

Review of health services for Children Looked After and Safeguarding in Southend-on-Sea

Children Looked After and Safeguarding

The role of health services in Southend-on-Sea

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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 Southend-on-Sea. 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 NHS England area teams.

Where the findings relate to children and families in local authority areas other than Southend-on-Sea cross-boundary arrangements have been considered and commented on. Arrangements for the health-related needs and risks for children looked after and 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 76 children and young people.

Context of the review

The majority (96.0%) of Southend-on-Sea residents are registered with a GP practice that is a member of NHS Southend Clinical Commissioning Group (CCG).

Published information from the Child and Maternal Health Observatory (ChiMat) 2016, shows that children and young people under the age of 20 years make up 23.7% of the population of Southend-on-Sea, with 23.1% of school children being from a minority ethnic group.

On the whole, ChiMat data shows that the health and wellbeing of children in Southend-on-Sea is mixed when compared with the England average. Southend-on-Sea was significantly better than the England average for 11 of the 28 applicable indicators but significantly worse than the England average for three of the 28 applicable indicators.

A&E admissions for zero to four years were considerably lower than the England average. Hospital admissions caused by injuries in both children and young people are in line with or better than the England average but children in poverty and hospital admissions for mental health conditions are significantly worse than the England average.

The Department for Education (DfE) provides annual statistics of outcome measures for children continuously looked after for at least 12 months. The DfE reported that as at 31 March 2015, Southend-on-Sea had 160 looked after children who had been continuously looked after for at least 12 months (excluding children in respite care). As at 31 March 2014, there were 20 children aged five or younger who had been looked after for at least 12 months.

The DfE data indicates that 90.6% of Southend-on-Sea's looked after children received a dental check-up, which is better than the England average of 85.8%. 90.6% of looked after children had received an annual health assessment which is better than the England average of 89.7%. The percentage of children whose immunisations were up to date was 71.9% which is significantly worse than the England average of 87.8%.

A strengths and difficulties questionnaire (SDQ) was used to assess the emotional and behavioural health of looked after children in Southend-on-Sea. The most recent average SDQ score of 14.8 is considered to be borderline cause for concern and is slightly above the England average of 13.9. The average score has increased since 2014 which suggests that the emotional health and wellbeing of looked after children in Southend-on-Sea may be deteriorating.

Commissioning and planning of most health services for children are carried out by NHS Southend Clinical Commissioning Group, NHS Castle Point and Rochford Clinical Commissioning Group and Southend Borough Council.

Commissioning arrangements for looked-after children's health are the responsibility of NHS Southend Clinical Commissioning Group and the looked-after children's health team, designated roles and operational looked-after children's nurse/s, are provided by NHS Southend Clinical Commissioning Group and South Essex Partnership University NHS Foundation Trust.

Acute hospital services are provided by Southend University Hospital NHS Foundation Trust.

Health visitor services are commissioned by Southend Borough Council (Public Health) and provided by South Essex Partnership University NHS Foundation Trust.

School nurse services are commissioned by Southend Borough Council (Public Health) and provided by Southend Borough Council (Public Health).

Contraception and sexual health services (CASH) are commissioned by Southend Borough Council (Public Health) and provided by South Essex Partnership University NHS Foundation Trust.

Adult substance misuse services are commissioned by Southend Borough Council and provided by Change Grow Live.

Child and Adolescent Mental Health Services (EWMHS) are provided by North East London Foundation Trust.

In-patient mental health services at Poplar Adolescent Unit at Rochford Hospital are provided by South Essex Partnership University NHS Foundation Trust.

Adult mental health services are provided by South Essex Partnership University NHS Foundation Trust.

The last inspection of health services for Southend-on-Sea's children took place in June 2012 (published in July 2012) as a joint inspection with Ofsted of safeguarding and looked after children's services. 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 spoke with several looked after children during our review and they told us:

“My health journey (booklet) is good because it documents all of your health info and jabs since you were a youngster”.

“I had a health assessment and had to travel to Southend. Journey took about two hours and then the appointment was only for ten minutes, it was a waste of time, we could have at least met half way”.

We also spoke with care leavers. They told us:

“I feel confident something would have been done if I had any problems”.

“My foster carer knew about everything we discussed in my health checks, but as I got older she didn’t sit in on them any more”.

“I knew my LAC nurse since I was five years old; it was a yearly catch up really”.

“I never thought the health assessments were needed, other children don’t have to have them, I felt singled out”.

“All my health checks were done at home, I would rather have had them done at the GPs, it was a bit disruptive for the rest of the house when they were done at home”.

We spoke with several foster carers who told us:

“I can contact the looked after children’s nurse between health reviews. If I leave a message they always get back to me. I have had condoms and sexual health kits dropped off to the house by the looked after children’s nurse”.

“Cannot fault the medical side of looked after children”.

“There are difficulties in young people accessing mental health services. Problems are at the front door in getting a referral and then waiting a long time for assessment”.

“Nurses do more thorough medical health assessments than doctors. Nurses incorporate chat into assessments. Doctors do a tick box exercise and send them home”.

“If a young person does not attend their first appointment for an IHA another appointment is sent out. If they don’t attend that appointment it is documented that the young person refused the assessment. The young person did not refuse the assessment they just don’t want to go where the doctor wants them to go”.

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 The children's emergency department (ED) at Southend University Hospital NHS Foundation Trust (SUHFT) is open from nine am to 10pm every day and the department is staffed by qualified paediatric nursing and medical staff. This ensures that children and young people are seen by clinical staff with appropriate skills at all times.
- 1.2 A paediatric liaison health visiting function is well embedded in the ED at SUHFT. This post is provided by South Essex Partnership Foundation Trust (SEPT) but co-located with the hospital safeguarding team. The paediatric liaison health visitor (PLHV) maintains close links between ED practitioners and community child health teams. ED attendances of all children and young people up to the age of 16 are reviewed by the PLHV who ensures that relevant information is appropriately shared with community colleagues. For example, all attendances of children under five are shared with the health visiting team through the electronic patient records system used by SEPT. Similarly, all attendances of school aged children and young people are shared with the school nursing service if there are any concerning features such as young people who attend with self-harming behaviour or children who have fractures. This effective joint working and information sharing ensures that children up to the age of 16 years who would benefit from early help are followed up by other health providers.
- 1.3 The PLHV also alerts community child health teams to concerns about children of, or who are known to adults who attend ED with behaviour that may be harmful to the child. This includes adults who have mental ill-health, have experienced domestic abuse or who misuse substances. However, this system relies on ED practitioners making a referral to the PLHV, so there is a risk that not all children and young people associated with such adults are flagged for her attention. (**Recommendation 1.5**)

- 1.4 The generic paperwork used in the ED means there are no additional prompts to ensure key information is recorded when a child or young person attends the department, such as who has parental responsibility, the name and relationship of the person accompanying the child, their school or siblings details.

Age specific paediatric triage documents are available for use within ED, but in the cases we reviewed these were not routinely used.

Although the next of kin was documented in most cases we looked at, it was not clear whether the next of kin was a parent, whether they had accompanied the child or what their contact details were. Commonly, the person shown in the clinical notes as accompanying the child was recorded as 'mum' or 'dad' without any other means of identifying them.

Recording this information relies on individual practice and its variability indicates that staff are not clear of the importance of capturing this information to consider risks, opportunities for early help or to determine who can provide valid consent. (**Recommendation 1.1**)

- 1.5 The maternity workforce at SUHFT is supported by three specialist midwives; a substance misuse midwife, a midwife for teenage pregnancies and a perinatal mental health midwife. As well as carrying their own speciality caseloads, the midwives provide support and guidance to community case-holding midwives working with vulnerable women who require additional care. This ensures that the skills and competencies of community midwives in identifying and supporting vulnerable women are maintained.

We saw evidence of effective input from specialist midwives in the care of vulnerable women resulting in positive outcomes. For example, in one case where a woman had disclosed that she regularly smoked cannabis and wanted help to stop, we saw that the substance misuse midwife had been involved and had facilitated work with the substance misuse service to support this woman's request.

- 1.6 In health visiting we saw that new birth visits, follow up of ED notifications, domestic incident reports and transfers-into caseload from other areas all occur within expected timescales allowing for timely assessment and early identification of need for children and families.

