

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

Children Looked After and Safeguarding

The role of health services in Greenwich

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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 Greenwich. It focuses on the experiences and outcomes for children within the geographical boundaries of the local authority area and reports on the performance of health providers serving the area including Clinical Commissioning Groups (CCGs) and Local Area Teams (LATs).

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

About the review

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

- The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.
- The focus was on the experiences of looked after children and children and their families who receive safeguarding services.
- We looked at:
 - the role of healthcare providers and commissioners.
 - the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
 - the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.
- We also checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, *Working Together to Safeguard Children 2015*.
- Where we found areas for improvement in services provided by NHS but commissioned by the local authority then we will bring these issues to the attention of the local public health team in a separate letter.

How we carried out the review

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

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

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

In total, we took into account the experiences of 96 children and young people.

Context of the review

The majority (90.4%) of Greenwich residents are registered with a GP practice that is a member of NHS Greenwich CCG 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 26.4% of the population of Greenwich with 65.5% of school age children being from an ethnic minority group.

On the whole, ChiMat data shows that the health and wellbeing of children in Greenwich is mixed when compared with the England average. Greenwich was significantly better than the England average for eight of the 27 applicable indicators and was significantly worse for nine of the 27 applicable indicators.

Hospital admissions due to injury and as a result of self-harm for children and young people were lower than the England average. Infant and child mortality, under 18s conceptions and young people's hospital admissions due to substance misuse were in line with the England average. However, children in poverty, family homelessness, child obesity, Accident and Emergency department attendances and hospital admissions for dental caries (age 1yr-4yrs) were significantly worse than the national 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, Greenwich had 370 looked after children that had been continuously looked after for at least 12 months (excluding those children in respite care). As at 31 March 2014, there were 40 children aged five or younger who had been looked after for at least 12 months. The DfE data indicates that 91.9% of Greenwich's looked after children received a dental check-up, which is better than the England average of 85.8%. 93.2% of looked after children had received an annual health assessment which is better than the England average of 89.7% (see comments within main report). The percentage of children whose immunisations were up to date was 90.5% which is better 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 Greenwich. The most recent average SDQ score of 13.7 is considered to be normal and is below the England average of 13.9. The average score has remained relatively consistent and below the England average since 2013. However a slight increase since 2014 to 2015 suggests that the emotional health and wellbeing of looked after children in Greenwich may have deteriorated.

Commissioning and planning of most health services for children are carried out by Greenwich Clinical Commissioning Group (CCG) and the Royal Borough of Greenwich local authority.

Commissioning arrangements for looked-after children's health are the responsibility of Greenwich CCG. Health services for looked after children were commissioned by the Royal Borough of Greenwich on behalf of Greenwich CCG from 1 September 2016 and the looked-after children's health team, designated roles and operational looked-after children's nurses, are provided by Oxleas NHS Foundation Trust.

Acute hospital services are provided by Lewisham and Greenwich NHS Trust.

Urgent Care Centre and out of hours services are commissioned by Greenwich CCG and provided by Greenbrook Healthcare (Hounslow) Limited.

Health visitor services are commissioned the Royal Borough of Greenwich and provided by Oxleas NHS Foundation Trust.

School nursing services are commissioned by the Royal Borough of Greenwich and provided by Oxleas NHS Foundation Trust.

Contraception and sexual health services are commissioned by the Royal Borough of Greenwich and provided by Oxleas NHS Trust and METRO (we did not visit METRO as part of this review).

Adult substance misuse services are commissioned by the Royal Borough of Greenwich and provided by South London and Maudsley NHS Foundation Trust (complex needs), CGL (Change, Grow, Live) under the branding of Greenwich Aspire (non-complex dependent adults) and Lifeline Health Limited (brief interventions service). We visited CGL Greenwich Aspire as part of this review.

Child and Adolescent Mental Health Services are provided by Oxleas NHS Foundation Trust.

Adult mental health services are provided by Oxleas NHS Foundation Trust.

The last inspection of health services for Greenwich's children took place in June and July 2010 (published in August 2010) 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

A parent with a young baby in the ED at Queen Elizabeth Hospital said:

"I was seen quickly, the nurses are very nice and kind. From 1.30 to 3pm the doctor has reviewed my baby twice and I was told about everything that was happening."

Another parent of a toddler said:

"The service we have received here has been phenomenal. The doctor told me clearly what my child's problem was and her breathing has now been stabilised."

Foster carers told us:

"The first engagement with CAMHS was not productive given the young person was not ready.....the LAC assessment was fine.....the LAC nurse is very good and she has re-referred to CAMHS."

"Health visitors and social workers have been very good, but it has taken a long time for us to be able to access specialist help."

"Can't fault the commitment of Greenwich to its looked after children."

“The looked-after children’s nurses are very available and they are really accessible.”

“The health visitor has been really good and helpful, giving us plenty of advice and guidance.”

“We have never been included in the initial health assessments, the social worker always goes in with the child. I think as the foster carer, I should be more involved in the health assessment. I’m not aware we ever get anything back after the assessment.”

“We don’t get enough information about the child’s health or their parental health history when the child comes to us. I think this is important as something might crop up that was known in the parents’ history. The young person should know this as they grow up too.”

A care leaver told us:

“My social worker has been very supportive. People in Greenwich care, they care about what’s going on with you. When you are in a bad situation you can talk to your social worker or others and get help. Annual health checks were good in making sure you had no problems. The Health and Wellbeing Bursary offered in Greenwich is great, I used mine for gym membership.”

A young commissioner said:

“We were treated as young adults and our voices mattered....we made a difference.”

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 paediatric emergency department (ED) at the Queen Elizabeth hospital is appropriately staffed by suitably trained and experienced staff. The paediatric ED waiting area provides a safe and welcoming environment for children and their families and the department accepts children and young people up to their 17th birthday.
- 1.2 People attending the ED benefit from easily accessible support to help them address alcohol, substance misuse and domestic abuse issues. The trust's alcohol and substance misuse team provides follow up support for young people and adults presenting under the influence of alcohol or drugs. The externally funded independent domestic violence advocate (IDVA) based within the hospital provides support where issues of domestic abuse are identified. Frontline ED staff routinely ask questions about domestic abuse in a clear and sensitive manner which is as a result of the IDVA's focused training sessions with staff. Also, good links have been established between the ED and a voluntary sector organisation to support young people involved in gang culture.
- 1.3 Both the urgent care centre (UCC) and the ED at the Queen Elizabeth hospital have appropriate policies and procedures in place for following up children whose parents or carers decide to remove them from the department before being seen and young people who choose not to wait to be seen. Each case is risk assessed and proportionate action taken to ensure the child or young person is safe and well.
- 1.4 We saw in the UCC that consultations are focused on the needs and wellbeing of the whole family; this includes practitioners identifying and recognising the specific needs of children who are young carers.
- 1.5 The Queen Elizabeth hospital ED notifies the child and adolescent mental health service (CAMHS) when a young person engaged with their service attends ED, and these notifications are of excellent quality. They provide detailed information about the young person's presentation, clinical examination, safeguarding risk assessment, outcome and treatment, and importantly, include a copy of any prescription given by the treating clinician.

