialist health visitor was instrumental in bringing professionals together to ensure appropriate support was offered to the mother, baby and family through a Team around the Child (TAC) approach. Contact with the family by all professionals was frequent and all professionals liaised regularly with each other ensuring all disciplines involved with the family were up-to-date with the current situation. Joint visits were undertaken with other professionals and multi-disciplinary team meetings have been arranged by the specialist health visitor, which included GOSH, ensuring the mother was supported and the baby safeguarded.

Due to growing concerns among all the professionals about the mother's mental health and her ability to parent the baby who has ongoing complex health needs, the case has been escalated to children' social care and child protection proceedings are being considered.

- 2.9 Thurrock women with perinatal mental health needs do not have access to a commissioned perinatal mental health pathway and this is not compliant with NICE guidance. We saw cases, such as that set out above, where the provision of a specialist perinatal mental health service in Thurrock would have been beneficial. We understand that the LSCB have also raised this gap as a priority issue (**Recommendation 2.4**).
- 2.10 We saw cases where vulnerable and complex families were being supported well by the health visiting service. The service makes good use of flags on the case record information system and flags are routinely added for vulnerable children; those subject to a child protection plan or Child in Need (CIN) plan. This means that practitioners are immediately alerted to vulnerable cases when accessing the case record.

- 2.11 However, once the child is no longer considered vulnerable or subject to a plan, the flag is removed. The impact of this is that health visitors who may be new to the case will not be alerted to the need to consider any additional vulnerability. Given that the health visitors in Thurrock are working a corporate caseload, this may raise the risk that vulnerability or recent risks in a case may not be promptly understood by a practitioner new to the case. Corporate caseload means that health visitors work with families registered at a number of different GP practices; the same health visitor might not necessarily see the same child or family again. Therefore, as an example, the health visitor who did the six week check may not necessarily do the one year development review. If there had been any safeguarding concerns or risks identified for that family, and the flags had been removed then the health visitor seeing them at the one year check may not know this information. Unless the health visitor is alerted to additional vulnerabilities, such as; “previously subject to CIN or child protection plan” or “history of domestic violence” through the case record home page there is a risk that the practitioner’s assessment and work with the family may not be fully informed. ***This issue has been drawn to the attention of Public Health, Thurrock Council as the commissioner of the health visitor service.***
- 2.12 We saw good evidence of CIN plans being used by health visitors to inform their development of individual health plans, however the plans we saw were not always fully SMART as in some cases, timescales for outcomes were loosely defined. ***This issue has been drawn to the attention of Public Health, Thurrock Council as the commissioner of the health visitor service.***
- 2.13 Transfer of care between health visitors and school nurses in the school health service (SHS) works well. A joint visit is usually scheduled to handover vulnerable cases and other children are transferred electronically from the health visitors to the school nurses via SystemOne. The current arrangements mean that families and children are more likely to receive support in a timely manner by the time the child starts school. Monthly inter-service meetings are held which facilitates cohesive and co-operative joint working to improve outcomes for children, young people and families.
- 2.14 The SHS provide additional assessment and support where additional health needs have been identified for individual children. School nurses in the SHS work under significant capacity pressure and prioritise high need cases with both Bands 5 and 6 practitioners having CIN and child protection as well as looked-after children cases on their caseloads. We were told that the new service specification introduced from September 2015 will have clear distinctions about the service offers to help support clearly targeted work.

- 2.15 A young person with an emotional wellbeing difficulty referred to the SHS is assessed and offered four sessions of intervention followed by review. At this stage further actions may involve discharge or signposting or referral to other services. However, currently, long waiting times for non-urgent CAMHS assessment and intervention often leads to the SHS continuing to provide support to children and young people with emotional health needs that require more specialist services.
- 2.16 Vulnerable families or children do not always receive a co-ordinated approach to their care involving primary care and community health practitioners however. It is well recognised locally that the engagement between primary care practices, health visitors and school nurses is not working effectively and we saw examples of inconsistency. Not all GP practices hold vulnerable family multi-disciplinary team meetings and where these do take place, health visitors and school nurses are not always invited or attend. Link health visitors and recently, link school nurses have been identified to engage with individual GP practices. We were informed that all GP surgeries have recently been sent a letter from the SHS informing them of the name of their link school nurse and contact details but engagement with SHS and health visitors is patchy and not embedded, with some GPs reluctant to engage. **(Recommendation 4.3). This issue has been drawn to the attention of Public Health, Thurrock Council as the commissioner of health visitor and school nurse services.**
- 2.17 BTUHT has an effective flagging system in place to alert practitioners to children and young people who are subject to a child protection plan or who are looked after. However, children or young people on a child in need plan are not flagged and this is identified as a gap by the trust **(Recommendation 3.5).**
- 2.18 Within the BTUHT adult emergency department, triage and admissions documentation does not prompt practitioners to ask questions of adults who attend as a result of risky behaviours; including overdose or abuse of alcohol or domestic violence. We found an over-reliance on the knowledge and experience of individual practitioners to ask the right questions. As a result, records showed significant variation in how practitioners assessed for hidden harm. In some cases, we found a lack of professional curiosity to ensure that important questions are asked and circumstances around the adult's attendance are probed sufficiently **(Recommendation 3.6).**
- 2.19 BTUHT paediatric ED practitioners are aware of how to make referrals to the MASH if they have any concerns about the safety of children and young people. The referrals we saw, however, were variable in terms of the quality of information and how clearly the practitioner had articulated their concerns and the risks to the child or young person. This lack of clarity does not facilitate optimum decision making in the MASH about what intervention or support may achieve the best outcome for this child **(Recommendation 3.8).**

- 2.20 Children and young people presenting to children's ED in acute mental health crisis who are then admitted to a paediatric ward to await further assessment, an appropriate in-patient placement or a community based support package, are cared for well. One-to-one care is provided by appropriately trained bank or agency staff with medical needs being catered for by ward staff. Paediatric nurses on both the Puffin and Wagtail paediatric wards at Basildon and Thurrock University Hospital have not received any additional mental health training. Practitioners told us that basic mental health training provided by CAMHS would be helpful in ensuring that they are best equipped to support this cohort.
- 2.21 Young people can wait a long time for mental health assessment unless identified as having urgent need, and then wait again for therapeutic intervention. There being an 18 week referral to assessment time and a period of 12 weeks from assessment to the commencement of intervention. We were told that the single point of access 'clinician of the day' provides guidance and advice for parents or carers on coping with behaviours where young people were awaiting treatment.
- 2.22 Once engaged with a young person, CAMHS demonstrate good planning of therapeutic interventions, undertaken with the young people where age appropriate. Agreed treatment plans are regularly updated and either signed as agreed by the young person or carer. Consent to share information with, for example, GPs, other health agencies and social care are also obtained at every update. This is good practice; demonstrating consent is sought regularly throughout the young person's engagement with CAMHS rather than only at the outset of therapeutic intervention. Service user feedback is consistently high and reflects a high satisfaction with the service from young people it supports.
- 2.23 Although initial risk assessments were completed at the time of young people beginning to receive CAMHS interventions, case evidence demonstrated that these were not always reviewed within the recommended three month period. In one case sampled, a risk assessment dated May 2015 had not been reviewed at the time of this inspection. We also saw a risk assessment in another case which had not been dated at all making it difficult to ensure it was reviewed within three months as expected **(Recommendation 2.5)**.
- 2.24 Young people begin transition to adult mental health services at age seventeen and a half. CAMHS practitioners make adult services aware of the transition at this time and where practicable, joint visits will take place with the young person. This is good practice; offering some continuity and reassurance to young people at what is often a very difficult time.

- 2.25 In the adult mental health service, provided by South Essex Partnership University NHS Foundation Trust (SEPT), the use of a 'zoning' electronic tool to regularly assess and update client risk is good. The tool uses a multi-coloured system to identify clients who have children, who are soon to be discharged from the service, who are in mental health relapse and who are in acute clinical relapse. This enables managers and practitioners to keep awareness of children high within the service while working with the adult.
- 2.26 Relapse indicators form part of the care planning process in adult mental health and we were told that they are used to inform other practitioners in health and social care about the signs and symptoms and what actions to take should a client's mental health deteriorate. This can be very helpful information for a health visitor or midwifery services to identify deteriorating maternal mental health early, thus facilitating good outcomes for mother and child through prompt engagement with appropriate support. However, we were not assured that these relapse plans could easily be shared with other agencies, due to the sometimes poor quality of care plans in adult mental health (**Recommendation 1.2**).
- 2.27 Practitioners in the adult mental health service generally liaise closely with practitioners from other health disciplines and agencies to ensure good outcomes for vulnerable children and young people in the care of adult clients with mental illness. We saw case examples of good co-operative working with midwives and health visitors although we also reviewed a case where liaison between adult mental health and midwifery had not worked well.