- 1.7 Liaison between the maternity and health visiting services requires strengthening. Health visitors are not reliably notified of a pregnancy and in some cases only become involved with a family following receipt of a birth notification. This limits the opportunity for early contact and support for families, as well as joint working. We are aware of ongoing work by the professional leads of both services to improve liaison and increase the opportunity for health visitors to provide early targeted antenatal contact. **(Recommendation 2.1)**. *This issue has also been drawn to the attention of Public Health, as the commissioners of the health visiting service.*
- 1.8 When the notification of pregnancy process is effective, parents can be seen up to three times antenatally by a health visitor depending on the family's needs. This allows for early support to be offered in situations such as the transition to parenthood and for a meaningful relationship to be developed with the family.
- 1.9 We are encouraged by the pilot MECSH (maternal early childhood sustained home visiting) programme. This is a voluntary structured home visiting programme offered from the antenatal period until a child is two years of age. In health visiting records where families were engaged with the pilot, we saw evidence of increased offers of support and focussed work around attachment, behaviour and parental mental health. Impact on outcomes is as yet unclear as although the pilot has ended no local outcome data is currently available.
- 1.10 Families accessing the health visiting service benefit from a variety of early help offers including 'Positive Parenting' and 'Delta Early Parenting' programmes plus weaning workshops which all empower parents to make healthy choices for their children. Universal health services, such as baby clinics, are held in children's centres which can facilitate access to other early help services that families may otherwise not be aware of or have the confidence to use.
- 1.11 Our review of cases showed that multi-disciplinary working between health visitors and other professionals such as midwifery, adult mental health and GPs is under developed, one example is given below. Working together with other appropriate professionals aids timely information sharing, joint working and the provision of cohesive support for children and families. **(Recommendation 3.1)**. *This issue has also been drawn to the attention of Public Health, as the commissioners of the health visiting and school nursing services.*

A woman was 35 weeks pregnant when a health visitor completed joint home visit at the request of a perinatal emotional wellbeing service (PEWS) worker. The woman had four year old twins who were living with their father. Concerns were raised during the home visit regarding the mother's presentation; she was slurring her words and did not know how many months pregnant she was.

Poor home conditions were noted, including an opened bottle of alcohol on the floor.

Hand held maternity records indicated that the mother had missed her last antenatal appointment. It was not clear in the maternity records whether the midwife had any concerns, and there had been no antenatal communication between the midwife and health visitor.

The health visitor completed a referral to children's social care. However, we saw no evidence of any liaison with midwifery services to share information, advise them of the referral, review whether this is a change in presentation for this lady or plan any future joint working.

- 1.12 We saw evidence of health visitors using NICE guidance to inform their assessments of maternal mental health at the six to eight week postnatal visit and at other contacts if required. Children and families are also benefiting from a thorough assessment of needs at the five mandated visits carried out by the health visiting team. For example, at the new birth contact there was clear documentation of discussion and recommendations around safe sleeping guidance and family's individual risk factors, such as smoking. This interaction is essential in empowering parents to make informed safe choices for their children.
- 1.13 Families living in accommodation for homeless people are benefiting from timely assessment of their needs from the health visiting service. In one case reviewed, the health visitor had seen and assessed a family who had transferred in to the area before being notified by the originating area that they had moved. This is expediting early referral to appropriate services for these vulnerable families.
- 1.14 Schools and parents have universal access to the school service via fax, telephone and school referral. School nurses have relationships and opportunities with schools to see children identified by core school staff who may have concerns around a child, and appointments are made accordingly. However, we were told that due to staff capacity pressures, school 'drop-ins' have ceased so there is limited opportunity for unscheduled contact with a child.

- 1.15 Only children specifically with a child protection plan and a health concern or unmet health need have an allocated school nurse. School nurses prioritise attendance at safeguarding meetings for this cohort of children. School nurses are therefore limited in their universal offer as their focus is on the child protection arena. (**Recommendation 9.1**). *This issue has also been drawn to the attention of Public Health, as the commissioners of the school nursing service.*
- 1.16 Regular liaison between school nurses and primary care has also ceased but this is reportedly also due to concerns around information sharing when a child is not subject to a child protection plan. This approach does not facilitate multi-disciplinary working. (**Recommendation 10.1**). *This issue has also been drawn to the attention of Public Health, as the commissioners of the school nursing service.*
- 1.17 School nurses are reviewing domestic abuse incident reports within five days of receipt and considering their impact on the child. There was clear documentation as to how an incident was informing their plan of care and all children's records seen were appropriately flagged (domestic abuse and child protection plan). This practice is affording children timely follow up.
- However, in other records examined it was not clear how information such as notification of ED attendances were actioned or contributing to any plan of care. (**Recommendation 9.3**). *This issue has also been drawn to the attention of Public Health, as the commissioners of the school nursing service.*
- 1.18 The mental health service for young people in Southend-on-Sea has been undergoing a service transformation programme as a result of re-commissioning in 2015 and as part of a larger programme of work by the provider throughout the remainder of the Essex area. Young people and their parents were asked how they felt the service should be configured at a series of engagement events, one of which was in Southend-on-Sea. As a result of this, the provider now offers a service that is intended to be more focused on emotional wellbeing as opposed to mental ill-health. In order to reinforce this, the service has replaced the traditional Child and Adolescent Mental Health Service (CAMHS) descriptor with the rebranded title 'Emotional Wellbeing and Mental Health Service' (EWMHS), a term that we have therefore used throughout this report.

- 1.19 The EWMHS offer is now centred around four main pathways; behaviour and conduct, mood and anxiety, neurodevelopmental health and complex mental ill-health needs. The intention is to reconfigure the service to devote resources to provide more opportunities for early intervention and therapeutic work to prevent the development of more complex or acute mental ill-health. For example, the provider is to pilot a behaviour drop-in service through the latter part of this summer. Further, all clinical staff have been provided with laptops so that they can see children and young people in locations that are more convenient for them such as GP practices and children's centres. Staff are able to record their interactions in a timely way to ensure records are contemporaneous. Lastly, the provider supports schools to identify ways in which young people's emotional needs or anxiety can be better managed by the training of school facilitators. However, the impact of these initiatives is yet to be fully evaluated at the time of our review.
- 1.20 The implementation of a children's single, weekday contact point and an out of hours crisis contact point has given young people the ability to self-refer to EWMHS through a simple route. Further, digital media developments through the provider's work with an external, web-based support resource have resulted in a more accessible service for young people and enhanced the opportunities for early help. This means that young people can access self-help and third sector support in a format that suits their needs and lifestyle.
- 1.21 The EWMHS provider has recently begun an initiative to benefit young people referred into the service and those referred into the local authority's early help team. The EWMHS manager has weekly meetings with the service manager of the early help team in order to improve the assessment of young people and thereby contribute to a more accurate or targeted approach to early intervention. Once again though, the impact of this has yet to be assessed at the time of our review.
- 1.22 The sexual health service in Southend-on-Sea is accessible to children and young people over the age of 13 and this includes contact with young people within the education community. The sexual health practitioners delivering the service within schools have access to electronic records to support continuity of care, record keeping and identification of risk and needs in offsite locations.

- 1.23 In sexual health services, we were informed that emergency contraception is available to young people over the age of 13 and there is no charge to clients when this is prescribed by pharmacies. Pharmacies keep a record of clients which is shared with the sexual health service, so that young people under the age of 14 or who are potentially vulnerable can be fast tracked within the service to appropriate care and support.
- 1.24 In Southend-on-Sea the rates of teenage pregnancy are slightly higher than the national average. To increase awareness of the sexual health service in relation to pregnancy prevention, the service has developed links with the areas family nurse partnership, teenage pregnancy midwife, and delivered educational sessions within local schools.
- 1.25 Most initial referrals to the adult mental health service are made via a GP or other health professional. Returning patients can also self-refer. The target is that once a referral is accepted clients are seen within 14 days. We were told that the 14 day target is usually met and that there are contingencies in place to manage increased demands on the service. Adults in Southend-on-Sea benefit from timely access to adult mental health services.
- 1.26 The adult mental health service provides a crisis resolution team which operates eight am to eight pm, seven days per week with the aim of preventing unnecessary hospital admissions or to work on a process of early discharge from hospital for their clients.
- 1.27 With the exception of perinatal mental health workers, the adult mental health service uses a stand-alone electronic patient record and staff do not have access to other electronic systems or prompt access to shared information. We saw that the system's alerts are used on client records, but these are scant in detail and do not clearly identify risk to children.
(Recommendation 4.1)
- 1.28 Perinatal mental health staff complete a home visit as part of their initial assessment and many of their subsequent contacts are also carried out in the home environment. This enables an assessment of home conditions and the wellbeing of children within a household to be carried out and we saw evidence of this being documented within records reviewed. However, in other areas of the adult mental health service when it is known that a client has parent or carer responsibilities routine home visits are not conducted. This is a missed opportunity to assess home conditions, and the wellbeing of children within a household. **(Recommendation 4.3)**