- 1.6 A paediatric liaison nurse (PLN) employed by Oxleas NHS Foundation Trust and based at the Queen Elizabeth hospital has, until recently facilitated the sharing of information between the ED and community health colleagues. The PLN also screened children's attendances within the department which strengthened the overall safeguarding risk assessment process by ensuring that appropriate actions were taken by staff where concerns were identified. However, this post has recently been decommissioned. This has weakened the oversight and governance of safeguarding risk assessments in the ED as well as the process of sharing information between key services.

Much of the work previously done by the PLN is currently being undertaken by the trust's safeguarding team, which will impact either on the timeliness of the screening of children's attendances in ED or on the team's capacity to fulfil other duties required of them.

Although we are aware of ongoing negotiations between the two trusts to resolve the issue around information sharing, further work is required to agree and embed a risk management system and pathway for sharing information about children and young people who present at the Queen Elizabeth hospital. (**Recommendation 1.1**)

- 1.7 Women can access maternity care in a variety of ways at the Queen Elizabeth hospital, for example via their general practitioner (GP), or by contacting the maternity department by phone. The majority of pregnant women access maternity services through an on line self-referral system.

Women's access to care has recently been streamlined and a new pathway developed which means that women will have contact from a midwife within four days of self-referring for care. The pathway has been successfully piloted and once fully implemented this will be a vast improvement in the timeliness of engaging women into the maternity service, as currently there can be a delay of up to four weeks.

- 1.8 The maternity workforce at the Queen Elizabeth hospital is supported by the 'best beginnings' specialist team of midwives for vulnerable women. These midwives take case holding responsibility for high risk cases, and are available to advise and support midwifery colleagues with lower risk cases. This ensures that the skills and competencies of community midwives in identifying and supporting vulnerable women are maintained.

- 1.9 When a woman books for maternity care at the Queen Elizabeth hospital, their general practitioner is informed of the pregnancy and a request is made for the GP to share any relevant medical or social information they may hold in respect of the woman. Response rates from GPs have recently been audited and although the findings are yet to be analysed, midwifery managers feel that overall the response rate is low. This is a missed opportunity for GPs to share information which may only be known to them, and to work together with maternity services from an early stage in pregnancy to identify and help meet the needs of vulnerable women. (**Recommendation 2.1**)

- 1.10 A comprehensive social risk assessment is completed during the maternity booking process at the Queen Elizabeth hospital; however, this is not formally revisited during pregnancy. It is important that emerging changes in women's lives are captured as early as possible to assess any associated risks and to help identify when women would benefit from the provision of additional support. (**Recommendation 3.1**)
- 1.11 The Oxleas NHS Foundation Trust funded PLN has, until recently, facilitated the sharing of information between the maternity and health visiting services but as previously mentioned, this post has recently been decommissioned. We understand the PLN will continue to provide a level of support until December 2016, however once this support has ceased there is a significant risk that information sharing between these key services will be weakened and women will not benefit from effective co-ordinated care during the antenatal and early postnatal period. We understand that Oxleas NHS Foundation Trust and Lewisham and Greenwich NHS Trust are working to resolve this issue. *This issue has also been drawn to the attention of Public Health, as the commissioners of the health visiting service.* (**Recommendation 1.1**)
- 1.12 This is particularly important as there are currently no routine formal meetings between midwives, health visitors and GPs to discuss vulnerable families. If discussions take place this is due to individual practitioners rather than a formal standardised arrangement. Good multi-disciplinary information sharing helps professional's involved in the care of families work together to ensure that those who have been identified as vulnerable can have their support needs met. *This issue has also been drawn to the attention of Public Health, as the commissioners of the health visiting service.* (**Recommendation 4.1**)
- 1.13 The Queen Elizabeth hospital maternity department has worked hard to engage with expectant fathers and improve how they are involved in the provision of maternity services. This has resulted in changes to the service such as partners now being accommodated overnight on the postnatal wards. This is proving to be particularly beneficial to new mothers who are experiencing low level anxiety issues and who feel much more comfortable with their partner present to help manage their anxiety and help with the care of their new-born.
- 1.14 Health visitors are strongly focused on work around improving health outcomes for children, such as reducing childhood obesity. Targeted work is being undertaken within children's centres to improve parental awareness through education, advice and guidance. The service acknowledges that further targeted work in partnership with local dental services is required to address growing concerns about the poor dental health of children in Greenwich.

- 1.15 In health visiting we saw some effective joint working and information sharing with other agencies, such as adult mental health services, specialist midwives and GPs, to assess and address risks to children. However links between health visitors and adult substance misuse services are under-developed with contact mainly limited to individual children who are subject to child protection plans. There is scope to improve liaison and work together to ensure that children within a household where adults misuse substances are visible, monitored and have their needs identified at an early stage. *This issue has also been drawn to the attention of Public Health, as the commissioners of the health visiting services. (Recommendation 5.1)*
- 1.16 Both GP practices we visited hold regular vulnerable families meetings and we were informed that health visitors attend these. However there are reportedly no specific health visitors linked to these practices so there is no consistency in the practitioner attending. Health visitors advised us that they are aligned to local GP practices and will attend vulnerable families meetings where they are established, but these are not regular occurrences in all practices. There is a lack of clarity and too much variation between what the local policy is and how it is being interpreted and implemented in relation to formal discussions between these two services.