Case example: *An expectant mother was receiving care and support from adult mental health practitioners. She was taking prescribed anti-psychotic medication and her mental health had deteriorated since becoming pregnant.*

The expectant mother requested involvement of a specialist mental health midwife as she felt she could not discuss her mental health with her usual midwife and she also felt her reliance on prescribed medication might also not be understood. We were told that the adult mental health practitioner tried several times to get the mental health midwife to engage with her client but she was not getting a response. Unfortunately, the adult mental health practitioner did not record her attempts within the client records so this could not be verified.

It was not until after the birth of her child that the specialist mental health midwife became involved in the case and the mother and child are now receiving support from the specialist perinatal maternal mental health visitors.

This case demonstrates the importance of effective communication and liaison between services which is a frequent finding in serious case reviews as well as the importance of discussion of any barriers to effective joint working being raised promptly with managers for resolution and recording all actions taken by practitioners within the client record.

- 2.28 In Addaction Visions, adult substance misuse service, the manager of the service keeps a manual list of cases where there are known to be children or young people subject to CIN or child protection plans. However, there is no routine use of the electronic flagging facility on the client record system to immediately alert practitioners and managers to the presence of a vulnerable child or a child subject to child protection procedures. Use of the flagging facility is inconsistent and the manager too reliant on the manual list of cases. The service is therefore unable to accurately identify the cohorts of vulnerable children or children subject to CIN or child protection plans in which the service is involved.
- 2.29 Addaction Visions has a weekly clinical case review meeting whereby all cases are reviewed on a 3 monthly basis and we were told that this meeting routinely considers safeguarding and child protection issues in cases. However, the case we saw and another we heard about demonstrated that this system is not robust in relation to exploring any and all child safeguarding issues in cases, particularly where there are unborn children.

- 2.30 Adult substance misuse practitioners do not routinely undertake home visits to clients but will make this decision on a case by case basis. Where home visits are undertaken, this is usually a joint visit with a social worker or in response to the client's needs. The presence of children in the household or the provision of a CIN or child protection plan does not prompt a home visit automatically nor do these raise the priority regarding the need to visit the client's home. As a result, the service cannot provide assurance that safeguarding issues for any children have been fully considered vis a vis the home environment in relation to parental substance misuse. **Issues set out in paragraphs 2.28, 2.29 and 2.30 have been drawn to the attention of Public Health Thurrock as the commissioner of the adult substance misuse service.**
- 2.31 While young people have good access to contraception and sexual health (CASH) support through NELFT's SRH in both appointment led and drop-in clinics. Although practitioners acknowledged there are no specific young people clinics, all clinics are accessible to young people. Where possible, young people are also seen when they present outside of clinic times and this provides responsive support to young people. The move to an integrated CASH and genito-urinary medicine (GUM) service imminently with a focus on Thurrock should facilitate strengthening of the early help offer. Risk assessment in SRH (CASH) including consideration of the potential for child sexual exploitation (CSE), is inconsistent. All practitioners are expected to consider the use of the CSE risk assessment tool for all young people attending SRH however it was seen that the analysis of risk identified was not completed by one member of staff. We did not see strong engagement with school nurses. Practitioners are inconsistent in how they capture and reflect the voice of the child.
- 2.32 The GUM operates a separate risk assessment pro-forma for young people under 16 years who present at the clinic in line with best practice. The assessment is comprehensive, giving practitioners the opportunity to cross check information taken at registration such as who has accompanied the young person in case the young person discloses different information during the session. Practitioners do not routinely record the child's demeanour however, and this would further strengthen an already good quality assessment.
- 2.33 We were told that the potential for female genital mutilation (FGM) is considered at GUM and SRH. However, we did not see evidence of this and the issue is not included in the risk assessment proforma. Given this is a growing concern nationally and known to be increasing locally, this is an area for development (**Recommendation 2.6**)
- 2.34 Thurrock WIC prescribes emergency contraception, however there is no CSE risk assessment in use to aid clinical decision making in assessing whether young people accessing such prescriptions are safe. This is a missed opportunity to discuss and identify potential cases of CSE (**Recommendation 4.4**).

3. Child protection

- 3.1 Referrals to the multi-agency safeguarding hub (MASH) are all made using the CAF (common assessment framework documentation). We did see some examples of good quality referrals, notably in Thurrock WIC, midwifery, the family nurse partnership (FNP), adult mental health and in a GP practice but overall there was a mixed picture of quality and consistency.
- 3.2 The majority of the referrals we saw from BTUHT midwifery services to the MASH were good. They shared information, analysed risk, the potential impact of parenting behaviour on a new-born and related to the threshold document. We also saw evidence within midwifery notes of information sharing with the MASH and appropriate case discussions to aid decision making for both agencies.
- 3.3 Across provider services however, the majority of referrals to the multi-agency safeguarding hub (MASH) that we saw did not articulate the risk of harm to the child sufficiently clearly. This lack of clarity does not best facilitate optimum decision making in the MASH. While we did see several examples in the BTUHT ED where the trust's safeguarding named nurse had sent the referral back to the original referrer requesting further information and this is good practice, there was still inconsistency in quality. This is an area for development across the health community, for SHS and adult substance misuse. Identification of exemplar referrals within services to model good practice and support improvement has not been explored fully, although we were told that this does happen in the health visitor service for newly qualified practitioners. Quality assurance at an operational level within services, prior to any trust safeguarding team's monitoring, is underdeveloped (**Recommendation 1.7, 2.18 and 3.8**). ***This key area for development has been drawn to the attention of Public Health, Thurrock Council as the commissioner of SHS, health visitors and the adult substance misuse service.***

- 3.4 Use of overly clinical language and lists of medication in the CAF, particularly in adult services, without an explanation as to the potential safeguarding impact, is not helpful to social care decision makers in the MASH. These decision makers may not immediately appreciate the safeguarding significance of what the health referrer has written. For example; side effects of a particular drug might increase aggression in a parent and this has safeguarding implications for a child, especially if there is a history of domestic violence in the family. Unless this is stated clearly, there is a risk that social care practitioners may miss this crucial risk indicator. The MASH manager and practitioners told us that they often have to look up drugs on the internet and “read between the lines” of referrals. It is beholden on health referrers to facilitate effective decision making in the MASH with clear and concise explanation as to the significance of the information they include in the referral. ***Areas for development in paragraphs 3.3 and 3.4 have been drawn to the attention of Public Health, Thurrock Council as the commissioner of school nurse and the adult substance misuse service.***
- 3.5 Health visitors told us that they receive timely notification of outcomes following referrals to the MASH by email or by telephone contact. This is good practice by MASH practitioners.
- 3.6 Adult mental health practitioners are aware of the escalation policy and how to invoke it through their line manager and through to the trust’s safeguarding team if thought necessary. However, we were told that it is rarely used due to the team having good working relationships with social care.
- 3.7 At BTUHT, attendance at pre-birth safeguarding meetings is prioritised and it is expected that a midwife will be present with the meeting being considered non- quorate if a midwife is not present. Attendance is monitored by the safeguarding team and escalated to the community midwifery manager if attendance is not possible. We saw good evidence of the outcomes of safeguarding meetings being appropriately disseminated to ensure the wider midwifery team is fully aware of the most up to date information and plan.
- 3.8 We saw evidence of a robust and thorough process at BTUHT where women disclose during pregnancy that they have been subject to female genital mutilation (FGM). The trust is in the process of incorporating FGM and a pathway into the existing safeguarding policy. All women are asked about FGM at booking, all cases are logged and detailed information is taken from identified cases. A comprehensive FGM questionnaire is completed, a consultant’s appointment arranged and the legal issues around FGM explained to the woman. We saw cases which resulted in a referral to the MASH where any risk to the new-born was identified.