- 1.29 Adults with alcohol dependence or substance misuse problems are supported effectively by the integrated service provided by Change Grow Live (CGL) locally known as Southend Treatment and Recovery Service (STARS). We saw good evidence of child centred practice based upon a 'think family' model, in both timely initial assessment and in ongoing work with clients who have parental responsibility or access to children and young people.
- 1.30 STARS clients are routinely asked as part of the initial triage whether they are a parent/carer or if they have regular access to children. All adults who are identified as having children are subject to more detailed screening. This process considers risks to children and includes routine information sharing with children's social care. A home visit is undertaken within five days of children being identified as in a home or in contact with a client. This ensures that the needs of children are identified early in the assessment process and their details captured on the patient's electronic record.
- 1.31 We were advised that the interface between STARS and the adult mental health services is variable and an area for development in order to effectively jointly consider risks to children. The presence of mental health difficulties and substance misuse is a known high risk factor in the safeguarding children arena and therefore effective joint working is essential. (**Recommendation 4.2**).
- 1.32 We were informed of a good working relationship between STARS and the specialist midwife from SUHFT in work with pregnant clients who may be difficult to otherwise engage in antenatal services. SUFHT and STARS should continue to develop formal partnership working arrangements to ensure the further improvement of service provision for this complex client group, such as the plans for joint maternity and substance misuse clinics which are temporarily stalled.

1.33 As reported, multi-disciplinary communication between relevant health professionals and GPs in Southend-on Sea about vulnerable children and families is underdeveloped, with only sporadic engagement with health visitors and little or no contact with school nurses or midwives. For example, in one GP practice we saw that liaison about vulnerable children was limited to a very short monthly meeting between the health visitor and the practice manager without any clinical input or direction from the safeguarding lead GP.

In another practice, meetings with the health visitor did not take place despite the efforts of the practice to engage the health visiting service. Neither practice had regular liaison with the school nursing or maternity service other than routine pregnancy booking notifications. This significantly limits the effective use of primary care information to safeguard vulnerable children and means that GPs are unsighted in much key information about vulnerable families. (**Recommendation 3.1**). *This issue has also been drawn to the attention of Public Health, as the commissioners of the health visiting and school nursing services.*

2. Children in need

- 2.1 The ED pathway for children and young people is child focused except for the initial reception. Children and young people coming into ED are booked in at the main reception; they wait in the adult waiting area until they can be seen by a GP from the South East Essex Doctors Service (SEEDS) who carries out the triage assessment. Thereafter, children are either seen and treated by the SEEDS GP or are taken to the paediatric ED to wait in more child focused surroundings. We acknowledge that children are prioritised for triage by the SEEDS GP; however, this still means that children and young people wait in an adult area for a period of time. (**Recommendation 1.11**)
- 2.2 Once children and young people have undergone triage and are directed to the paediatric ED at SUHFT, the waiting area is well designed and equipped and decorated in a child focused way. A one-way window affords a view from the nurses' station into the waiting area. This enables any deterioration in the physical, emotional or mental health of children and young people to be identified and addressed. Older children and young people, particularly those with more demanding emotional or behavioural needs are offered the use of an adolescent's room in which has equipment that is age appropriate. Young people who are, for instance, awaiting an assessment by EWMHS can wait in this area in comfort and avoid the more anxiety provoking environment of the main paediatric waiting area.
- 2.3 The arrangements for providing emotional support to young people who attend ED with harmful behaviours is variable dependent upon the age of the young person. For example, young people under 16 years of age who have medical needs are admitted to the paediatric ward for treatment and once medically fit they are assessed by a clinician from the EWMHS. Young people over 16 years of age without medical needs are assessed in the adolescent area of the children's ED. Out of hours (nine pm to nine am) young people are assessed by the on call mental health junior doctor, if required they remain on the paediatric ward until the EWMHS crisis team can follow up on ongoing needs the next morning. There are robust arrangements for assessing risk to the young person or to other children on the ward. An 'Enhanced Observation Assessment' tool supports staff to determine the level of support and monitoring the young person needs whilst on the ward.

However, the arrangements for young people aged 16 and over are not robust or supportive. The Mental Health Act 2007 and the recommendations of the Crisis Care Concordat (2014), call for young people under 18 to have access to crisis care and to be accommodated in an environment suitable for their age. At SUHFT, young people aged 16 or 17 remain in adult surroundings until such an assessment can be made. In two recent incidents this has resulted in young people being accommodated overnight in an adult medical ward in one instance, and in the ED in another. In the first case, the EWMHS assessment did not take place until the afternoon following admission which resulted in significant problems with the discharge arrangements for this young person. We consider this timescale to be unacceptable.

We acknowledge that this particular case was raised as a significant incident and has resulted in ongoing discussions between SUHFT, the adult mental health trust (SEPT), EWMHS (NELFT), the CCG and the local authority in order to reach agreement about a suitable pathway and appropriate accommodation for young people aged 16 to 18. We understand a local agreement is now in place. (**Recommendation 5.1**)

- 2.4 In maternity services at SUHFT, we saw that during their initial ante-natal assessment pregnant women are asked whether they have experienced domestic abuse. Their response is noted according to a numbered code that signifies whether they have disclosed current or historic abuse or have declined to answer. An additional code indicates that the question was not asked because of the presence of the woman's partner at the time of the assessment. We learned that there is no scope to record whether this question is asked again during subsequent visits, which is not in line with the Royal College of Midwives who support routine enquiry into domestic abuse throughout pregnancy and the postnatal period. (**Recommendation 1.2**)
- 2.5 There is no mandatory policy to ensure women are seen alone (that is, without her partner/friend/family member being present) at least once during the ante-natal period as recommended by NICE. This limits the opportunity for women to discuss sensitive health or social problems including domestic abuse. (**Recommendation 1.3**)
- 2.6 We understand that SUHFT intends to carry out an audit on their approach to domestic abuse as part of the forthcoming year's audit programme, but there remains a current risk that key information is being missed and that follow-on action required to meet the needs of a vulnerable woman, an unborn or new-born baby is not being taken.

2.7 The EWMHS provider has developed a training programme for children's centre staff to enable them to deliver short focused work with parents of pre-school children, in relation to attachment and achievement. We learned that this programme has been well received and has begun to form the basis of achievable objectives for parents of children subject to child in need plans. We have been advised that the delivery of this training is currently on hold whilst further training programmes are being developed.

2.8 Sexual health, outreach, reproduction, education (SHORE) successfully gained the tender to provide contraception and sexual health services in Southend-on-Sea with effect from 1st July 2015. SHORE was the result of a coalition of services from SUHFT, Kingsley Ward Centre (SEPT) and Brook. Two locations have been maintained to support the preference of the local population.

However, the hospital and community teams use separate electronic patient records record systems. There is therefore no single record for clients or access to a uniform assessment tool for staff. The systems are not interactive and are reliant on practitioners checking both systems for full information. We were told that the sexual health service is currently in early discussions to adopt one patient electronic record system.

(Recommendation 4.5). This issue has also been drawn to the attention of Public Health, as the commissioners of the sexual health service.

2.9 In sexual health services alert facilities on both systems are underdeveloped and in records seen some of the alerts in place did not correlate with case records, were inaccurate and not reflective of current risks. For example, one record we looked at identified that the young person was subject to female genital mutilation (FGM), but this is not recorded elsewhere within the client records so practitioners are unclear if this is correct information or an error in recording. Record keeping is also disjointed and does not aid practitioners in identifying or assessing need. *(Recommendation 4.6). This issue has also been drawn to the attention of Public Health, as the commissioners of the sexual health service.*

A 13 year old attended an appointment at the sexual health service at SUHFT. No alerts are present on the client's SUHFT record although there are indications within their records that the young person is subject to a child protection plan.

Both electronic patient record systems had to be checked before it became evident that the community sexual health team had referred this young person to the hospital service for sexual health screening due to historic sexual abuse.

Within the young person's SUHFT client record an 'under 18 proforma' had been completed in addition to a 'sexual assault proforma'. The detail within these documents is confusing and unclear. Information is recorded in the wrong sections and at times reads that the young person's abuser is their significantly older current partner. Further exploration of their records clarifies that the young person is not sexually active and their current partner is aged 14 years. The clinical assessment reads that the young person has been sexually active from the age of seven, not explaining that this was due to sexual abuse.

It is not clear in the record if the young person was seen alone for their appointment or was given this as an option.