We did see that where health visitor links with GP practices are strong, effective joint working to address risks to children was evident and where such meetings are held, they provide good opportunities for wider discussion about families of concern. *This issue has also been drawn to the attention of Public Health, as the commissioners of the health visiting service. (Recommendation 4.1)*

- 1.17 The school nursing service is offering the Healthy Child Programme for children aged five to 19yrs to all schools in Greenwich and the majority have welcomed school nursing input. It is positive that the school nursing service is offering weekly 'drop ins' to all secondary schools, this supports young people accessing advice in an environment they are familiar with and at a time suitable for them.
- 1.18 The school nursing service is not confident that they currently have details of all the children known to the local authority as being educated at home. The associated safeguarding risks and issues for this group of children have been raised nationally and it is essential that these children are visible to services. Oxleas NHS Foundation Trust are working with the local authority to ensure that a school nursing service is offered to the full cohort of home educated children. *This issue has also been drawn to the attention of Public Health, as the commissioners of the school nursing service. (Recommendation 6.1)*

- 1.19 A new initiative to help improve the emotional wellbeing of young people in Greenwich secondary schools has been established. Following specific CAMHS training, school nurses can provide a short term series of therapeutic sessions for young people presenting with low level mental health needs. The young person can be referred on to CAMHS if it is considered their needs are escalating.
- 1.20 Young people in Greenwich have good access to CAMHS support and most have their mental health assessed well within the service's eight week target with intervention beginning within 12 weeks of their initial assessment. Performance on the timeliness of access to mental health services for young people is rigorously monitored by Oxleas NHS Foundation Trust and the commissioners.
- 1.21 All new referrals to CAMHS are discussed at their daily multi-disciplinary triage meeting where a decision regarding a young person's eligibility for the service is made. Decisions are therefore made promptly and if a young person is not eligible for CAMHS, a letter is sent to the young person and the referrer signposting them to alternative support services.
- 1.22 The relatively newly developed 'Headscape' website offers young people an opportunity to conduct a self-assessment of their emotional health and wellbeing in a format they are comfortable with. The website has been very well accessed and a few young people who have taken the opportunity the site offers to make a self-referral into CAMHS are still engaged with the service.
- 1.23 Young people with experience of CAMHS have informed the development, design and décor of a new mental health unit in Greenwich and have also been involved in developing some CAMHS practice guidance. Young people have also been involved in staff recruitment and the 'Bursting Stigma' group which is an active consultation and young people's support group.

CAMHS initiated a 'physical health clinic' in the summer of 2015, employing a team of nurses who are based in the CAMHS adolescent team in Greenwich.

Nurses help young people look at how their mental health and physical health relate to each other and the service is helping to foster a holistic approach to a healthy body and healthy mind ethos. There are plans for the nurses to undertake some basic health assessment tasks such as electrocardiograms and blood testing and they can deal with minor cuts and abrasions, reducing the need for a young person to access ED or the UCC.

The service has recently been reviewed using the health improvement scale as an outcome measure, and young people are encouraged to complete clinical experience surveys to capture their views of the service.

Managers in the trust overseeing this innovative service are working with Greenwich University, Department of Integrated Care and are hopeful that a paper on the service and outcomes will be published as a result of this collaboration.

- 1.24 Young people in Greenwich can visit the fully integrated open access contraception, sexual health and genitourinary medicine service, in a choice of locations within the borough. This ensures that young people have access to sexual health advice and support in a range of venues that are easily accessible for them.
- 1.25 The sexual health service is extremely flexible in engaging young people in their service and staff will see them at times and locations which meet their needs. For example, clinic hours are mindful of school and college times and young people attending a clinic are fast tracked through the system, which means they are seen and assessed whilst avoiding long waits.
- 1.26 Staff are persistent in their attempts to engage vulnerable young people who miss appointments with the service, and will conduct joint visits with other professionals where appropriate. We saw evidence of sexual health staff visiting young people at home and at school for example.

1.27 It was evident that sexual health staff have good working relationships with professionals in local agencies such as children's social care, education, school nursing, looked after children's nurses and CAMHS etc. although the interface with the local young people's substance misuse service is underdeveloped. Good multi agency working aids timely co-ordinated intervention or support for vulnerable young people and this is a missed opportunity to ensure that young people with substance misuse issues and often other complexities in their lives are offered a clear pathway into sexual health services. *This issue has also been drawn to the attention of Public Health, as the commissioners of the sexual health services.*
(Recommendation 6.2)

1.28 A robust risk assessment tool is routinely used at all contacts with young people under the age of 16 who access the sexual health service and for any 16 to 18 year olds for whom there are any concerns. The tool incorporates questions to prompt practitioners to consider the risk of child sexual exploitation and questions are also routinely asked about alcohol and substance misuse, as well as mental health issues. When safeguarding concerns are identified, the tool includes a flowchart guiding staff on the actions they must take.

This means that sexual health practitioners are assessing potential vulnerabilities of young people at every contact. Collecting and recording important information can also help ensure that where necessary relevant information can be shared with appropriate professionals to improve outcomes for young people.

1.29 We were informed of the involvement of young people in the development of the sexual health service including 'mystery shoppers' and young assessors. Resources for young people were designed with the help of young people and they are also included on interview panels for posts when possible.

This ensures that information produced is relevant to the target population and improves young people's confidence in accessing appropriate care and advice.

1.30 There is more to do to ensure there is consistently close co-operative working between adult mental health and health visiting services in Greenwich and that best use is made of the integrated client record system in Oxleas NHS Foundation Trust. While we did see some examples of good practice, in one case reviewed the health visitor and the adult mental health practitioner were working in isolation from each other. This was at a time when a new mother, identified as being at risk of post-natal depression, was disengaging with services. Elevated indicators of risks were not picked up and acted upon. *This issue has also been drawn to the attention of Public Health, as the commissioners of the health visiting service.*
(Recommendation 6.3)

- 1.31 The 'Time Team' provides good support to mothers with perinatal mental health difficulties. The weekly multi-disciplinary clinic at the Queen Elizabeth hospital enables women developing mental health issues during pregnancy to access appropriate support. However, Greenwich does not have a specialist perinatal pathway under a specialist perinatal psychiatrist which is compliant with national guidance and this is an area for commissioners to address. (**Recommendation 7.1**)
- 1.32 The adult mental health service operates an effective model of caseload risk assessment and cases are reviewed weekly in a multidisciplinary team meeting. When clients of the service become pregnant the case is automatically flagged as high risk. This is good practice, ensuring service managers and practitioners are well sighted on the need to consider safeguarding risks to unborn babies plus the need to liaise with other relevant professionals such as midwives.