- 3.9 Midwifery has an agreement in place with the MASH that women who fail to attend four prenatal appointments without reasonable explanation are referred. This is effective partnership working to safeguard vulnerable women and unborn children.
- 3.10 Health visitors have access to the generic did not attend (DNA) policy which is used across NELFT services. We heard that the policy stipulates that two appointments should be offered following DNA; however we heard that the health visiting team offer more than two appointments in practice. A letter is sent to family and the GP to inform of the non-attendance and to offer contact details again and remind them of available universal services. We were informed that the health visitor will risk assess each individual case; liaise with the GP, NELFT safeguarding named nurse team, and children's social care where necessary. This demonstrates that the health visitors in Thurrock are proactively working to ensure that children are safeguarded and protected from harm.
- 3.11 Child sexual exploitation (CSE) is included in midwifery training but managers acknowledged that this needs further development. A plan is in place whereby the named midwife will attend training imminently on the CSE risk assessment toolkit and this will then be rolled out across the midwifery service.
- 3.12 In the BTUHT ED, practitioner's awareness of CSE and how this applies to daily risk assessment practice is also underdeveloped. We were informed that paediatric ED practitioners have access to the CSE toolkit which is based on a traffic light matrix system. However, we saw no evidence of the screening tool being used and of the risk of CSE being assessed. As a result, opportunities to identify young people at risk of exploitation may be missed (**Recommendation 3.7**).
- 3.13 We were told in all services that health practitioners are expected to attend initial child protection case conferences (ICPC), core groups and child protection case conferences. Whether a practitioner is expected to attend and submit a written report, which would constitute best child protection practice, varies according to the service; and how well attendance is monitored by operational managers is also variable. There was close monitoring of attendance in SEPT's adult mental health service and managers also dip sampled conference reports; all of which are compiled using a template to promote consistency. We saw variable quality in child protection case conference reports that we reviewed: those we reviewed in adult mental health were good (**Recommendation 2.19**).

Case Example: *We reviewed a child protection case conference report submitted by a school nurse practitioner for a school aged child subject to a child protection plan.*

The ethnicity of the child had been recorded and the family structure which would be information helpful to the conference in its assessment of cultural issues pertinent to the case and give an understanding of the family network.

The report lacked depth of detail and analysis of risks to the child's health and well-being and the impact of these on short and long term outcomes for child. For example; when asked about what the parents needed to do, the written response recorded was they needed to engage with services. Engagement with services alone does not offer protection. Further expectations of the parents by the school nurse practitioner could have included the need for parents to prioritise the needs of the child and keep them safe, protecting them from physical and emotional harm. It would also have been helpful to conference for the practitioner to include what about the child's health and wellbeing needed to change and what actions the parents needed to take to demonstrate that they were actively promoting that change.

- 3.14 There is more to do to ensure that CAMHS are properly engaged in child protection forums. We were informed that CAMHS practitioners are generally not able to attend most child protection conferences due to the lateness of the invitation. We were also told that they are sometimes unable to offer relevant information because the young person, although referred to CAMHS, has not yet been assessed by the service. Best child protection practice is for reports for conferences to be submitted in advance of the conference and for the practitioner to attend. Managers told us that reports are not routinely provided unless for exceptional circumstances and acknowledged that this is not best practice. We would expect the new provider to address these issues in partnership with the local authority to ensure an effective child protection invitation pathway is in place and that the attendance and submission of report by CAMHS becomes routinely aligned with best practice (**Recommendation 2.7**).
- 3.15 In the SHS, targeted weight management is provided to children of primary school aged identified as having weight issues following the national childhood measurement programme (NCMP) or from referral to SHS. School nurse practitioners told us that independent reviewing officers (IROs) who chair child protection meetings routinely include, as part of the child protection plan, growth measurements to be undertaken by the SHS. Practitioners told us that they feel that it is often unclear what the evidence base for this is if there are no growth concerns and that it adds little to the child protection plan. It was not clear whether this issue has been escalated for discussion and resolution between the NELFT safeguarding team and children's social care and **this has been drawn to the attention of Public Health, Thurrock Council as the commissioner of the SHS.**

- 3.16 We saw particularly good conference reports in the health visitor service. Reports clearly articulated health visitors concerns, as well as what was working well for the family. However, conference reports are not currently being quality assured by health visitor managers.
- 3.17 Adult mental health practitioners prioritise attendance at child protection initial and review case conferences and this is monitored well by senior managers who also 'dip sample' reports submitted to conference. Reports we reviewed were detailed and relevant, clearly articulating any current risk. However, it is not clear that decisions and outcomes from child protection conferences or discussions at core group routinely inform the on-going work with the client as these are not well reflected in care plans or the case record (**Recommendations 1.4 and 1.5**).
- 3.18 There is a robust policy in place in adult mental health to manage decisions about clients who do not attend appointments, especially where they have parental or carer responsibilities. This includes making unannounced visits at home, telephone calls, notifications to GPs and even police involvement if judged necessary.
- 3.19 Addaction Visions adult substance misuse service is not working on the implementation of a "Think Family" model of service delivery to ensure that the safeguarding of children is prioritised in a service which works with adults. The manager and practitioner we spoke to were aware of the toxic trio and the potential for hidden harm to children, although there was little understanding of "Think Family" or "See the Adult, See the Child" principles or protocols. Addaction's initial assessment proforma used by the service has clearly been informed by Think Family principles, however. The assessment template contains good prompts and questions for the practitioner to follow and ascertain the presence of children within the family or household or with whom the client has regular contact. However, case records and discussion with the manager and practitioner demonstrated that assessments are not sufficiently rigorous in practice. Assessments are not revised regularly or robustly updated when a client or their partner becomes pregnant or children are added to the household.
- 3.20 Addaction Visions also acknowledged that communication and liaison with other health professionals, particularly with health visitors, is an area for development. While the manager and frontline staff were able to articulate an understanding of the need to regularly communicate and liaise well with other professionals outside of formal CIN or child protection forums, we did see no evidence that this happens routinely.

Case Example: *A male had been engaged with the adult substance misuse service for some years. He informed his case worker early in 2015 that his partner was pregnant. The man also informed his case worker during the pregnancy that he was planning to commence the use of steroids, however potential risks to the unborn were not considered, recognised, analysed or recorded. There was no contact made by the substance misuse practitioner with midwifery services during the pregnancy to ensure that the midwife was aware that the woman's partner was a client of the service and that the family was living in very poor housing conditions.*

Once the baby was born, the practitioner considered the potential risks to the new-born of needles being in the property and recorded a plan to provide the client with safe storage. The substance misuse practitioner did not contact the health visitor involved with mother and new-born to ensure all professionals involved with the family were working effectively to protect a vulnerable child.

According to the service's practice of undertaking weekly clinical case reviews, this case should have been reviewed at least three times during the antenatal and post-natal period. No safeguarding issues had been identified during this period however.

The substance misuse practitioner made a referral to the MASH when the mother, carrying the baby, attended the service trying to access needle exchange on behalf of the client. The referral set out good information about the client's engagement with the service but did not include clear articulation of the risks to the child and why the practitioner was concerned beyond the family's poor housing situation.

We visited the MASH and tracked the case. The MASH had received the referral and information was promptly gathered from Police, health visiting service and midwifery service. Midwifery had identified no safeguarding concerns; as had the health visitor who has undertaken several visits to the child's home. Neither service were aware of the child's father having a history of substance misuse, being a current service user and his declared intention to start using steroids which are known to increase male aggression. Police had identified the child's father had a history of serious domestic violence against a previous partner, as a result was subject to a court order and had been on probation. The case was passed as a priority to children's social care who undertook a home visit the following day. The case is now open to children's social care.

The substance misuse service had key information about a family which should have been identified immediately on learning of the pregnancy as having significant potential for risk of harm to the unborn child. Risks had not been recognised nor acted upon.

The lack of effective communication and routine liaison between professionals involved in cases where there are vulnerable children is a frequent feature of SCRs.