- 2.10 An increased level of professional curiosity about child sexual exploitation (CSE) and FGM was generally evident within sexual health client records, positively reflecting the recent training provided to staff. We were informed that once a single electronic patient record system is adopted the plan is to incorporate in the system the 'Spotting the Signs: Child Sexual Exploitation' tool.
- 2.11 In adult mental health services the interface with EWMHS is described as good with an established pathway to facilitate the preparation of case transfers for those young people aged over 17 who are likely to need ongoing support from adult services. This is seen as a vital process in enabling young people to adjust to the different style of support offered by adult services in comparison to the family systems models that are generally offered by EWMHS.

2.12 In records examined and following discussions with adult mental health staff, although we did see some individual good practice, overall we did not see enough evidence to satisfy us that safeguarding children is embedded in practice utilising a ‘think family’ approach. Records did not show that checks are made against client’s parenting and caring responsibilities as part of the initial information gathering process. Details of children within a household or for whom the client had caring responsibilities for were either difficult to find within case notes, not recorded or details were sparse or incorrect. Risks to children resulting from adult mental health problems are not robustly being considered. (**Recommendation 4.3**)

3. Child protection

- 3.1 The electronic patient record system used in the ED at SUHFT carries pop-up alerts to make staff aware of any known safeguarding concerns for children who attend ED, such as a child who is subject of a child protection plan or who is looked after by the local authority. Further, receptionists who book in children and young people also carry out a search of the electronic patient records system used by the community health teams (such as health visitors and school nurses) and most of the GP practices in Southend-on-Sea for any similar alerts and the record is marked with a 'SystemOne checked' rubber stamp.

The printed hard copy paperwork that accompanies the child on their journey through the department is then marked with a coloured sticker to alert the clinician in ED that safeguarding information exists. Thereafter, the clinician marks the patient's record to confirm that 'safeguarding information has been considered' with another rubber stamp and signs the record to that effect.

However, no detail is held within the patient's record about the nature of the safeguarding information, how it is considered or what it might mean for the safety of the young patient. In one case we sampled, where a young child had attended with an injury, we saw that a record had been marked in the way described. However, our interview with the practitioner revealed that they had been unable to locate the safeguarding information relating to the alert even though they had signed to say they had considered it.

This means that the alert is ambiguous and provides a future user of the record with a misleading assertion that safeguarding information has been taken account of. We were able to subsequently locate the information with the named nurse and found it to be less significant than first thought, but there remains the risk that more significant information could have been missed. We were assured that in such cases the ED practitioner would use a checklist to ensure that appropriate questions were asked but no such checklist was evident in the patient record.

In our review of further records, we noted that the 'SystmOne' rubber stamp had been used in the case of every child attender but there was no record of whether any information had been found or how the information informed the consultation. In this way the stamp is meaningless to the conduct of the consultation and means that the process is wholly reliant on the professional curiosity of the clinician to identify any risks or matters of concern.

(Recommendation 1.4)

- 3.2 In the ED at Southend University Hospital, the 'think family' approach is not well embedded into practice when adults attend with risk taking behaviours and who might have contact with children and young people. For example, in one case we sampled a young pregnant woman had attended with a threatened risk of miscarriage, the records noted that she had two previous children and a number of previous miscarriages. There was no record of the children's names, their ages, who the father was or whether the woman had a current partner. This was relevant because, on further exploration, we found that the woman had recently attended with a significant overdose when she was said to be depressed. This had not been taken account of during her latest attendance and no potential risks to her children had been explored. We subsequently discovered that the woman's previous children were looked after and so there was no current risk to them of her behaviour or her mental ill-health; nonetheless this demonstrated a failure to make relevant enquiries about potential risks.

In another case a woman had attended in mental health crisis and following an overdose. The assessing mental health team established that the woman had a five year old child living at home but the ED record had limited information about the child or of any risks. No action was taken by ED staff at the time although we have seen that the information has subsequently been passed to the local authority by the PLHV. **(Recommendation 1.5)**

3.3 The professional curiosity of staff at the ED about potential abuse was variable in its effectiveness. For example, in the cases we have mentioned elsewhere in this report there was an absence of such curiosity. However in two other cases we noted good identification by the nursing staff of potential risks to children. In one case, a child who had attended with a head injury was referred to children's social care after the nurse had concerns about the interaction between the parents and the child whilst waiting in the ED, even though the initial history given by the parents had not been concerning. In another case, the nursing staff had escalated concerns about a young child who had repeated attendances with foreign bodies lodged in the nose or ear after an initial referral had been rejected. This case also illustrated the effectiveness of the escalation procedures. However, further work is needed to eliminate this variability and ensure all opportunities to identify vulnerable children/young people are taken and actioned appropriately.

(Recommendation 1.1)

3.4 In maternity services we noted that the referrals made to children's social care were generally of a poor quality in that they did not analyse or articulate risk well and could not often be sourced to original information. For example, in one referral examined we saw that the woman was engaging in particularly risky behaviour which involved the use of drugs and association with people whom were said to have a criminal history. We were unable to establish where this information had come from as it there was no record of it in the maternity file. Further, there was no information about the identity of the other adults in the woman's life or what their criminal history was that had given rise to the concerns. This was consistent with all referrals we saw where information about other people, including women's partners or the fathers of unborn children, parents and siblings was often missing. This information is key in enabling social care to assess the risk to women and their unborn children and its absence does not support effective decision making. **(Recommendation 1.6)**

3.5 Child protection pre-birth conferences are routinely attended by the case-holding midwife or by a member of the trust's safeguarding team if the midwife is unable to attend. We also noted that, where possible, written reports are sent to the local authority so that they can be shared with the family prior to the conference. However, we saw that it was not always possible to provide a written report due to the short notice in receiving the invitation and the ability of the case holding midwife to set aside time to complete such a report. In these cases we saw that a verbal contribution is made to the conference by the midwife who attends. This ensures the conference is always informed of key information from the maternity service and ensures effective midwifery contribution into the multi-agency safeguarding arena and decision making processes.

- 3.6 Record keeping within the maternity department was inconsistent. As detailed in the example below, there was some evidence of good record keeping reflecting good care and demonstrating strong safeguarding awareness and multi-agency liaison. However in other cases poor record keeping made it difficult to understand what contribution, if any, a midwife had made to safeguard an unborn. For example, it was not always clear whether a midwife had attended a core group meeting or not as women's records were incomplete. (**Recommendation 1.7**)

In one case where the multi-agency plan was to seek a care order to remove a new-born baby, the records showed extensive liaison between the perinatal specialist midwife, the acute trust's psychiatric team and the local authority social worker. This ensured that the removal of the baby from the mother's care and her subsequent admission to hospital for her mental health needs was managed in a sensitive and compassionate way

- 3.7 A safeguarding file is held on the maternity ward which contains details about all women who are due to give birth and about whom there are identified safeguarding concerns. Information held in this file contains details of child protection plans, birth plans and relevant contact information for other agencies. This file supports hospital midwives at the time a woman comes in to give birth and ensures that all steps required to keep a new-born baby safe can be taken.
- 3.8 Good quality referrals to children's social care by the health visiting team facilitate timely assessments by social workers. All relevant family details including ethnicity, father's details and address were included on the referrals seen. The reason for referral was detailed and fully described the behaviours that were of concern. This part of the assessment could be strengthened by better analysis and articulation of the risks to the child. The named nurse for safeguarding children has good oversight of all referrals and continues to drive improvement in quality and standards.
- 3.9 Health visitors attend child protection conferences and generally provide detailed, child focused reports reflecting the strengths and difficulties structure of the conferences held in Southend-on Sea, although again analysis of risk could be strengthened. The service is aiming to share conference reports with parents prior to meetings but this is not routinely happening. We were informed that compliance with sharing reports prior to conference has been identified as a concern by the local safeguarding children's board (LSCB) and there is a strategy to monitor improvement.

3.10 Liaison between health visiting and school nursing is weak and means information is not shared when one service has safeguarding concerns about a child and there is a sibling with the other service. For example, in one case we reviewed there are two children in the household, one aged under five and one aged over five. There are multiple concerns including maternal substance misuse and domestic abuse from a number of partners/people involved in the mother's and children's lives. The case has been escalated to an initial child protection conference. There is no evidence that the school aged child has had a health assessment by the school nurse or that the school nurse is aware of the concerns raised by other professionals. The health visitor said she had not contacted the school nurse despite being heavily involved with the family and younger child herself.

The opportunity to work together and ensure all children within a family are supported and protected is therefore being missed. (**Recommendation 11.1**). *This issue has also been drawn to the attention of Public Health, as the commissioners of the health visiting and school nursing services.*

3.11 The transfer of children from the health visiting team to the school nursing team is via electronic transfer unless a child is subject to a child protection plan when the school nurses expect a telephone handover. A template has recently been developed by health visiting to aid transition of cases from health visiting to school nursing but this could be strengthened by further collaboration to ensure it meets the needs of both services.