2. Children in need

- 2.1 Access to CAMHS advice and support for children and young people attending the Queen Elizabeth hospital ED outside of working hours is limited, which means children and young people may have to be admitted to a paediatric bed to await a mental health assessment. If a bed is not available on the paediatric ward, children and young people remain overnight in the ED to await a CAMHS assessment. This is not appropriate or acceptable practice. (**Recommendation 1.2**)
- 2.2 Young people who are admitted to the paediatric ward with mental health needs do not have their individual needs accurately reflected in their care plans. Lewisham and Greenwich NHS Trust does not have a formal risk assessment tool in place to support young people with mental health needs who are admitted to its paediatric wards. The lack of any formal risk assessment also means that there is no aid for nursing staff to effectively assess, manage or reduce a young person's self-harm risk or any potential risks a vulnerable young person's behaviour may pose to other children within the ward environment. Ward staff acknowledge deficits in their confidence and competences in supporting young people with mental health needs. (**Recommendation 3.2**)
- 2.3 CAMHS recognise the pressure experienced by the Queen Elizabeth hospital's paediatric staff as a result of young people being admitted due to mental health or self-harm issues and are developing a range of ways to support them, some of which are detailed later in this report. One example is that there are plans to develop a CAMHS psychiatric paediatric liaison post which should promote closer liaison between psychiatric or child mental health and paediatric services.
- 2.4 Where vulnerabilities have been identified there is robust oversight and good multi-agency liaison during a woman's antenatal period at the Queen Elizabeth hospital maternity department. Maternity staff highlight concerns or vulnerabilities to the named midwife electronically on a structured proforma to ensure a standardised information sharing process. This could be strengthened by aligning the concerns raised with the Greenwich threshold document.
- 2.5 All cases referred to the named midwife, and all active safeguarding cases are discussed at the weekly multi-disciplinary maternity safeguarding meeting (maternity concerns meeting). This forum facilitates the early identification of risks, promotes good interagency working and sharing of information as well as ensuring all professionals working with a family have an up to date overview of the case including emerging concerns or vulnerabilities.

- 2.6 Pregnant women are not routinely offered the chance to be seen alone at any stage in their pregnancy to discuss possible domestic abuse or other social or sensitive issues. The issue of domestic abuse is raised with women during their booking appointment and at 28 and 36 weeks of pregnancy if women attend on their own. Research widely recognises an increased risk of domestic abuse beginning or escalating during pregnancy and although we were assured overall that processes are in place to support the identification of women who are experiencing domestic abuse this could be strengthened.

Adapting the antenatal appointment care plan to inform all women that at certain visits they will be seen on their own for a proportion of the appointment standardises practice. This would help ensure that vulnerable women have the opportunity to disclose any issues and therefore access early help and support, particularly as the hospital currently has the benefit of an IDVA working on site. (**Recommendation 3.3**)

- 2.7 At Queen Elizabeth hospital maternity department we were informed of and saw within records good liaison with other professionals such as mental health services, social workers and ED practitioners. We saw good evidence of the specialist midwives role in intra and multi-agency liaison which helps ensure that vulnerable women are well supported and receive co-ordinated services throughout their period of care.
- 2.8 We saw within maternity records robust mental health assessments and plans for around the time of birth, covering diagnosis, risk factors, triggers and strategies to manage any problems. It is essential expert services share information which can assist professionals in ongoing risk assessments of women to ensure their safety as well as that of their unborn or new born.
- 2.9 Children's health visiting records do not routinely contain genograms or chronologies. The use of these important tools is under developed within the service. Robust consistent use would help with easier recognition of any increase in risk to children, particularly those who frequently move between areas and consequently health visiting teams. (**Recommendation 6.19**)
- 2.10 Children not brought to their appointments are not easily identified by practitioners across the trust who use the integrated IT system. We heard that work is being undertaken to strengthen the 'did not attend' guidance for staff particularly in relation to the known associated safeguarding risks in failure to attend health appointments. This should assist staff to more easily identify patterns of missed appointments over several services.

- 2.11 School age children who are referred to the multi-agency Fair Access Panel are supported effectively by the school nursing service. This includes unaccompanied asylum seeking children, children within army families who are resettling, children of complex or vulnerable families changing schools and children facing permanent exclusion. The meeting allows the early identification of any health issues, and subsequent liaison with the school nurse so that a care plan can be reviewed or developed at the earliest opportunity.
- 2.12 When children newly register with a GP practice, GPs routinely record the school they attend which is in line with good practice. However, school nursing managers recognise further work is needed to ensure GPs are aware of the school nursing offer. Currently GPs do not know which school a school nurse is linked to and school nurses are not making GPs aware when they are undertaking specific work with children and young people. This does not promote a joint approach to supporting families.
- 2.13 Children and young people who self-harm are benefitting from an effective multi-agency pathway which ensures a co-ordinated respond to their needs. The pathway supports school nurses in the management of such cases and indicates lessons are being learnt following a recent local serious case review (SCR). We saw evidence that use of the pathway and the appropriate multi-agency involvement in case management, resulted in young people being effectively supported.
- 2.14 We saw and heard case examples of vulnerable children being effectively supported by a co-ordinated multi-agency approach. The provision of a substance misuse worker based in the CAMHS adolescent team facilitates close co-operative working between the CAMHS practitioners, Addaction, the youth offending team (YOT) and the gang lead worker.
- 2.15 Most key decisions about CAMHS cases, such as the need to refer a child or young person to additional services or to close a case, are made through discussion with the practitioner's manager or through a multi-disciplinary team meeting. This supports practitioners in their work with complex cases and minimises the risk of drift or poor decision making.
- 2.16 We were told that young people in mental health crisis requiring in-patient treatment can wait for weeks either at home with support or on an acute hospital ward, whilst NHS England special commissioning identify an available suitable placement. This can often be at a significant distance from Greenwich but CAMHS practitioners are creative in using a range of ways of maintaining regular contact with young people, such as skype, teleconferencing as well as face to face visits.

2.17 The sexual health service is appropriately invited to attend multi-disciplinary meetings where it is suspected that young people are subject to child sexual abuse (CSE). These meetings facilitate information sharing and joint decision making about any actions to be taken. Relevant information is placed within a young person's sexual health records if they are active to the service. This is a good opportunity for sexual health practitioners to have access to and also share meaningful information and intelligence, which can support decision making about potentially vulnerable young people at risk of CSE in Greenwich.