- 3.21 Addaction Visions told us that they prioritise attendance at CIN and child protection case conferences. Practitioners either attend or submit a written report to the conference. Best practice would be for a written report to be submitted prior to the case conference and for the practitioner to attend the meeting. We did not see evidence that CIN and child protection documentation is routinely uploaded onto the client case record and therefore plans are not easily accessible to practitioner and manager to ensure these inform casework effectively and this is a significant and acknowledged gap. **Issues set out in paragraphs 3.19, 3.20 and 3.21 have been drawn to the attention of Public Health, Thurrock Council as the commissioner of the adult substance misuse service.**
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4. Looked after children

- 4.1 Notifications of children and young people coming into care are sent weekly by post by children's social care to the CLA health team. This means that a significant proportion of children will have been in care for at least five days before notification is sent through, creating challenge for the health team in ensuring IHAs are completed within required time scales. Although we were told that timescale compliance for the last quarter for IHAs was 100%, all cases we reviewed in the service had been subject to delay which in some cases was significant; one young person had been in care for 5 months before having their health needs assessed. This child, in common with two thirds of Thurrock's looked-after children, was placed out of area. Once paperwork from the local authority was received by the looked-after child health team, the child was seen for an IHA within 20 days. There is more for both social care and the CCG to do to ensure that notifications are prompt, conveyed efficiently from children's social care to the looked-after child health team and that performance data is an accurate reflection of case activity (**Recommendations 2.8 and 2.9**).
- 4.2 Initial health assessments (IHAs) are undertaken by paediatricians in line with best practice. Those seen for older looked-after young people were good quality with clinicians clearly taking time with the young people and giving attention to including the voice and individual personality of the young person. However, we saw few examples where the words of young people were actually quoted and this would strengthen this aspect of the assessment. For younger children the scope for practitioners to utilise creative ways to gain the voice of the child and engage them in the health assessment has not been fully explored (**Recommendation 2.10**). **This issue has been drawn to the attention of Public Health, Thurrock Council as the commissioner of health visitor and school nurse services.**

- 4.3 At the time of this CLAS visit, there were 63 unaccompanied asylum seeking children (UASC). This is a high number; expected to increase in the future. The specialist looked-after child nurses work closely and well to support this cohort. The CLA nurse demonstrates a high level of understanding of the issues faced by unaccompanied asylum seeking children (UASC) and the potential impact on their health and wellbeing. The potential cultural barriers of a lack of gender balance in the looked-after child health team and among paediatricians in meeting the physical wellbeing and sexual health needs of unaccompanied asylum seeking children are acknowledged by the service. The importance of the young person being accompanied by an appropriate interpreter is also recognised within the specialist service, although less well understood in primary care.
- 4.4 Review health assessments performed by health visitors highlighted that developmental checks were informative and comprehensive. Health visitors are active participants in the lives of LAC in Thurrock. They contribute to statutory LAC reviews effectively. We saw evidence of continued support to children from health visitors and school nurses, providing opportunities to follow up on health actions identified.
- 4.5 GPs and CAMHS are not contributing to IHAs and RHAs even though they may hold key health and emotional wellbeing information, although we heard of plans to introduce this for GPs imminently. We understand that from 2014, LAC has been a standing item on the agenda at the GP safeguarding forum; topics have included GPs contribution to health assessments. We saw case evidence however, of the low awareness of GPs in the role and responsibilities they play in the health of looked-after children overall and for unaccompanied asylum seeking children particularly **(Recommendations 2.11 and 5.1)**
- 4.6 Looked after children placed out of area remain in the care of Thurrock CAMHS in most cases apart from those that are placed at long distances. CAMHS practitioners are enabled to travel to meet with clients placed out of area which is good practice providing continuity for particularly vulnerable young people.
- 4.7 Thurrock CAMHS are not commissioned to provide training to foster carers although this has happened once and was well received. We found that CAMHS offer good support to foster carers, in particular giving guidance in maintaining relationships with the young people in their care to provide them with continuity and reduce the risk of placement breakdown.

Case Example: *Two looked after siblings were both placed in the same foster home. One of the young people was receiving care and support from CAMHS although consideration was now being given for the young person to disengage from the service. This decision was clearly articulated to the foster carer and the rationale explained*

The foster carer had spoken of her concerns regarding the young people having renewed access to their birth mother. The CAMHS practitioner met with the foster carer, clearly documented those concerns and then went on to put in place an action plan to offer continued support both prior to the meeting taking place and after.

The foster carer was encouraged to discuss her own emotions with the CAMHS practitioner, how she managed violent behaviour sometimes exhibited by one of the young people and her feelings following discussions held at review meetings. Advice was given to the foster carer and other support networks available to her and the young person were considered.

The outcome of those regular meetings and discussions between the CAMHS practitioner and foster carer has meant that a stable carer/young person relationship has been maintained and the risk of placement breakdown has been significantly reduced.

- 4.8 All practitioners involved in IHAs and RHAs give good attention to gaining the child or young person's consent to the assessment and evidencing that on the documentation. Young people have a choice about where their health review is undertaken and they are also given choices about what topics they want included. This is positive in engaging the young person in the assessment of their health.
- 4.9 We saw some parental health history set out in IHAs although this was inconsistent even when the child had entered care under voluntary arrangements and therefore this information should be more easily obtained. Young people frequently tell us that the lack of any parental health history and reason why they came into care, available only at the time they become looked after, has a lasting impact on them when they enter adulthood. Securing this information at the outset of the child's journey through care must be seen as a priority of the looked-after child partnership between children's social care and health (**Recommendation 2.12**).
- 4.10 Health plans were satisfactory with evidence that actions had been followed up although some timescales were loose and non-specific. The universal public health offer was not included in health action plans and we felt that while plans were essentially SMART there were missed opportunities to identify pro-active working around public health.

- 4.11 A multi-agency group (MALAC) comprised of CAMHS, the specialist looked-after child nurse, children's social care and NELFT practitioners meets regularly to discuss individual children who have high strengths and difficulties questionnaire (SDQ) scores. Mental health needs and support to looked-after children is well provided by Thurrock Targeted Therapeutic Service (Three T's). This is helping to ensure that this vulnerable cohort of young people has attention focused on their needs and how these are being met. We were told that there is an expectation that under the new emotional wellbeing and mental health service (EWMHs) looked-after children will continue to be well supported.

Good Practice Example: *In order to support social workers with decisions about children who have behaviours that would ordinarily be at the threshold of need for a Tier two or Tier three CAMHS service, the CAMHS provider, NELFT, has created a dedicated consultation facility.*

This service offers three extended appointment slots each week for individual case discussion between CAMHS child psychotherapists and social workers, most often from the local authority's looked-after team or those with responsibility for children subject to child protection or child in need plans.

The social worker is provided with advice and guidance about how to support families with children with particular behaviours and gives the clinician the opportunity to assess whether a child ought to be referred to the Tier three service.

We looked at the detailed notes taken of consultations in respect of three children. Each of the children was looked after and one child was subject to a child protection plan. The records contained a clear description of the concerns and the recommended activity to be taken by the social worker to support the child and the carers. Although these discussions are not comprehensive assessments and do not involve the children, they are nonetheless an effective means of understanding the support needs of children and their carers in the absence of a Tier two service.

This is an example of innovative practice.

- 4.12 IHAs and RHAs of children and young people placed in out of area placements are managed by the specialist looked-after children's nurse, with issues being raised with the designated nurse for looked-after children when necessary. Although the designated looked-after child nurse operates a payment by result and poor quality assessments are returned to the assessor, it is acknowledged that this system is not yet sufficiently robust (**Recommendation 2.13**).

Management

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

5.1 Leadership and management

- 5.1.1 The establishment of the MASH over the past year demonstrates positive partnership working between the local authority, health and Police to ensure children and young people are kept safe. We saw that arrangements are working well in the MASH at this stage of its development. Health have a permanent presence through NELFT practitioners, operating on a rotational basis. This is best practice, ensuring good support to practitioners working in what can be an intense environment. Adult mental health is a 'virtual' partner at the MASH via IT links. Secure emails are used to share information successfully and alerts pertaining to adult mental health are shared efficiently.
- 5.1.2 All key health agencies are members of the LSCB. The multi-agency performance panel is new to the LSCB and provides a "deep dive" into section 11 audit outcomes and any other areas that the LSCB wishes to scrutinise. The designated nurse for safeguarding chairs the SCR sub group of the LSCB. We saw evidence of how learning from SCRs and external inspection eg the 2014 CLAS review in Essex has resulted in learning being applied in Thurrock.
- 5.1.3 From a slow start, progress is being made towards developing a strong approach to CSE with an appropriate multi-agency infrastructure in place to oversee and implement the multi-agency strategy and scrutinise and monitor individual cases. A pan-Essex CSE strategy is now in place, the delivery of which is supported by a CSE strategic group and a MASE group chaired by the Head of Children's Services. The designated nurse is a member of MASE. Below this is the risk assessment group (RAG), which replaces the missing children panel. This looks at individual cases of young people who participate in risky behaviours or go missing. Health and social care partners are positive about how this work has strengthened approaches, although there is scope to better secure routine representation from the BTUHT safeguarding team, who attend at the request of the RAG as per their terms of reference, rather than regularly.