3.12 We found that school nurses do not analyse or articulate risk well in reports for child protection conferences. Risks were often a list of issues such as 'child's weight', these statements need to be developed to explicitly state what the risks are to the child to aid multi-agency understanding and better inform the safeguarding decision making process. (**Recommendation 9.2**). *This issue has been drawn to the attention of Public Health, as the commissioners of the school nursing service.*

- 3.13 There is inconsistency in the handling and recording of child protection conference information in the school nursing team. For example, we saw that case conference dates were recorded in practitioners diary's but not documented on client records and that invites to child protection conferences were not always brought to the attention of a school nurse. Minutes from child protection conferences are uploaded to the child's records, but school nurses are not always made aware that the minutes have been received. This limits the ability to offer a consistent service to the target group that school nurses are delivering to. **(Recommendation 9.3)**. *This issue has also been drawn to the attention of Public Health, as the commissioners of the school nursing service.*
- 3.14 The standard of risk analysis in referrals for child protection concerns is underdeveloped in EWMHS. In cases we sampled referral forms did not consistently analyse or articulate risks well, relying instead on the practitioner's chronological narrative. This does not enable the recipient of the referral to easily understand the risks of harm as perceived by the practitioner and accordingly make appropriate safeguarding decisions. **(Recommendation 6.1)**
- 3.15 In EWMHS we found that practitioners' ability to identify and act upon risk indicators of significant harm to the children and young people they are supporting was variable. In some cases, such as in the example below practitioners identified concerns and acted upon them appropriately.

In EWMHS we noted that the behaviour of a primary school aged child and the risky behaviour of their parents led to a practitioner correctly identifying concerns of potential of sexual abuse. The child was appropriately referred without any delay to children's social care for a child protection investigation. The resulting reluctance of children's social care to accept the referral and the subsequent escalation of the matter through first line management illustrates the benefit of supportive supervision for the practitioner and the effective application of the escalation procedures. The case is ongoing.

However, in other cases safeguarding awareness and practice was not as robust. For example, in a visit to one GP practice we identified a child whose consultation revealed significant concerns of potential sexual exploitation. On closer examination of the young person's records, notably records that had arisen from an EWMHS consultation, we saw that serious circumstances had been described that showed a clear risk to this young person but a referral to children's social care had not been made because of confusion around the historic nature of the abuse. The issues raised in this young person's case were addressed whilst we were on site.

(Recommendation 6.2)

- 3.16 The 'think family' model is not embedded within the sexual health service. If an adult client is identified as being vulnerable an alert is created within their electronic patient record system to highlight that there are safeguarding concerns. However, details of any children they have carer responsibilities for are not easily visible or well recorded, so it is unclear what, if any, action would be taken to ensure they are protected. ***(Recommendation 4.7)*** *This issue has also been drawn to the attention of Public Health, as the commissioners of the sexual health service.*
- 3.17 We were informed that when a referral is sent to children's social care from the sexual health service, the trust's named nurse for safeguarding children is notified to ensure a degree of quality assurance and oversight of trust wide safeguarding children activity. The referral to children's social care from the sexual health service that we saw was of a good standard in respect of clearly identifying practitioners concerns. Staff advised that if a referral is not accepted by children's social care they would appropriately escalate this through the named nurse for safeguarding children.
- 3.18 Sexual health service staff report they are not invited to contribute to any children's social care meetings and therefore do not share any information they may hold about young people. This is a potential gap as many young people currently have no on-going involvement with health services such as school nursing who could provide relevant information to inform decision making in safeguarding meetings. ***(Recommendation 4.8)***. *This issue has also been drawn to the attention of Public Health, as the commissioners of the sexual health service.*

- 3.19 In adult mental health services the composition of a client's household is not readily identified in the electronic patient record system. Children's details are within the narrative of the assessment and therefore not immediately detectable and hard to find, even when it is known there are children within the family.

Assessments do not demonstrate sufficient consideration of the impact of parental mental health, particularly deteriorating mental health, on the wellbeing of children. The main consideration of the presence of children is how the child represents a 'protective factor' in reducing the parental risk of self-harm. The potential impact on children in a household where there are adult mental health concerns is not being robustly or routinely considered.
(Recommendation 4.3)

- 3.20 Adult mental health managers have a clear expectation that practitioners will attend child protection case conferences and participate in core group meetings. They also were clear that they expect practitioners to submit written reports in advance of conference meetings. Practitioners informed us that they do not always receive minutes of safeguarding meetings but we noted that some practitioners are more persistent than others in their attempts to gain these and to ensure clients' records are complete.
- 3.21 As part of the initial triage process STARS routinely identify adults who have parent/carer responsibility for children. All adults who are identified as having responsibility for children are subject to a detailed assessment which considers risks to those children so that practitioner/client interactions can be planned accordingly to better protect potentially vulnerable children and young people.
- 3.22 Details of all parents/carers who engage with STARS are forwarded to children's social care to seek any additional relevant information held by the local authority. This is good practice as it ensures transparency of inter-agency information sharing at an early stage of engagement. Staff report that the information is not always returned in a timely way but key workers do actively follow up the information sharing requests.
- 3.23 In all cases where it is evident that a client has parent/carer responsibilities, a substance misuse practitioner undertakes a home visit and the expected standard is that this will be undertaken within five days of children being identified as in the home or in contact with the client. In exceptional cases where a home visit is not undertaken the reason why is documented. This ensures that the needs of children are identified early in the assessment process and details captured on the patient record system. This good practice was demonstrated in records seen.

- 3.24 Where STARS clients are identified as having care of or involvement with children under the age of five years, or are pregnant, a safeguarding flag and node is activated on the client's record. The flag remains in place until the case is closed but then remains part of the record along with the safeguarding information. This ensures that historical important information is retained for future use and risk assessment and is good practice.
- 3.25 Staff at STARS attend initial and review child protection conferences as well as core group and child in need meetings as requested. If not able to attend they will provide a report. This means that relevant information is shared in the multiagency forum as part of good safeguarding practice.
- 3.26 There are systems in place to manage safeguarding information streams in the GP practices we visited, including responses to requests for information from children's social care. In one practice in particular, the system was well developed with a tracking and monitoring process supported by weekly protected discussion time between the administrator and the lead GP. This facilitates the ability to discuss the management of information about vulnerable children and ensure that all requests are responded to in a timely way.
- 3.27 Generally, GPs in Southend-on-Sea are unable to attend initial child protection conferences due to clinical commitments and short notice periods, but in each instance a report is submitted to the social worker to enable the health history of children and their families to inform the conference. GPs also respond to requests for information from children's social care for child in need or child protection enquiries.

However, in the records we examined we saw that information is generally returned to children's social care in the form of copies from the electronic patient records system without any analysis of risk or a view as to the significance of health information.

We heard from GPs that there are frustrations about the paucity of information from children's social care accompanying any request for information. Whilst we acknowledge that GPs may be better placed to interpret their health information if they have more understanding of the reason for the enquiry, it is unhelpful to effective and timely decision making processes if bulky health information is simply reproduced from patient records for review by a social worker without any clinical insight.

(Recommendation 7.1)

3.28 The process for making referrals to children's social care is not well understood in GP practices. In one practice we saw that there no referrals for child protection or early help had been made for several years. This is unusual, given the location and demographic population. In another practice, the clear risks of sexual exploitation to one young patient had been identified but there was a delay in ensuring a written referral was made due to a lack of understanding the process. Neither of the practices were aware that they could make use of an abridged version of the multi-agency early help form to facilitate their referrals. (**Recommendation 7.2**)

4. Looked after children

- 4.1 Initial health assessments in Southend-on-Sea are completed by a consultant paediatrician. When the consultant paediatrician's clinic is full, the health assessment can be referred to a GP who has had relevant training. This should be facilitating timely initial health assessments but a proportion of the initial health assessments seen were completed out of statutory timescales. (**Recommendation 8.1**)
- 4.2 We heard from the children's looked after team and foster carers that GPs conducting health assessments offer a flexible service tailored to the needs of a child or young person. For example, we saw one assessment which was, at the request of the young person, completed during a hospital admission. It is best practice that health assessments are carried out in a location of the child's or young person's choice.
- 4.3 Within most of the initial health assessments we examined, there was no evidence of requests for information from the child or young person's GP to inform and support the completion of their initial health assessment. This could impact on the depth of historic information and identification of current health needs. (**Recommendation 8.2**)
- 4.4 In the initial health assessments we examined we saw that the opportunity to capture parental health histories was not gained even when parents were present. This does not support the areas specified in Section one of Schedule one of The Care Planning, Placement and Case Review (England) Regulations 2010 that the child's health history should include, as far as practicable, his or her family's health history and the effect of the child's health history on his or her development. It is also important for care leavers to have access to parental health information to give them sense of their background and own identity. (**Recommendation 8.3**)

4.5 Looked after children and young people do not benefit from an initial health assessment that formulates a meaningful health plan and this can lead to needs not being met. Outcomes for young people cannot be monitored following an initial health assessment as the plans are not measurable and do not always reflect the current health needs of the child or young person. For example, in an initial health assessment for a young baby we saw that there had been maternal substance misuse antenatally. The social care history documented that the baby had been monitored for signs of withdrawal in the special care baby unit. However, the health assessment did not mention the outcome of the monitoring or the impact that maternal substance misuse could have on the child's ongoing health or development.