2.18 Children and young people in families where there are adults with mental health conditions are safeguarding well. Adult mental health services are being developed on 'think family' principles and this was demonstrated in most cases we looked at. Mental health assessments undertaken by practitioners in the adult mental health service are of good quality; comprehensive and detailed. Where the assessment is of a parent or carer or an adult who has contact with children, priority is given to identifying the needs of the children and assessing the adult's parenting capacity. Assessments of children and young people undertaken out of hours at the Queen Elizabeth hospital were highly child focused and thorough. The level of detailed information obtained demonstrates that practitioners give time to the assessments and are skilled in gaining the trust of individuals, enabling them to share details of often difficult personal histories.

We saw examples in the adult mental health service where practitioners had taken prompt and appropriate action when they had identified safeguarding concerns.

2.19 Adult mental health practitioners routinely share relapse indicators and contingency plans with other professionals and we heard about a number of case examples including one where this had supported effective 'team around the family' multi-disciplinary practice resulting in good outcomes for the children and family.

A woman with a number of children ranging in age from infant to adulthood, had her first contact with adult mental health services in early 2015 following an attendance at the ED with low mood.

Later the same year she was taken into police custody under Section 136 of the Mental Health Act 1983 and admitted to an in-patient mental health unit. She was treated by the ADAPT mental health team due to exhibiting paranoid, chaotic and bizarre behaviour.

The ADAPT pathway provides focused, therapeutic interventions to adults who require care and treatment for Anxiety, Depression, Affective disorders, Personality disorders and Trauma.

We saw evidence of a good assessment by ward clinicians; this was comprehensive and fully considered all potential safeguarding risks to the baby and its siblings. Mother and baby were transferred to a mother and baby mental health unit due to the mother's diagnosis of a severe postnatal depressive episode with psychosis. The mother disclosed that there was ongoing domestic abuse within the family.

Multi-agency concerns around the children were on the edge of child protection proceedings but were successfully managed at child in need level. On discharge from the mother and baby unit, there was a good multi-disciplinary 'team around the family' approach, ensuring the family was supported.

Mother's mental health is now stable. She is no longer in a violent and abusive relationship with the baby's father who has supervised contact with his child. The older children are explicitly benefitting from not living in an abusive household. The team are moving towards discharge from ADAPT at the end of the calendar year and the children have been stepped down from child in need to universal services. The mother has taken lots of courses at the children's centre and is to become a mentor to other women experiencing similar issues.

3. Child protection

- 3.1 Health professionals are essential partners in the MASH process supporting multi-agency information gathering and analysis, risk assessment and decision making. This helps to ensure children are effectively safeguarded or that appropriate help and support is provided in a timely manner.
- 3.2 The health professionals working within the multi-agency safeguarding hub (MASH) benefit from the co-location of several different services, including the CCG and social workers as well as the actual or virtual presence of colleagues from education, police, probation and the youth offending team (YOT).
- 3.3 Children and young people who attend the UCC at Queen Elizabeth hospital benefit from a robust risk assessment being conducted to ensure they are safe. We saw clear systems in place to identify risks to children and young people and these were appropriately acted upon in a timely manner. We saw that practitioners were vigilant to wider family issues including domestic abuse, and we saw one case where a risk of child trafficking was explored. Referrals to children's social care were followed up and information was shared with relevant health colleagues. However, referrals to children's social care from the UCC did not address the child's experience or express the voice of the child, and observations of parenting capacity in almost all cases seen was limited. (**Recommendation 8.1**)
- 3.4 Safeguarding arrangements in the paediatric ED ensure that staff have a clear focus on the vulnerability of children and young people presenting to the department. A safeguarding checklist underpins each ED presentation to support early identification of risk of harm to children and young people. Risks are effectively explored and any identified concerns shared with relevant professionals prior to a child being discharged home. We saw that the trust's safeguarding team have good oversight of referrals from the ED to children's social care.
- 3.5 In the adult ED, appropriate systems are in place and practitioners have a clear focus on identifying risks to children and young people within the households of adults who present with issues which may negatively impact on their parenting capacity, such as following an overdose or mental health concerns.

- 3.6 New families are being discharged home from the Queen Elizabeth maternity department without essential information being shared with health visitors, GPs and community midwives. Pre-discharge planning meetings and resultant plans for ongoing postnatal support were recorded well in the cases seen; however the information was not fully transferred to the electronic discharge summary which is shared with health visitors, GPs and community midwives. The electronic discharge summaries seen contained minimal safeguarding information even when there were clear concerns and additional postnatal support was planned.

This is a missed opportunity to ensure community colleagues, including GPs, are fully aware of all safeguarding issues and also that their safety is considered as many are lone workers entering home environments and are therefore vulnerable themselves. (**Recommendation 3.4**)

- 3.7 Although vulnerable expectant women have clear plans in place to support safe care for them and their unborn infant, these are not always immediately available to other professionals. Plans, along with other pertinent safeguarding information, are not always immediately identifiable or easily located within women's paper hospital records. Although the named midwife ensures safeguarding issues are appropriately flagged on the electronic patient record system, there is a risk that an up to date plan or relevant safeguarding information held in the paper hospital records may be missed which could inadvertently place an unborn at risk of harm. (**Recommendation 3.5**)

- 3.8 It is acknowledged that work around identifying young people at risk of CSE requires development within the maternity department at the Queen Elizabeth hospital. There are plans to include CSE in forthcoming mandatory training sessions for midwives and the local CSE screening tool needs to be adopted and routinely used to aid midwives in this important aspect of work. (**Recommendation 3.6**)

- 3.9 The quality of the referrals we saw from Queen Elizabeth hospital midwifery services to children's social care were variable in quality. Overall, although they shared appropriate information, there was limited analysis of risk, the expected outcome of the referral was not clear and they did not relate or refer to the local threshold document. We were informed that there is a planned audit of the quality of referrals to children's social care about to be undertaken. (**Recommendation 3.7**)

- 3.10 At the Queen Elizabeth hospital midwives are expected to write reports for and attend pre-birth safeguarding meetings. The named midwife is available to support midwives in this aspect of their role if necessary. There are issues around timeliness of receiving invitations to such meetings and this has appropriately been raised with the Greenwich safeguarding children board (GSCB). This proactive action should lead to an improvement in timeliness and therefore midwifery engagement and input into meetings.