- 5.1.4 Designated lead professionals and the GP safeguarding champion demonstrate strong leadership across the health community, clearly working in close co-operation with each other to drive improvement. Named nurses and professionals are accessible to staff to give safeguarding advice and guidance. Practitioners across services spoke positively about the responsiveness of safeguarding teams and how they found their advice and guidance helpful in their practice. We also heard about quality visits to services being undertaken by the designated nurse jointly with a NELFT manager.
- 5.1.5 The safeguarding children's clinical network (SCCN) operating pan-Essex meets monthly to share common issues and good practice. This is helping to drive continuous improvement across the patch and we heard examples of good practice which the designated nurses for both safeguarding and looked-after children had identified through the SCCN and was introducing these into Thurrock.
- 5.1.6 The part-time safeguarding midwife post at BTUHT is an ongoing secondment rather than a substantive post. Given the increasing complexity of safeguarding in maternity services and the need to ensure effective oversight of practice and support to the named midwife and practitioners, the rationale for the impermanence of the post is not clear. Along with the recent reduction in safeguarding team members with the loss of a full-time Band 7 safeguarding midwife and administrative worker, this role's impermanence may impact on the continued development of the safeguarding service within maternity services.
- 5.1.7 The CAMHS service was in transition from SEPT to NELFT at the time of this inspection with practitioners being TUPE'd to the new provider. Inevitably, this was a time of some uncertainty for staff and clients and practitioners and managers were very committed to ensuring continuity of service to patients. This was principally in relation to uncertainties about the locations from which they would be able to access consultations. We were assured that a robust transition plan was in place and managers were working to ensure that sufficient consultation rooms would be available beyond the transition date at the beginning of November 2015.

- 5.1.8 Healthwatch told us of the good partnership working that they see in Thurrock between health and social care services and with Healthwatch via the children's partnership board and local safeguarding board meetings. Healthwatch also reported good relationships with Public Health and Thurrock CCG. They have been and continue to be involved with the transfer of 0-5 services to the local authority as well as being part of the engagement group looking at the future of the services. These include breastfeeding support and Community Mums and Dads and how these can be more effective. Health watch expressed their concerns about the access to CAMHs for young people and gave case examples of young people not meeting service thresholds and therefore falling between services. Health watch are involved in the transition process as CAMHS transitions to NELFT and have a positive view of NELFT's commitment to young people's engagement in the development of the new service.
- 5.1.9 The school health service (SHS) is undergoing a transformation and re-design. This is in response to the implementation of the new service specification from September. Workforce and capacity of the SHS is to be reviewed using nationally recognised methodology. Managers informed us that they predict that this will identify the need for more band 6 staff.
- 5.1.10 There is some inequity in how the SHS provides health support to certain cohorts of young people. They provide universal and targeted services to around 23,000 5-19 year olds on roll at the 10 secondary or 41 primary schools in Thurrock. Service provision includes the pupil referral unit. Those who are home educated are also included although this is reliant on the SHS receiving notification of young people within this cohort from the local authority or other sources. The service is not commissioned to provide a service to 16-19 year olds accessing training or further education in colleges. These children and young people are required to access other health services such as primary care for their health needs. ***This issue has been drawn to the attention of Public Health, Thurrock Council as the commissioner of the SHS.***
- 5.1.11 It is very positive that most of the health services in Thurrock and all but two of the GP practices operate the same electronic patient record system. This facilitates information sharing well and enables practitioners across services to quickly and easily access case record detail to better safeguard vulnerable children and young people.
- 5.1.12 Where SystemOne is not used in some GP practices, there are reported problems with GPs being notified of safeguarding issues in a timely manner, such as being invited to a child protection case conferences or not being aware that an ICPC had been conducted or what was the outcome. There are concerns that some children registered at the practice are therefore not flagged as vulnerable and the GPs contribution to discussions is being missed (***Recommendation 4.5***).

- 5.1.13 GPs we visited value the GP safeguarding leads forum and attend when possible. The establishment of this forum and the leadership to primary care demonstrated by the strong presence of the GP safeguarding champion, designated doctor and CCG designated professionals for safeguarding and looked-after children is very positive. The routine attendance by the local authority's Head of Children's Services is also a real strength. The forum gives GPs a chance to discuss issues with strategic leads and primary care peers and keep up to date with changing practice, taking this back to share with practice staff. The forum provides a good opportunity to support the embedding of the CAF referral across primary care and we saw one CAF referral example which could be used as an exemplar.
- 5.1.14 There is a strong leadership structure in the school health service with junior and non-registered staff being supervised effectively by band 6 staff and operational leads. This is a positive contributory factor in the service being able to demonstrate that improved practice resulting from learning from serious case reviews (SCRs) has become embedded.
- 5.1.15 The looked-after child health steering group is a key forum for driving improvement in the provision of effective health care for looked-after children, with membership including foster carer representation. A foster carer told us that they valued the group and felt listened to: their suggestion of a medication booklet for looked-after children has been taken up and these are being issued to young people. The Thurrock looked-after child nurse hot desks one day per week in the local authority. This is supporting the development of a whole system approach across social care and health although this is not yet sufficiently developed.
- 5.1.16 Addaction Visions case recording has safeguarding issues and risks as a standing item for each client contact. This is a positive inclusion as it should serve to prompt practitioners to routinely consider, record and act upon any emerging risks to children or unborn children. We did not see routine and robust analysis of emerging risks to children in cases in practice however and operational governance of practitioner's recording and safeguarding activity is significantly lacking in rigor. ***This has been drawn to the attention of Public Health, Thurrock Council as the commissioner of the adult substance misuse service.***

5.2 Governance

- 5.2.1 It is good governance practice that all datix entries made by NELFT practitioners are reviewed by the trust's safeguarding practitioners who give instant feedback or advise the practitioner to send information to other professionals or to make a safeguarding referral, if this has been missed. This is helping to develop individual practitioners' practice and drive continuous improvement. NELFT's recent provision of a single point of access to a duty safeguarding advisor is also very positive; supporting staff well in their safeguarding risk assessment and activity through prompt recourse to knowledgeable advisory staff.
- 5.2.2 BTUHT paediatric ED practitioners are aware of how to make referrals to the MASH if they have any concerns about the safety of children and young people. A copy of the referral form is copied to the trust's safeguarding children's team, which quality assures all referrals. Feedback on the quality of referrals is provided on an individual basis and any referral that is deemed to be lacking in detail is amended and more information is added by the safeguarding team. This is good managerial oversight on referrals to children's social care, which should help to ensure that children and young people are safeguarded well, with any learning points being shared with practitioners to facilitate continuous improvement. However, despite this monitoring, the referrals we saw were variable in terms of the quality of information and how clearly the practitioner had articulated their concerns (**Recommendation 3.8**).
- 5.2.3 Basildon & Thurrock University Hospital NHS Foundation Trust has strengthened its governance of child safeguarding practice since the 2012 joint inspection, although there is scope to further strengthen operational arrangements. Weekly consultant led safeguarding teaching sessions include learning from safeguarding cases. The safeguarding paediatric peer assessment review (SPPEAR) meeting, led by the named safeguarding doctor and attended by the multidisciplinary team, including social workers is also held on a monthly base. We saw minutes from this meeting, which demonstrated professionals coming together to safeguard vulnerable children and young people. This is good practice as the meeting is a useful way of ensuring that children and young people are being safeguarded through a multi-professional approach.