In another example, for an unaccompanied asylum seeking young person who did not speak English, language line rather than a face to face interpreter was used during the assessment. There was no evidence of any attempt to ask about or document the child's recent experience and how this may impact on their emotional or physical health. The young person was reported to have answered 'no' when asked whether they felt safe and had anyone they could trust or talk to. They were advised to talk to their social worker. In regards to peer and social relationships, there were reportedly no concerns; however the young person had been in the country for four weeks, did not speak any English and did not have access to education.
(Recommendation 8.1)

4.6 We saw that all initial health assessments are quality assured by the practitioner completing the assessment. However, the quality assurance documentation did not correlate with the content of the health assessments. For example, in one case the quality assurance tool stated that during an initial health assessment concerns over a child's learning difficulties were identified, however the corresponding section of the child's health assessment was not completed. There is no additional oversight of the quality assurance process. **(Recommendation 8.4)**

4.7 Review health assessments take place within recommended timescales, are child focussed and tailored to the individual being assessed. The voice of the child was present throughout the assessments, which helps make the review process meaningful for the child or young person. The health assessments could be further developed by ensuring that the health plans are specific, measurable, achievable, realistic and time-based (SMART).

4.8 For review health assessments, we saw that when a request for information from a GP is made in preparation for a child's health review, GPs respond in a timely manner thereby avoiding any delay in the assessment.

- 4.9 Oversight of quality assurance processes for review health assessments is provided through peer review and by the looked after children's nurse. The effectiveness of this process is reflected in the good quality of the review health assessments.
- 4.10 Looked after children placed out of area are offered an equitable service from the looked after children's team through reciprocal arrangements that facilitates timely completion and quality assurance of health assessments.
- 4.11 Children and young people have been involved in the development of a health passport given to young people leaving care. This is a comprehensive document that is completed in partnership with each young person and provides detailed information about their health history, gives advice about health needs and services for future reference.
- 4.12 Looked after children who access unplanned care such as 111 or ED benefit from timely follow up. We heard from the children's looked after team that the paediatric liaison health visitor at SUHFT and shared electronic patient record systems reduce delays in information sharing.

A young person aged 17 years attended SUHFT ED reportedly hearing voices. The young person was assessed by the crisis team, a referral to EWMHS was made and the young person was discharged home to semi-independent living.

The paediatric liaison health visitor at SUHFT shared the attendance with the looked after children's health advisor who contacted the young person and visited them at home. The young person reported that they had previously been referred to EWMHS but following a telephone assessment had not received an appointment which they were expecting.

With consent, the health advisor contacted EWMHS and learnt that because the young person had turned 17 years and six months of age between the assessment and any appointment being offered, their case had been transferred to the adult mental health team. The young person subsequently successfully accessed the adult service for treatment. This case is a good example of the challenges of transition for a young person, timely information sharing and the positive impacts of health assessments being a continuous cycle.

4.13 EWMHS are not commissioned to provide a bespoke looked after children service. However, the EWMHS manager attends the monthly 'acute and complex panel meeting' with the local authorities looked after children team where the needs of young people who are looked after are considered in relation to the appropriateness of any planned placement. This helps to provide an element of assurance about the suitability of placements for young people with emotional or mental health needs.

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 designated professionals within Southend-on-Sea provide expertise and leadership across the local health system to support other professionals and their agencies on all aspects of safeguarding and child protection. The designated nurse and doctor attend the monthly safeguarding committee meetings at SUHFT for example.
- 5.1.2 There are no long term vacancies within the designated safeguarding team and team members feel they have sufficient capacity to fulfil their roles. The stability of the team was viewed as a strength during recent periods of transition and change in the local health economy.
- 5.1.3 The safeguarding children clinical network is a forum for designated professionals to meet regularly and work together to drive improvements in safeguarding and looked after children work across the area. Professionals feel this promotes strong working relationships.
- 5.1.4 The local operational group is a forum for all safeguarding professionals to meet and discuss local safeguarding issues. The group meets quarterly and feeds into the Health Executive Forum (Essex Safeguarding Children Board) and Southend LSCB Executive (Southend Safeguarding Children Board) through attendance and exception reporting.
- 5.1.5 The SUHFT safeguarding team are highly visible and provide advice and guidance to staff to ensure they are supported in making safeguarding decisions. Each referral made by staff to children's social care is copied to the trust's safeguarding team who use a database to monitor progress and ensure the referrer is updated with the outcome. This is important as it improves staff knowledge, competence and confidence in the process.

5.1.6 Elsewhere throughout this report we have commented on the variable record keeping in maternity files examined. In part this is due to the fragmented means of recording information in the service. For example, the initial ante-natal assessment and the woman's ongoing antenatal appointments are recorded in the patient's hand-held notes and these are reconciled with the hospital medical files after the baby is delivered. As well as the hospital medical files, the trust also uses two different electronic databases; a clinical systems record that shows nominal or demographic data arising from the initial ante-natal assessment and an electronic document library where correspondence and files should be lodged. Lastly, the community midwives themselves carry case notes that they use to record their own copies of the antenatal interactions with the woman. We acknowledge that the nature of community midwifery means that the hospital and patient hand-held records are kept separate. However, the integrity of information recorded must be maintained by a system that ensures the records are accurate, complete and faithfully reflect information that is held from one record to the next.

In the referral forms to children's social care that we looked at, we noted that information about safeguarding risks did not appear anywhere in any of the records we had access to. We learned that this information was held in the midwives' case notes that they carry with them and that these are not reconciled with the main hospital notes. We also learned that the practice is to destroy these notes once the baby is delivered. This is not robust record keeping. Whilst action was immediately taken by the trust safeguarding team to ensure this practice ceases, the trust should carry out a review of recording practices to preserve the integrity of information and to ensure an audit trail is maintained for each case and that patient records are complete. **(Recommendation 1.7)**

5.1.7 The EWMHS provider has recognised and planned for an increase in demand for service through its increased accessibility and has therefore embarked on a recruitment campaign that will see significant numbers of new staff take up post. At the time of our visit this campaign had yet to be completed and so we are unable to assess its impact.

- 5.1.8 Southend-on-Sea benefits from the support of a named GP for safeguarding children who works to improve primary care's contribution and liaison across the area. Engagement of GPs in the safeguarding and looked after children arena has reportedly improved since the safeguarding and looked after children inspection in 2012. However, as detailed within this report there is more work to do to ensure GPs are competent in identifying and appropriately responding to safeguarding concerns. (**Recommendation 7.2**)
- 5.1.9 Each GP practice in Southend-on-Sea has a lead GP and they are supported through quarterly GP safeguarding lead forums where individual cases, serious case reviews and information on national and local topical safeguarding issues, such as CSE and FGM is disseminated. This is further supported by regular newsletters issued by the named GP on topical issues and learning from serious case reviews.
- 5.1.10 GPs in Southend-on-Sea predominantly use a single electronic patient records system (SystemOne), the same system used by the community child health teams and EWMHS. Where information sharing agreements are in place GPs have access to the records made by other teams and good use is made of the alerts relating to children at risk.