- 3.11 Children and families are benefitting from increased awareness of the impact of domestic violence in families through a training programme and the appointment of a new full time specialist domestic abuse health visitor. The specialist health visitor is available to provide advice and guidance to staff as needed and has delivered focused training to all health visitors and school nurses. It is reported that the training has increased practitioner confidence in making routine enquiries around domestic abuse and therefore improved the identification and early involvement of services with families exposed to domestic abuse. We saw evidence of a health visitor's involvement in a particularly complex domestic abuse case. We saw that this was sensitively identified and that the health visitor worked in conjunction with multi agency partners to safeguard the family.
- 3.12 The domestic abuse health visitor specialist practitioner has prioritised the development of joint initiatives with 'Hercentre' (local Women's Aid organisation) and is to facilitate domestic abuse training with Language Connect interpreters and a local churches pastoral and clerical staff. This is good evidence of outward facing work and the importance of raising the awareness of domestic abuse within the local community and forging links with services beyond health.

The role has also enabled close joint working with the local women's refuge and CAMHS on individual cases to support women manage the emotional impact of domestic abuse on children.

A young mother and her three year old child had fled domestic abuse and were living in a local refuge. The child was exhibiting challenging behaviour which mother was finding extremely difficult to manage.

The specialist domestic abuse health visitor was able, together with the refuge worker, CAMHS and the mother to draw up a care plan which included strategies for managing his emotional distress.

Consistent support was offered by all three workers over an eight month period and with time the child's behaviour settled. The mother was encouraged to access therapeutic help which improved her relationship with the child and the cycle of abuse.

The specialist domestic abuse health visitor was able to coordinate appropriate health services when the woman and her child moved to another borough, where she is accessing universal services.

- 3.13 Increased awareness on the importance of early identification of FGM has seen the introduction of a question around FGM by school nurses at the Year 6 health assessment. Oxleas NHS Foundation Trust has worked closely with schools to help them understand the benefits of this approach, which raise the awareness of FGM and allow children and young people the opportunity to discuss the issue with a known health professional in a safe one-to-one setting.
- 3.14 School nurses engage with multi-agency safeguarding processes by submitting reports and attending relevant meetings and we saw clear evidence of this in records reviewed. However, greater analysis and articulation of risks to children and young people would strengthen the overall quality of reports submitted by school nurses. *This issue has also been drawn to the attention of Public Health, as the commissioners of the school nursing service. (Recommendation 6.5)*

The quality assurance process is retrospective with reports being reviewed with the practitioner during supervision sessions. It would be a more robust process for reports to be reviewed prior to submission, as long as this did not cause unnecessary delay.

- 3.15 Young people who attend school nurse 'drop in' sessions are benefitting from increased identification of potential CSE risk. Oxleas NHS Foundation Trust have been proactive in supporting practitioners to identify children at risk of CSE by developing a risk assessment tool. The tool has been endorsed by the GSCB and evidence of its use was seen within school nursing records. One school nurse advised that using the tool had increased her confidence in identifying risks when offering sexual health advice to young people during school 'drop in' sessions.
- 3.16 The CSE risk assessment tool has also been tested in a number of CAMHS services; it has evaluated well with practitioners and is to be rolled out across CAMHS services.
- 3.17 Children at risk of CSE are not being highlighted by a bespoke alert on their electronic patient record at Oxleas NHS Foundation Trust. Although the IT system does have an alert facility which is used for children subject to child protection plans, children in need and looked after children, children at risk of CSE are not currently flagged. The trust is not confident that it is aware of all the children the local authority has identified as being at risk of CSE. There is more work to do to ensure that this cohort of children and young people are routinely shared between relevant agencies and clearly identified on IT systems. **(Recommendation 6.6)**

3.18 The referrals we saw from CAMHS practitioners to children's social care were of variable quality with not all practitioners clearly articulating the identified risk of harm to the child clearly or succinctly. Although copies of the referrals are sent to the trust's safeguarding team for review, there is no quality assurance of the referrals by frontline operational team managers prior to the referrals' submission. Poor quality referrals can impede good decision making in the multi-agency safeguarding hub (MASH) and the lack of practice oversight at the frontline is an area for development.
(Recommendation 6.5)

3.19 Vulnerable children benefit from individualised care planning and case management when they miss appointments with the CAMHS service. Where children are known to be at risk, are subject to a child protection plan or are recognised as needing encouragement to engage with the service, responses to non-attendance at appointments are based on the risks specific to each case. Decisions about how CAMHS practitioners respond to two or more missed appointments are made following a discussion with a manager or at the multi-disciplinary team meeting.

A young person aged 15 years with a complex background, including historic parental alcohol abuse, had until recently lived with their mother but was currently living with their father.

The GP had referred the young person to CAMHS several times but it was felt each time that the case did not meet the service's eligibility criteria.

The young person attended ED and was seen by the out of hours duty adult psychiatrist who undertook a highly comprehensive assessment during which the young person disclosed non-consensual sex with their boyfriend, historic physical abuse by extended family members, and a risk of radicalisation.

The psychiatrist was able to record the assessment straight into the young person's electronic patient record due to the trust's integrated recording system.

The clinician discussed the case with the duty CAMHS doctor and made a referral to the Prevent lead worker, thus helping to develop local intelligence about the risks of radicalisation, sites where radicalisation may be taking place and coerced conversions.

The young person was admitted onto the paediatric ward due to a physical illness and there was good liaison between the ward and CAMHS.

The newly allocated CAMHS practitioner is working with the young person and their father to identify the best way to support them to engage with the service.

This case is recognised as needing medium to long term CAMHS involvement and there will not be a move to close the case if they do not engage within the usual offer of 3 appointments.

- 3.20 Young people who access the sexual health service in Greenwich are adequately safeguarded. Practitioners in the sexual health service are aware of the process to follow if they have any safeguarding concerns about a young person. When a referral forms is sent to children's social care a copy is also sent to the trust's safeguarding lead and a copy is scanned onto the young person's records. The lead nurse within the sexual health service maintains a database of all referrals made, ensuring good oversight of concerning cases.