- 5.2.4 The named doctor for safeguarding at BTUHT chairs a twice monthly directorate of quality, innovation and patient safety (QIPS) meeting. The meetings are minuted and items discussed include: safeguarding supervision, action plan progress, general children safeguarding best practice, lessons learned from incidents and staff training and support. This provides a good governance forum, however daily operational practice monitoring and monitoring and review of all under 18 years presentations at the ED is currently less robust. QIPS oversaw a review audit of safeguarding practice which was undertaken in 2014. The aims and objectives of the audit were to review case notes of identified child protection cases against Lord Laming's recommendations and compare practice at the hospital against national recommendations. Conclusions from the audit included examples of good practice and cases where there were clear areas for improvement identified. One example of an identified improvement area was that 26% of cases; including fractures, bites and burns were not discussed with social services. This is a very high percentage, given that these were children known to be on child protection plans who were not discussed with children's social care at the time of their ED attendance. Recommendations from the review included always ask any verbalising child for their account for their attendance at children's accident and emergency. Regular audits provide a valuable strand of governance, but without effective operational monitoring of day-to-day practice to ensure there is minimal risk of issues or expected actions being overlooked, governance arrangements cannot be considered to be fully robust.
- 5.2.5 At the time of this inspection, BTUHT did not have a paediatric liaison in place. Although this role is not a mandatory requirement it can often act as a highly effective "back stop" or safety net when in place in acute settings. The role is used to provide, in best practice examples, a daily review of all under 18s cases attending the ED with an additional role in monitoring the assessment of potential hidden harm to children in adult ED. This can be highly effective in minimising the risks of child safeguarding issues being missed. The trust recognised this as a gap and was in the process of advertising for a part time health visitor paediatric liaison nurse. In the meantime, the role of the paediatric liaison was being covered by the trust's safeguarding named nurse team, although it was not clear whether they were able to review all presentations given their other responsibilities. Additionally, CAMHS staff told us they felt that the absence of a paediatric liaison function at BTUHT ED had led to less effective coordination between the mental health crisis team and the paediatric ward (**Recommendation 3.9**).
- 5.2.6 In cases where there is suspected fabricated induced illness or non-accidental injuries, an information safeguarding advice leaflet is given out to parents, which sets out professionals responsibility when safeguarding children and young people. There is no signage, however, in the paediatric waiting area at BTUHT to inform young people and adults attending with them that information obtained might be shared with other services, including children's social care. (**Recommendation 3.10**).

- 5.2.7 There is no effective or robust quality assurance framework in place to govern the quality of IHAS and RHAs although we did not identify any significant concerns with the quality of examples we reviewed. The specialist looked-after children's nurses do review documentation to ensure it is completed by health visitors and school nurses but this is more a process assurance than picking up issues of quality (**Recommendation 2.13**).
- 5.2.8 The use of a customised RHA template in tandem with British Association of Adoption and Fostering (BAAF) documentation on the case record system is a positive introduction since the last inspection in 2012. It enables information on the previous assessment to be used by the practitioners to inform the assessment they are undertaking, reducing the risk of health reviews being episodic in nature and enabling good continuity. The template is detailed, including body maps, BMI and growth centile charts which are completed for the child. This is good practice.
- 5.2.9 However, in the looked-after child health records, we found that the lack of a clear coding and naming convention for looked-after child specific documentation makes it difficult to quickly and easily access key documents. This does not support the establishment of an effective audit process and performance and quality assurance framework as practitioners and managers cannot easily locate key documents in the case record.
- 5.2.10 We also found that practitioners were not recording significant events for the child consistently in the relevant section. In cases reviewed in looked-after children's health we found that practitioners were recording and updating the journals of the children's SystmOne record. However, information recorded here was not consistently added to the safeguarding node of children's records. In some services, the changing needs of children were not fully reflected in the special notes template. In the SHS there was appropriate use of flags overall to alert staff to known risks or vulnerabilities of children, but when reviewing a looked-after child's record, we noted that the looked-after status of the child was not flagged on the system. On further investigation, it transpired that this young person was not known to be LAC as this was a young person placed in Thurrock from out of borough and this had not been notified to NELFT by the local authority (**Recommendations 2.14 and 2.15**).
- 5.2.11 In health visitor records reviewed, we saw that records were often descriptive and did not always articulate concerns or risks with sufficient clarity. Outcomes following visits were not clear and were embedded within the assessment template. This makes identifying plans of care difficult and does not facilitate effective managerial oversight of progress or practitioner practice through the case record. Where plans were being identified they were not always SMART. **These issues have been drawn to the attention of Public Health, Thurrock Council as the commissioner of the health visitor service.**

- 5.2.12 Health visitors record any significant events in the safeguarding node on SystmOne, although we were told that the effective use of the safeguarding palate is down to individual practitioners with no routine managerial oversight being in place. We were told that a recent audit has been completed, which identified a need to train practitioners further. An action plan is reported to be in place to address this although it is not clear whether this will also address the gap in managerial oversight of practice as reflected in the case record through regular case recording monitoring. ***This issue has been drawn to the attention of Public Health, Thurrock Council as the commissioner of the health visitor service.***
- 5.2.13 The named midwife and safeguarding team lead and prioritise safeguarding within the maternity services at BTUHT. The team has a strong impact on governance, management oversight, audit and quality assurance which has resulted in the development of robust safeguarding processes, and standardised practice. There is a clear governance structure and regular meetings ensure safeguarding issues within maternity services are reported appropriately to the trust senior management and board. The safeguarding team is available to provide ad hoc staff for advice and guidance to staff. The safeguarding team's office provision ensures that trust staff and multi-agency colleagues and the team are able to openly discuss sensitive issues in a secure and private setting.
- 5.2.14 We felt that the 'huddle' meeting held on the paediatric assessment unit (PAU) at BTUHT is a positive, regular forum which facilitates effective information sharing and early risk identification. We were able to observe one of these meetings, which gave practitioners a 'snapshot' oversight of current cases on the unit as well as cases expected to arrive. Similarly, the weekly meeting held between the safeguarding team, ED managers and practitioners and twice monthly directorate of QIPS (quality, innovation and patient safety) meeting chaired by the named doctor, contributes well to governance within the trust.
- 5.2.15 While school nurse services add flags to the client record system for young people on plans, flags are not removed or the child's status changed efficiently if risks reduce and the child's at risk status is down-scaled.
- 5.2.16 South Essex Partnership University NHS Foundation Trust has a robust safeguarding governance structure in place. This included formal safeguarding discussion at executive and board level where safeguarding issues and significant events affecting the trust are discussed. There is also a dedicated safeguarding working group that meets monthly and manages ongoing safeguarding actions, training compliance and the development of practice for particular themes such as FGM and CSE. Safeguarding is also a standing agenda item on all senior management team meetings and this ensures that the progress of individual or complex cases is monitored at an appropriate level.

- 5.2.17 In all CAMHS records examined we saw that child and family consultation service case notes were comprehensive and detailed. Interventions with children, young people, parents and carers were filed in attendance order and clearly articulated meetings, discussions and agreed actions. Files seen were divided into clear sections which means practitioners reading case files can obtain important information with minimal delay.
- 5.2.18 CAMHS client records were wholly paper based at the time of this inspection, however the service would soon be moving to using SystmOne electronic records in line with many other services in Thurrock. We were advised that plans for data transfer were well advanced with 'live' records being prioritised for transfer first and non-live records thereafter. It was acknowledged that there would be a period of time where both paper and electronic records would be in use but there was a clear plan in place to keep this to a minimum with a single person delegated to ensure records are appropriately converted.
- 5.2.19 In SEPT's adult mental health service a 'Think Family' approach was not clearly be evidenced other than in conversation with practitioners. We reviewed cases in which practitioners considered risks to children and young people in the care of adults living with mental health issues, and we heard good practice in discussion. However, case records showed that identified risks and recommendations arising from core groups or child protection case conferences were not always clearly written into client care plans and risk assessments (**Recommendation 1.3**).
- 5.2.20 The patient record system in adult mental health is relatively new. It is not easy to navigate and practitioners cannot currently input directly into it. Child protection and other documentation essential to ensure effective guidance to practitioners working with complex cases and a comprehensive case record where children are vulnerable or known to be at risk were not well secured. There is also no agreed system in place to ensure like-for-like documents, such as client care plans, are stored in the same place within a client record and practitioners, when asked to find documents that they told us existed, could not find them. This is not acceptable and increases risk that essential information will be overlooked. Effective recording practice monitoring by operational managers is not in place (**Recommendation 1.4**).
- 5.2.21 We found variation in the quality and provision of care plans on the adult mental health electronic client record system and it was not always possible for practitioners to locate the current care plan in place for their client. A robust care planning process subject to effective operational monitoring and oversight is an essential component of best mental health service delivery and safeguarding practice (**Recommendation 1.5**).

5.2.22 The GUM and contraception and sexual health service provided by NELFT is being integrated. The introduction of the new, stand-alone IT system will mean that practitioners will have access to all important sexual health records of young people living in Thurrock, which could help build on integrated working in order to improve services for young people. Currently SRH uses SystmOne, in common with many health services in Thurrock and GUM uses the stand alone system, Lilley Blythe. It is to be hoped that the ability for the service to access and share information will not be compromised by any future change in IT system.