Although this enables information about vulnerable children to be shared, the absence of formal face-to-face liaison with other health practitioners means that such information exchange is not targeted and relies upon the GP reviewing significant amounts of a patient record to isolate key information. (**Recommendation 3.1**)

5.2 Governance

- 5.2.1 The CCG safeguarding children team works closely with the named professionals in provider services.
- 5.2.2 The chief nurse and designated doctor represent Southend CCG on the 'Southend Safeguarding Children Board'. The designated nurse attends the LSCB executive meetings and there are CCG representatives on all LSCB sub groups.
- 5.2.3 Arrangements are in place to provide assurance to the CCG that providers are compliant with evidence based and locally agreed safeguarding children practice. 'Clinical Quality and Review' meetings take place monthly and are chaired by the executive lead for safeguarding children.
- 5.2.4 All NHS providers are expected to complete an annual self-assessment 'Section 11' audit. These are scrutinised by the CCG safeguarding team and progress against resultant action plans are reported to the relevant quality and governance committees.
- 5.2.5 GPs engagement with a section 11 style self-audit is strong in Southend-on-Sea. The CCG's 2014/2015 annual report states that the latest self-audit of safeguarding practice within Southend-on-Sea's GP practices achieved a good response rate of 88%. The completed safeguarding audits were analysed by the named GP and indicated that further training in the recognition of signs and symptoms of abuse and child development would benefit practitioners in primary care. As detailed elsewhere in this report, the findings from our review re-emphasise this.
- 5.2.6 Safeguarding governance structures are well embedded in SUHFT. The quarterly safeguarding committee meetings are central to this and are attended by key personnel from the trust and are also supported by the designated nurse and doctor at the CCG. The committee maintains oversight of safeguarding policy and operational activity in the trust, reporting internally to the CCG and the 'Quality Assurance Group'.

- 5.2.7 The named safeguarding midwife at SUHFT is also the head of midwifery and has no protected hours for the safeguarding element of the role. However, the day-to-day management and monitoring of safeguarding activity in the maternity department is undertaken by a full time specialist safeguarding midwife who is co-located, and works in collaboration with the trust's safeguarding team. There are clear lines of accountability between the midwives, the specialist safeguarding midwife and the trust's board.
- 5.2.8 Within health visiting, children and families benefit from scrutiny of safeguarding referrals and effective escalation procedures when there is a dispute with regards to the outcome of a referral. If the practitioner making the referral is unable to resolve the issue, the named nurse at SEPT has established lines of escalation and enquiry with social care colleagues.
- 5.2.9 The perinatal mental health team have been using a new patient electronic record system since April 2016 and records are in the process of transferring over from paper to the electronic system. The timeframe for completion of the migration of records is not clear and therefore whilst two systems are being used there is a risk of vital information being missed.
(Recommendation 4.11)

5.3 Training and supervision

- 5.3.1 The CCG advised that safeguarding children training within Southend-on-Sea is in line with the national 'Safeguarding children and young people: roles and competences for health care staff, intercollegiate document, third edition: March 2014' and that all providers have submitted their in house training packages to the LSCB for accreditation, which helps to promote consistent standards across the locality.
- 5.3.2 The expectation of the CCG is that safeguarding children training compliance for all providers is at a minimum of 95%. However, at SUHFT level three safeguarding training compliance is relatively low at 75%. We were advised that this is due to a recent review of the numbers of staff eligible for this training that identified approximately a further 100 staff who required level three training. The annual safeguarding report of 2016 shows that the compliance rate for most departments is around 80% to 84% as at June 2016. However, despite a steady increase since March 2016 the figure for emergency care stands at 49%. Although the trust acknowledges this shortfall, the rate of improvement is slow. With more than half of the relevant staff currently not having been updated, the trust cannot be assured of the general level of competence in emergency care. Some of the key findings during our review echo this supposition. (**Recommendation 1.8**)
- 5.3.3 The SUHFT safeguarding team have arranged a large scale multi-agency study day on FGM for later this year. The trust hopes to increase the level of competence in this area across the partnership whilst providing greater access to level three training for its own staff.
- 5.3.4 Safeguarding supervision in the ED at SUHFT is seen as a challenge and is variable across the professions. Paediatricians benefit from monthly peer review of safeguarding cases, and a consultant paediatrician is on call out of hours for support and guidance. The offer of opportunistic supervision by the safeguarding team provides additional support for issues that arise day-to-day. We acknowledge that staff working in ED do not hold caseloads, however the arrangements for providing regular, scheduled support for staff who have managed or dealt with difficult or upsetting safeguarding situations could be improved from the current offer of bi-annual group sessions. Regular safeguarding supervision offers staff a degree of support and challenge, as well as ongoing learning and development. (**Recommendation 1.9**)

5.3.5 The maternity department staff at SUHFT participate in the same level three safeguarding training as the rest of the trust. The most recent update training has included FGM with additional training in CSE being sourced externally. We learned, however, that there was no specific training in domestic abuse, a key topic for midwives. Although the trust training figures show that 84% of eligible staff in women's and children's services have received level three training, we were advised that it was unlikely that midwives had complied with the requisite number of learning hours over a three year period as specified in the intercollegiate document. Therefore, there is risk of knowledge or skill attrition in key areas of safeguarding practice. (**Recommendation 1.10**)

5.3.6 All caseload holding community midwives receive one-to-one safeguarding supervision every two months from the trust's specialist safeguarding midwife. The midwives are obliged to bring all individual cases involving child protection or child in need procedures to supervision sessions. Midwives can access opportunistic supervision as and when it is required. This supervision model ensures that community midwives are supported in their safeguarding roles.

The specialist midwife makes a full record of all supervision sessions on a separate maternity file note that is held on the woman's hospital based maternity records and also within the safeguarding team section of the trust's shared document storage system. This ensures that there is clear guidance and direction available to any midwife who might use the file whilst supporting the woman during pregnancy or at delivery. It also enables the specialist midwife to keep track of and follow-up agreed actions arising from the supervision and this is good practice.

5.3.7 Health visiting staff in SEPT are compliant with level three safeguarding children training and this is monitored by a training tracker.

5.3.8 School nurses are compliant with level three safeguarding children training and school nursing staff are receiving three monthly one-one safeguarding supervision and can access the safeguarding team at SEPT as required.

5.3.9 The EWMHS clinicians receive safeguarding training at level three which is delivered by the provider's safeguarding team on a multi-disciplinary basis with health workers from other parts of the trust. Recent training topics have included domestic abuse, CSE, Prevent and training in harmful behaviours such as FGM and belief in spirit possession. In addition, all practitioners are required to undertake topical e-learning training.

5.3.10 The EWMHS provider has introduced a new safeguarding supervision procedure across the trust. It is intended that all staff will be required to undergo a 90 minute one-to-one case reflective safeguarding supervision session with a member of the trust's safeguarding team every 12 weeks. However, since the EWMHS staff have historically received only limited safeguarding supervision, the new model is currently being introduced on a group basis. For a young person facing service, group supervision does not provide sufficient opportunities for good quality, individual case reflections or for robust record keeping of supervision discussions. However, we have been assured by the trusts that the one-to-one methodology will be implemented in its entirety by the end of this financial year.

(Recommendation 6.3)

5.3.11 In sexual health services it was reported that all band six staff and above receive safeguarding level three safeguarding children training. Staff at band five and below are only required to complete level two training, which is not compliant with intercollegiate guidance. To ensure all clinical staff have the competencies to undertake their safeguarding children duties they must be equipped with an appropriate level of knowledge. The intercollegiate guidance states that level three training is appropriate for all clinical sexual health staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding or child protection concerns. ***(Recommendation 4.9)***. *This issue has also been drawn to the attention of Public Health, as the commissioners of the sexual health service.*

5.3.12 The safeguarding supervision offer for sexual health staff is biannual group sessions, which could be strengthened by a more frequent offer considering the front line contact this staff group have with vulnerable clients. ***(Recommendation 4.10)***. *This issue has also been drawn to the attention of Public Health, as the commissioners of the sexual health service.*

5.3.13 In adult mental health services all qualified staff are expected to achieve level three safeguarding children training in keeping with the requirements of the intercollegiate guidance. The overall compliance currently stands at 90%.