- 3.21 The quality of the referral forms we reviewed in the sexual health service was satisfactory but could be improved by being more outcome focused and by relating concerns to the local threshold document. This would aid the receiver of the referral to explicitly understand the concerns being raised. *This issue has also been drawn to the attention of Public Health, as the commissioners of the sexual health service. (Recommendation 6.5)*
- 3.22 We were informed that sexual health practitioners are invited to attend and contribute to safeguarding meetings and we saw evidence of their full engagement in the records reviewed. Participation in the safeguarding process is essential for sexual health practitioners, who often hold significant information, to contribute to the protection and well-being of young people.
- 3.23 Children within families where adults are accessing mental health services are effectively safeguarded. Practitioners working with adults who have parenting or caring responsibility for a child who is subject to a child protection plan, attend child protection conferences and core group meetings. Practitioners share written reports with the client in advance of conference meetings. This is good practice and compliance is closely monitored.
- 3.24 When a child protection plan is put in place, we saw evidence that adult mental health practitioners develop a care plan for their adult client which explicitly links to and underpins the child protection plan.
- 3.25 Although the quality of the referrals we reviewed from the adult mental health service to the MASH are good, being clear, succinct and articulate the risk of harm to children well, referrals are not quality assured prior to their submission. This is in common with other services operated by the same trust and managers and the trust safeguarding lead recognise this as an area for development. *(Recommendation 6.5)*
- 3.26 In Greenwich, facilities for young people who are taken into police custody under section 136 of the Mental Health Act are satisfactory. Young people have access to two health based place of safety suites provided by Oxleas NHS Foundation Trust which are staffed by trained mental health practitioners. These suites generally provide sufficient capacity to meet local needs but on the rare occasions where the provision is full, young people are accommodated in a neighbouring borough's facilities. This ensures that young people in mental health crisis are accommodated locally within a safe environment.

3.27 Of the cases we reviewed, findings indicated that children within families where adults are accessing services provided by CGL Greenwich Aspire substance misuse service are not adequately safeguarded. We saw evidence that joint working and information sharing between CGL practitioners and GPs is good, information is actively shared in relation to a client's progress in attaining their treatment goals.

However, records demonstrated extremely variable safeguarding practice. This included a lack of professional curiosity, case workers not adequately understanding the level of risk posed to children within families, and home assessments not being undertaken within the timescales outlined within CGL policy. Frontline practice is therefore not adhering to CGL safeguarding protocols. Management oversight of the quality of safeguarding practice in some cases we reviewed was weak. (**Recommendation 9.1**)

3.28 GPs are effectively engaged in the safeguarding of children and young people who access primary care in Greenwich. The GPs we visited were clear on the safeguarding referral pathway into the MASH and they also make good use of the MASH advice line when seeking guidance on safeguarding issues. We were told that this is often their first point of contact before contacting the named GP. We heard some examples where primary care practices had identified safeguarding concerns and made appropriate referrals.

3.29 The named GP sets a clear expectation that GPs should participate in child protection case conferences either by attending, although this is rare, or by submitting a written report. A report template has been developed to facilitate GPs' contributions. Participation is monitored closely by the named GP who is informed by children's social care if reports are not received; this is then addressed with individual practitioners.

3.30 The GPs we visited use appropriate alerts to identify individual children and young people with known vulnerabilities, risks or who are looked-after. However, not all safeguarding lead GPs are well sighted on the full cohort of vulnerable children within their practice. GPs expressed doubt that children's social care informs them about all children within their practice population who are subject to child in need or child protection plans. Although it is not clear how proactive GPs have been in seeking this information, it would benefit the vulnerable children and young people to whom GPs are providing care if GPs were fully aware of current safeguarding concerns. (**Recommendation 2.2**)

4. Looked after children

- 4.1 Children and young people who are accommodated by the local authority and those who are on the edge of care have their emotional health needs effectively met by a specialist CAMHS team in Greenwich. Recognising that children who are subject to child protection plans and who are at high risk of being taken into care have similar emotional health needs to children and young people who have been accommodated by the local authority is a positive step. Where children may be moving in and out of care, this service delivery model provides stable support to children who may be experiencing little stability elsewhere in their lives. We saw good outcomes resulting from the therapeutic intervention and the trusting relationships carefully developed by practitioners with children and young people over a period of time.
- 4.2 Referrals to the specialist CAMHS service are based on a range of factors including strengths and difficulties questionnaire (SDQ) results. However, the specialist looked-after child nurses were unable to make direct referrals to the looked-after child CAMHS team; referrals had to be made via the young person's social worker. This issue was resolved whilst we were on site and CAMHS will now accept direct referrals from the looked-after children's team therefore preventing any unnecessary delays in young people's access to a CAMHS assessment and support.
- 4.3 Children and young people who are looked-after are now benefitting from an improvement in their health plans following their initial health assessments (IHA) and review health assessments (RHA). An audit undertaken by the looked-after child health team found that the quality of health plans needed to be strengthened. We saw that that health plans now have specific timescales and accountabilities identified against actions and are therefore specific, measurable, achievable, realistic and time-bound (SMART).
- 4.4 The looked-after children's health team are inviting GPs to contribute to young people's RHAs which is a positive step as GPs often hold significant health information. We acknowledge that this is a recent initiative; however we could not find any GP contributions in the cases we reviewed despite a recent audit showing that 75% of GPs do respond to requests for information. The looked-after child health team is working to strengthen GP engagement further by being clear to GPs what information should be submitted and also by giving GPs clear response timescales.
- 4.5 All IHAs are undertaken by paediatricians under the supervision of the designated doctor for looked after children and all RHAs are undertaken by the specialist looked-after child nurse team. This is a best practice model of service delivery as it facilitates continuity for young people and ensures a consistency in quality of assessment.