5.3 Training and supervision

- 5.3.1 Most health practitioners undertake level 3 safeguarding training commensurate with their role responsibilities, subject to managerial oversight and compliance monitoring. However, for the most part, this is training provided by the individual provider and while multi-disciplinary, lacks the multi-agency component that would make it fully compliant with guidance. (**Recommendation 6.1**).
- 5.3.2 Midwives are specifically identified within the intercollegiate document 2014 as requiring multi-disciplinary, inter-agency level three training at specialist level (a minimum of 12-16 hours over a three year period). We were advised that midwives at BTUH hospital fulfil the learning hours required as they attend mandatory safeguarding children training annually and compliance is monitored. Competencies are reportedly in line with the intercollegiate document however the training received by midwives is single agency only and therefore training is not fully compliant with the intercollegiate document. Multi-agency training opportunities are available via the LSCB but midwives are not currently required to attend this training which is a missed opportunity to better understand the roles and responsibilities of other agencies involved in safeguarding children work and also promote the principles of working together (**Recommendation 3.11**).
- 5.3.3 A weekly Band 7 meeting with the safeguarding children's team takes place at BTUHT children's ED, where good or sub-optimal practice in relation to safeguarding children is discussed. A 'learning conversation' then takes place with the individual practitioner concerned. This is a useful forum facilitating continuous practitioner development.

- 5.3.4 Health visitors are appropriately required to undertake level 3 safeguarding training every year. This is being delivered in-house and the training is currently multi-disciplinary but is not multi-agency. We were informed that the trust is not currently accessing the multi-agency level 3 safeguarding training provided by the LSCB. Ensuring that level 3 training comprises a multi-agency component is an expectation of *Working Together 2015* and Intercollegiate Guidance and therefore this is a gap for NELFT. ***This issue has been drawn to the attention of Public Health, Thurrock Council as the commissioner of the service.***
- 5.3.5 The current midwifery preceptorship programme for recently qualified practitioners does not include safeguarding competencies which would aid the learning and development of newly qualified midwives; duly prioritising this essential element of their role at an early stage of their professional career (***Recommendation 3.12***).
- 5.3.6 Newly qualified health visitors are well supported through a 12 month preceptorship period based on the national health visiting preceptorship programme. We heard that the preceptorship consists of scheduled dates throughout the year for peer group meetings, chaired by a community practice teacher (CPT). Newly qualified practitioners are also allocated a mentor, based in the same office for additional support and guidance. Mentors will support practitioners at child protection conferences and ensure that reports produced for conference are of a good standard.
- 5.3.7 Newly qualified school nurses are also offered preceptorship that is competency based in line with best practice. At the time of the inspection, there was no school nurse CPT in post to support student or newly qualified school nurses. However support and supervision followed the long arm model often seen in health visiting. The current provision in the SHS consists of students and newly qualified school nurses being supported by a qualified school nurse mentor with long-arm supervision from a health visitor CPT. This is a pragmatic solution to ensure that practitioners going through preceptorship are well supported.
- 5.3.8 We heard that mentors will assess safeguarding competencies of newly qualified practitioners, however currently there is no formal documentation. It is important to formally document safeguarding competences as it can help practitioners understand, demonstrate and build their knowledge and awareness of good safeguarding practice. ***This issue has been drawn to the attention of Public Health, Thurrock Council as the commissioner of the health visitor service and SHS.***
- 5.3.9 The NELFT safeguarding team attend preceptorship group meetings for newly qualified health visitors and share examples of good and poor CAF referrals. This supports newly qualified practitioners well in developing their understanding and skills in making effective referrals.

- 5.3.10 Safeguarding training for practitioners in Addaction Visions adult substance misuse service is set at level 2. This is unacceptable and requires urgent attention. Practitioners must be trained to level 3 in order to discharge their responsibilities in safeguarding the child while working with the adult and it was clear from case evidence that practitioners are working with clients and families requiring a high level of safeguarding awareness, knowledge and competence, only supported by level 3 training. Operational managers require higher levels of training in order to understand and recognise both good and poor safeguarding practice and discharge effective governance. ***This issue has been drawn to the attention of Public Health, Thurrock Council as the commissioner of the adult substance misuse service.***
- 5.3.11 Staff at MIU Orsett hospital are required to undertake level 2 training and compliance is good, however this is not compliant with the requirements of the inter-collegiate document and does not equip staff sufficiently to discharge their safeguarding responsibilities (***Recommendation 2.16***).
- 5.3.12 Training for health visitors and school nurses who undertake the RHAS for looked-after children is good and competency based with practitioners not able to undertake health reviews until trained. We were informed that the training was being reviewed at the time of this inspection.
- 5.3.13 School nurses told us that they have not undertaken mental health training to support their practice for some time. Given the paucity of Tier 2 support for young people in Thurrock, and that the SHS is commissioned to provide Tier 1 and Tier 2 support, a good understanding and ability to support emotional and low level mental health needs well in the school health service is essential. Supervision of these cases which would also provide an essential strand of support to practitioners is also not routinely offered. ***These issues have been drawn to the attention of Public Health, Thurrock Council as the commissioner of the school nurse service.***
- 5.3.14 In SHS, safeguarding supervision is regularly provided by operational leads on a one to one and ad hoc basis as necessary and we saw evidence for this in case records we reviewed. The case record is reportedly quality assured as part of this process. We found scope, particularly in regards to complex cases, to involve the trust's safeguarding team on occasion in individual practitioner's supervision to give expert insight. In one complex case this may have aided the practitioner and operational manager's development of clear identified actions and expected outcomes for the child and the SHS.

- 5.3.15 The BTUHT named midwife receives safeguarding supervision from the designated nurse every three months, but in recognition of the stressful and sometimes difficult issues around safeguarding work, the trust also funds private monthly supervision sessions ensuring the post-holder is well supported. Group safeguarding supervision is offered within the maternity department of the BTUH as well as practitioners having good access to safeguarding advice and guidance on an ad hoc basis. However, community midwives do not currently benefit as caseload holders from in depth one-to-one supervision sessions in accordance with Working Together 2015. This would ensure practitioners have the opportunity for a degree of professional challenge in individual cases and strengthen the trust's continuous improvement and professional practice governance arrangements (**Recommendation 3.13**).
- 5.3.16 The health visiting operational leads receive a monthly training report, and are proactive in reminding practitioners when they need to book onto mandatory safeguarding training. We were informed that training is discussed monthly at the team meeting, and individually with practitioners at one-to-one meetings every 4-6 weeks.
- 5.3.17 Health visitors have good access to additional training, including CSE, learning from serious case reviews and domestic violence and harmful practice, which currently incorporates FGM. This training is not mandatory however, but we were told that all safeguarding supervisors have accessed it. It is important that practitioners are accessing specialist training relevant to their role in order to ensure that they are up to date in relation to safeguarding children and providing families with appropriate support, guidance and advice. Given the growing issue of CSE nationally and FGM locally, ensuring all health visitors and school nurses have undertaken training on these topics, is a training priority.
- 5.3.18 Operational leads in SHS have recently completed an audit around the use of the safeguarding sections of SystemOne. An outcome NELFT identified following on from their audit, involves the offer of further training to staff on using SystemOne. This could be strengthened further with an expectation that staff must attend the update training. **Areas for development set out in paragraphs 5.3.14 and 5.3.17 and 5.3.18 have been drawn to the attention of Public Health, Thurrock Council as the commissioner of these services.**

- 5.3.19 Health visitors are expected to access one-to-one safeguarding supervision every 3 months in line with best practice and this is monitored by the management team. Safeguarding supervision is led by the supervisee however, and therefore cases for discussion are identified by the individual health visitor. There is currently no clear management oversight of children looked after, CIN or child protection through supervision or other governance arrangements and the reliance on health visitors to identify cases to raise at supervision, presents a potential risk. For health visitors undertaking regular RHAs on particular children, LAC supervision is provided but again, there does not appear to be a benchmarked process. The existing model is driven by individual practitioners based on their expertise, competence and the complexity of the case. Without a review of all cases on a caseload on a regular basis there is a risk that emerging health needs and safeguarding risks may be missed. ***This issue has been drawn to the attention of Public Health as the commissioner of the health visitor service.***
- 5.3.20 Health visitors complete an electronic safeguarding supervision template on the information system, which prompts the practitioner to discuss key issues and concerns and identify actions that need to be taken following the supervision. In records reviewed, we saw the safeguarding supervision template being used consistently where practitioners had identified a case for discussion; however actions identified were not SMART.
- 5.3.21 All CASH practitioners have accessed in house multi-professional level 3 safeguarding training subject to effective monitoring arrangements.
- 5.3.22 CAMHS and adult mental health practitioners are trained to safeguarding children level three in line with SEPT expectations. Monitoring processes were in place to measure uptake and at the time of this inspection, CAMHS level 3 training was at 93% , just below SEPT's target of 95%.The training although not multi-agency is multi-disciplinary and is adapted according to local and national trends. It has been approved by the LSCB, however there is more to do to ensure practitioners benefit from multi-agency training to be fully compliant with guidance. CSE training delivered by NSPCC trained named nurses from SEPT was delivered to CAMHS practitioners earlier this year.
- 5.3.23 Adult mental health and CAMHS safeguarding supervision forms part of clinical supervision and was held both individually and in peer groups. A record was kept separately of client notes regarding discussions held and decisions made. This is not best practice and we did not see any evidence of safeguarding supervision and resulting decisions being recorded in client electronic records (***Recommendations 1.6 and 2.17***).