- 5.3.14 Safeguarding supervision in the adult mental health service is provided by the safeguarding team on an ad-hoc case by case basis. There is a safeguarding lead clinician in each team and staff can also seek advice from the safeguarding team. Management oversight and safeguarding supervision actions or decisions were not evidenced in case notes. The establishment of effective operational governance and quality assurance supports practitioners in delivering best safeguarding practice and facilitates continuous professional development. The absence of this in adult mental health is a gap which raises risk. (**Recommendation 4.4**)
- 5.3.15 In substance misuse services all staff are subject to a comprehensive induction programme and trained to the CGL equivalent of level three safeguarding children training in keeping with the requirements of the intercollegiate guidance and staff receive monthly face to face supervision which includes a safeguarding element.
- 5.3.16 One to one safeguarding supervision is offered by the named nurse to the looked after children's nurses on a quarterly basis. Any member of the team can also access advice and guidance as required. Following formal supervision sessions an action plan is developed by the named nurse, this is uploaded to the child's records. It is the responsibility of the practitioner to ensure the action plan is completed. This process could be strengthened by having greater management oversight to ensure actions are completed.
- 5.3.17 GPs in Southend-on-Sea receive training that meets the requirements of level three of the intercollegiate guidance. This is comprised of a combination of e-learning, pre-course studying and attendance at classroom based learning events co-ordinated by the named GP and based on case discussion. Attendance at such events is monitored by the named GP and we have been assured that all GPs have received the required amount of level three training. However, in our review of the cases we sampled in the practices we visited suggests that basic safeguarding procedures are not well understood and so GPs would benefit from additional knowledge in identifying and referring child protection concerns. (**Recommendation 7.2**)

Recommendations

- 1. Southend University Hospital NHS Foundations Trust should:**
 - 1.1 Implement a robust and age appropriate safeguarding assessment tool for use with all children and young people aged under 18 who attend ED. This should include the social history and background of the child and their family and comply with NICE guidance (*When to suspect child mal treatment, 2009*). Ensure staff understand the importance of capturing this information and monitor compliance with adherence to any new or adapted documentation.
 - 1.2 Assure themselves that midwives are making and recording ongoing enquiries about domestic abuse with all pregnant women to ensure vulnerable women are identified, offered support and where appropriate, safeguarding processes are instigated.
 - 1.3 Ensure that women are seen alone at least once during pregnancy to promote routine enquiry into sensitive issues including domestic abuse, and incorporate this into the antenatal appointment care plan.
 - 1.4 Fully and explicitly document within ED records how the identification of any pre-existing safeguarding information has been considered and informed a consultation with a child or young person under the age of 18 years.
 - 1.5 Implement a 'think family' approach in ED. Establish and clearly record whether an adult is a parent/carer when they attend ED following risk taking behaviours. Assessments should consider the potential or actual impact of an adult's behaviour on their parenting capacity and on any children in a household. A pathway to notify relevant professionals should be developed and compliance with this monitored.
 - 1.6 Develop a robust quality assurance process to improve the standard of maternity services referrals to children's social care. Ensure information contained within referrals is complete, relevant, clearly analyses and articulates risk, relates to the local threshold document and is outcome focused.
 - 1.7 Evaluate records to ensure that maternity staff comply with professional record keeping requirements as detailed in the Nursing and Midwifery Council, *The Code: Professional standards of practice and behaviour for nurses and midwives (2015)*.
 - 1.8 Put measures in place to significantly improve level three safeguarding children training compliance figures in ED and closely monitor to ensure the CCG key performance indicator target of 95% is achieved and maintained.

- 1.9 Review the safeguarding supervision provision in ED to ensure staff have regular access to an appropriate level of professional scrutiny and challenge but also support in fulfilling their safeguarding responsibilities.
 - 1.10 Ensure that the safeguarding children training provision for maternity department staff meets the level, competencies and hours of learning as indicated in the intercollegiate guidance issued by the Royal College of Paediatrics and Child Health.
 - 1.11 Provide an appropriate environment for children and young people who are awaiting triage that accommodates their needs and those of their accompanying parents, carers and siblings.
- 2. Southend University Hospital NHS Foundations Trust and South Essex Partnership University NHS Foundation Trust should:**
- 2.1 Improve liaison and communication between the maternity and health visiting services to ensure an equitable provision of antenatal advice and guidance is offered to all women from both services. Develop a joint working pathway so that midwives and health visitors actively work together to support vulnerable woman and safeguard unborn or new born babies.
- 3. Southend CCG, Southend University Hospital NHS Foundations Trust , South Essex Partnership University NHS Foundation Trust and Southend Borough council should:**
- 3.1 Strengthen and formalise arrangements for liaison between GPs, maternity and the community health teams, including health visiting and school nursing, to ensure that multi-disciplinary exchange of information takes place for vulnerable families, children and young people.
- 4. South Essex Partnership University NHS Foundation Trust should:**
- 4.1 Standardise the utilisation of alerts on the adult mental health electronic patient record system to ensure the information entered is clear, relevant and contains sufficient information to aid staff in considering risks to children within a household.
 - 4.2 Develop liaison and communication pathways between adult mental health services and STARS to improve partnership working when clients who have parent or carer responsibilities are accessing both services.
 - 4.3 Establish a ‘think family’ approach in adult mental health services. All assessments should consider caring responsibilities and the potential or actual impact of an adult’s mental health difficulties on their parenting capacity. This includes fully recording children’s details and undertaking home assessments when appropriate.

- 4.4 Establish effective operational governance and quality assurance to support adult mental health practitioners in delivering best safeguarding practice and to facilitate practitioners' continuous professional development.
 - 4.5 Expedite the transition to a single electronic patient record system within the sexual health service.
 - 4.6 Improve the record keeping standards, including the use of alerts, in sexual health services to ensure client records are accurate, complete and comply with NMC guidelines.
 - 4.7 Establish a 'think family' approach in the sexual health service. Assessments should consider the potential or actual impact of an adult's behaviour on their parenting capacity and on any children in a household. Children's details should be fully recorded along with the decisions made and actions taken to ensure they are safe.
 - 4.8 Work with their commissioner to increase the visibility and contribution of the sexual health services into the wider safeguarding and child protection arena, particularly in relation to young people's risk of CSE.
 - 4.9 Ensure that the safeguarding children training provision for clinical sexual health staff meets the level, competencies and hours of learning as indicated in the intercollegiate guidance issued by the Royal College of Paediatrics and Child Health.
 - 4.10 Review the safeguarding supervision provision in the sexual health service to ensure staff have regular access to an appropriate level of professional scrutiny and challenge but also support in fulfilling their safeguarding responsibilities.
 - 4.11 Until the transfer from paper to electronic patient records in the perinatal mental health team is complete and whilst two recording systems are in place, ensure there are robust processes to ensure practitioners do not miss vital information which may only be held within one system.
- 5. Southend CCG, Southend University Hospital NHS Foundations Trust, South Essex Partnership University NHS Foundation Trust and North East London Foundation Trust should:**
- 5.1 Closely monitor compliance with the local agreement regarding 16 to 18 year olds who attend ED with harmful behaviours. Ensure the agreed pathway is adhered to and that young people are accommodated in age appropriate surroundings.

6. North East London Foundation Trust should:

- 6.1 Develop a robust quality assurance process to improve the standard of referrals from EWMHS to children's social care. Ensure information contained within referrals is complete, relevant, clearly analyses and articulates risk, relates to the local threshold document and is outcome focused.
- 6.2 Ensure practitioners in EWMHS receive sufficient training and safeguarding supervision to enable them to identify and confidently act upon risk indicators of significant harm to the children and young people they are working with. Strengthen the management caseload oversight of EWMHS workers when they are working with children or young people for whom there are safeguarding concerns.
- 6.3 Monitor the planned implementation of the new safeguarding supervision model in EWMHS to ensure that the target timescales are met so staff have regular access to an appropriate level of professional scrutiny and challenge but also support in fulfilling their safeguarding responsibilities.

7. Southend CCG and NHS England should:

- 7.1 Review how GPs can provide patient information in a more structured and analytical way to better aid the receiver of the information in their decision making process.
- 7.2 Ensure that GPs are competent in identifying safeguarding concerns and are able to respond to risk indicators by being clear and confident in the process of referring children or young people to children's social care.

8. Southend CCG and South Essex Partnership University NHS Foundation Trust should:

- 8.1 Improve the quality of initial health assessments to ensure they are undertaken within timescales, are child focussed and accurately reflect the child's health and individual needs.
- 8.2 Ensure that GPs are routinely requested to contribute information to inform initial health assessments for looked after children.
- 8.3 Make every effort to incorporate a looked after child's family's health history in their initial health assessment and include the impact of this history on the child or young person's own health and development.
- 8.4 Review the quality assurance process for initial health assessments to ensure it is robust and accurately reflects the quality of the assessments undertaken and effectively drives improvement.

9. Southend Borough Council should:

- 9.1 Identify a strategy to address the vacancies within the school nursing service to ensure that the provision of services to children and young people is as agreed in the commissioning contract.
- 9.2 Ensure information contained within reports from the school nursing service to child protection meetings are improved to clearly analyse and articulate risk which will aid multi-agency understanding and better inform the safeguarding decision making process.
- 9.3 Develop a clear process and pathway for assessing and acting upon relevant information received into the school nursing service. Ensure that decisions and actions are accurately reflected within children and young people's records.

10. Southend CCG and Southend Borough Council should:

- 10.1 Facilitate appropriate information sharing agreements between primary care and school nursing services to benefit vulnerable school age children in Southend-on-Sea.

11. Southend Borough Council and South Essex Partnership University NHS Foundation Trust should:

- 11.1 Strengthen the liaison and relationship between the health visiting and school nursing services to improve information sharing and promote joint working.

Next steps

An action plan addressing the recommendations above is required from Southend-on-Sea 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.