5.3.24 There is a good safeguarding support structure in each CAMHS team with a dedicated safeguarding champion being available for support, advice and guidance. Safeguarding champions take part in quarterly champions meetings where they are apprised of developments and benefit from additional guest presentations. This helps to ensure that staff in the CAMHS teams have access to up to date information to support their safeguarding decision making and practice.

Recommendations

1. Thurrock CCG should work with Castle Point and Rochford CCG and South Essex Partnership University NHS Foundation Trust to:

- 1.1 Ensure there are effective processes in adult mental health to notify health visitors and school nurses of the service's involvement with cases where there are potentially vulnerable children
- 1.2 Ensure that adult mental health relapse indicators and crisis plans are routinely shared with other professionals, subject to client consent, to facilitate early recognition of and response to deteriorating parental mental health thereby safeguarding children and young people effectively
- 1.3 Ensure that a Think Family model of service delivery is clearly demonstrated in adult mental health through care planning, practice and case recording
- 1.4 Ensure that the adult mental health patient record system is able to provide a complete client record, fully reflective of practitioner decisions and actions and in which child protection and other key documentation in relation to the client and family is properly secured
- 1.5 Ensure care planning, review and operational practice monitoring is robust in the adult mental health service
- 1.6 Ensure that case records include a record of the case being discussed in supervision and what decisions and actions have been agreed in order that individual young people's records are comprehensive
- 1.7 Ensure that governance of the quality of referrals to the MASH is effective in raising the overall quality

2. Thurrock CCG and North East London NHS Foundation Trust to:

- 2.1 Ensure that MIU documentation sets out prompts and triggers that facilitates clinicians in demonstrating that the potential risks of hidden harm to children are fully considered when treating adults, subject to effective governance arrangements
- 2.2 Put in place documentation and processes at the MIU in order that practitioners are well supported in their assessment of risk when treating children and young people, subject to effective governance
- 2.3 To work with Thurrock Council to explore the potential need for specialist health visitor roles to meet the needs of cohorts known to be vulnerable

- 2.4 Put in place a specialist perinatal mental health service in line with NICE guidance
- 2.5 Work with West Essex CCG to ensure that risk assessments in the Emotional Wellbeing and Mental Health Services (previously CAMHS) are routinely reviewed within expected timescales and subject to effective operational governance arrangements
- 2.6 Ensure the assessment of potential risks of exploitation to young people accessing GUM and sexual health services are comprehensive, inclusive of the potential for FGM and reflective of the voice and demeanour of the child
- 2.7 Work with West Essex CCG and Thurrock Council to ensure Emotional Wellbeing and Mental Health Services engagement with formal child protection processes is in line with best practice, embedded and subject to effective operational governance
- 2.8 Work with Thurrock Council to establish efficient processes whereby notifications of children coming into care are conveyed to the looked-after children's health
- 2.9 Work with Thurrock Council to ensure that the performance monitoring of the timeliness of initial and review health assessments is effective, based on accurate, agreed shared data
- 2.10 Ensure that the voice of the child is included in initial and review health assessments as appropriate
- 2.11 Work with West Essex CCG to ensure that Emotional Wellbeing and Mental Health Services routinely contribute to the initial and review health assessments of looked-after children with whom they are working
- 2.12 Work with Thurrock Council to ensure parental health history and the reason for the child becoming looked after is routinely secured in documentation at the outset of the child entering the care system
- 2.13 Put in place effective arrangements to quality assurance initial and review health assessments for looked after children, including those who are placed outside of Thurrock
- 2.14 Ensure that a clear coding and naming convention for looked-after child documentation is in place on the case record information system and that looked-after children are flagged as a having higher level of vulnerability
- 2.15 Ensure that the special notes template in the information system is used effectively to include the changing health needs of the child
- 2.16 Ensure that staff at the MIU undertake level 3 safeguarding training in line with their roles and responsibilities and fully meet the requirements of the intercollegiate guidance.

- 2.17 Ensure that case records include a record of the case being discussed in supervision and what decisions and actions have been agreed in order that individual young people's records are comprehensive
 - 2.18 Ensure that governance of the quality of referrals to the MASH from is effective in raising the overall quality
 - 2.19 Ensure that written reports to child protection case conferences are submitted routinely and to a consistent standard
- 3. Thurrock CCG with Basildon & Brentwood CCG and Basildon & Thurrock University Hospitals NHS Foundation Trust should:**
- 3.1 Ensure that young people aged between 16-18 attending the ED are subject to paediatric documentation
 - 3.2 Ensure that the notifications of children's, young people and adults' attendance at the ED sent to GPs and community health services routinely set out sufficient information to facilitate optimum decision making about any follow-up actions necessary to safeguard children
 - 3.3 Ensure that women are made aware that they will be seen alone at least once during pregnancy and incorporate this into the antenatal appointment care plan
 - 3.4 Ensure that inter-service liaison meetings between midwifery and health visitor teams are embedded to support consistent effective information sharing and cohesive multi-disciplinary practice
 - 3.5 Work with Thurrock Council to establish an effective process by which Child in Need cases are flagged on the trust's information system
 - 3.6 Ensure that ED documentation sets out appropriate prompts and trigger questions to best support staff's assessment of the potential for hidden harm to a child when adults present as a result of risky behaviours
 - 3.7 Ensure that practitioners make effective use of the CSE toolkit to inform their assessments of whether a child or young person is at risk of exploitation
 - 3.8 Ensure that governance of the quality of referrals to the MASH from the ED is effective in raising the overall quality
 - 3.9 Ensure that there is sufficient paediatric liaison capacity to support best safeguarding risk assessment and practice in the ED and facilitate effective communication and co-operative working between hospital and community services

- 3.10 Ensure that all patients attending the ED are informed about the hospital's policy on sharing information with other agencies
- 3.11 Ensure that midwives undertake multi-agency safeguarding training to ensure full compliance with Intercollegiate Guidance
- 3.12 Develop the preceptorship programme for midwives to include safeguarding competencies
- 3.13 Put in place safeguarding supervision for midwives that fully supports practitioners in the discharge of their safeguarding responsibilities in line with best practice

4. NHS England and Thurrock CCG should:

- 4.1 Work with the Walk-in Centre to put in place documentation and processes in order that practitioners are well supported in their assessment of risk when treating children and young people, subject to effective governance
- 4.2 Work with GPs to ensure consistent GP practice in enabling health professionals' access to patient information stored on information systems held in common across services
- 4.3 Work with GPs to ensure that vulnerable families meetings involving health visitors and school nurses take place in GP practices on a regular basis
- 4.4 Work with the Walk-in Centre to ensure the risks of CSE are considered when children and young people access the service
- 4.5 Work with Thurrock Council and primary care to ensure that all GPs are routinely notified of child protection processes, decisions and required actions in a timely way

5. NHS England and Thurrock CCG and North East London NHS Foundation Trust should:

- 5.1 Work with primary care to ensure that GPs have a good understanding of the role and responsibilities they play in the provision of good health care for looked-after children and unaccompanied asylum seeking young people and that they contribute routinely to initial and review health assessments

6. Thurrock CCG should:

- 6.1 Work with the LSCB to increase capacity, access and uptake of level 3 multi-agency safeguarding training

Next steps

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

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