- 4.6 Children and young people who are looked after and placed up to 60 miles out of Greenwich benefit from continuity of practitioner for their review health assessments. The specialist nurse practitioners for looked-after children will travel up to 60 miles routinely and in some exceptional cases further afield to carry out review health assessments. Once again this facilitates good continuity for young people. Maintaining the same looked-after child nurse throughout their life in care can benefit children enormously, as this may be one of the few stable relationships in otherwise chaotic lives.
- 4.7 However, there is some risk that when children leave care, the handover pathway into universal services and the consequential transfer of responsibility is not always clear. We were advised that if a child is returning to the care of their health visitor or school nurse a verbal handover takes place which is recorded in the electronic patient records. However, as there is no template or proforma to support a robust handover there is the potential for identified health needs to remain unmet.
(Recommendation 6.7)
- 4.8 Young people are routinely seen alone as well as with their foster carers for their health reviews, giving them good opportunity to speak freely. The looked-after child health team are flexible in their approach to venues for review health assessments which are conducted in the child's home, school, clinical or other settings of the child's choosing, for example a fast food outlet. We heard about reviews being undertaken in evenings and weekends and overall, the team has a clear, child focused, child led ethos.
- 4.9 The looked-after child health team make good and regular use of SDQs when undertaking IHAs and RHAs. It was particularly positive to see young people completing their own Young Minds SDQ. This helps encourage the young person to engage with and manage their own emotional health and wellbeing and gives the opportunity for them to track their own emotional growth over time.
- 4.10 It was not always clear in case records whether earlier RHAs fully informed current health reviews. There was no clear evidence to show that previously identified issues were reviewed to ensure a child or young person's needs had been met before exploring current needs. This may result in identified needs being overlooked. **(Recommendation 6.8)**
- 4.11 We saw good attention paid by the looked-after child health team in gaining appropriate consent for health assessments. Consent was obtained from and signed by the young person whenever possible or clear reasons were recorded as to why consent had been given by someone else.

- 4.12 Looked-after child nurses routinely use a substance misuse screening tool and the locally adapted version of 'Spotting the Signs' CSE risk assessment tool when undertaking RHAs. However, the looked-after children's health team is not sufficiently engaged with the multi-agency CSE arrangements, either strategically or in relation to individual looked-after young people who are known or thought to be at risk of CSE.
- 4.13 Children and young people in the care of a local authority are nationally recognised as being at risk of CSE. We understand that in Greenwich the local CSE multi-agency panel was, in November 2015, replaced by the CSE missing and child exploitation (MACE) strategic group who maintain an oversight of individual cases. However, the looked-after children's health team have reportedly been involved in only one CSE MACE strategy discussion. It is essential that the looked-after child health team are well sighted on the cohort of the looked-after child population who are at risk of CSE and also that relevant meetings benefit from their input and knowledge about a young person. (**Recommendation 6.9**)
- 4.14 Unaccompanied asylum seeking children in Greenwich do not have their emotional health needs adequately acknowledged or addressed during their health assessments. There is a continuous transient cohort of unaccompanied asylum seeking children (UASC) in Greenwich. The looked-after child health team are efficient in their provision of interpreters for initial and review health assessments for these children and IHAs are always undertaken by paediatricians in line with guidance. We understand that collaborative work has been undertaken between the designated doctor for looked after children in Greenwich and a neighbouring designated doctor to ensure that UASC health assessments follow Royal College of Paediatrics and Child Health (RCPCH) guidance. However the example IHA we reviewed was very basic in content and showed no evidence that the clinician had considered or recognised the emotional impact of the asylum seeking experience on the young person; this section of the assessment was left blank.

It is essential that practitioners working with this cohort of children and young people undertake specific training and can demonstrate a clear understanding of the asylum seeking experience, particularly in relation to emotional wellbeing. To date, the paediatricians and the looked-after children's nurse team have not undertaken any such training.
(**Recommendation 6.10**)

- 4.15 Record keeping in the looked-after child health team requires improvement. We saw case records where some documentation was not clearly secured within the case record. In one case the UASC had neither a NHS number or GP recorded although these were recorded in several places within the assessment documentation that had been scanned into the case record.

The 'voice of the child' was not strong in the looked after children's notes we reviewed. While it was clear in most cases that practitioners were making efforts to engage with young people and build a trusting relationship, there was variation in how the child's voice, character, behaviour and personality was captured. Few practitioners quoted the child's actual words.

(Recommendation 6.11)

- 4.16 While we were told that the designated doctor and the designated nurse quality assure IHA's and RHA's, we did not see evidence of this on the assessments we reviewed. There was no counter signing of assessments and no evidence that quality assurance had been carried out using a benchmarking tool or set of standards. Some assessments were not of satisfactory standard and one in particular was difficult to read.

(Recommendation 6.12)

- 4.17 Young people leaving the care system in Greenwich are not provided with relevant health information to adequately support their transition into adulthood. We are aware that young people in care are currently engaged with the looked-after child health team in developing a health history or passport for care leavers, but currently the care leavers' health offer is underdeveloped. Young people do not receive a health passport or health history on leaving care which is not compliant with the statutory guidance for promoting the health and wellbeing of looked-after children (2015). Instead, care leavers are encouraged to see their GP if they wish to obtain their health history and they can contact the looked-after child nurses at any time for information. A health history or passport is an important part of a young person's sense of identity as well as an important aspect in helping them to prepare for independence and transition to adulthood.

(Recommendation 6.13)

- 4.18 The looked after child health team appropriately involve young people in improving their service provision and delivery. Young people were included on the recent recruitment panel for the two looked-after children's nurse posts and their views were taken into account in appointing the successful candidates. The designated nurse and the named nurse for looked-after children meet with the Children in Care council regularly.

Mockingbird Family Model

Royal Borough of Greenwich is one of eight local authorities in the country to introduce the Mockingbird Family Model for foster carers. Originally developed in the USA and funded through the Department of Education, the model has been so successful that Greenwich has committed to its continuation.

An experienced foster carer partnership is identified as 'hub' foster carers to a small number of other foster carers, to encompass children who exhibit challenging behaviour and who are receiving CAMHS support.

The hub foster carers provide advice and guidance to their 'constellation' of foster carers and provide active respite care for the young people in the constellation. This enables the young people to view the hub foster carers in a grand-parent role, mirroring an extended family.

The hub and constellation meet monthly and all foster carers involved are supported by a liaison officer in the local authority children's services and extensively by CAMHS.

The hub foster carers meet with a CAMHS psychologist every six weeks and aspects of the children's progress and recent behaviours or disclosures made to the hub foster carers are discussed. Young people are fully aware that the hub foster carers will share any disclosures they make with the appropriate professionals.

Royal Borough of Greenwich is working with Loughborough University to evaluate the effectiveness of the model.

Foster carers involved in the Mockingbird Family Foster Care Model told us that;

"It has made an enormous difference to these young people. They have the experience of an extended family. We are like grandparents. A trust is built up in the young people that the adults around them care about them and they are fully aware that we will discuss what they tell us so that we can all help. We are working as part of the team with CAMHS and children's social care. They know the young people well. The liaison officer and clinical psychologist are amazing. Without CAMHS we would struggle. The psychologist just gets us and gives us all the support we need. This MFM is something all local authorities should do".

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 and named professionals within Greenwich provide leadership across the local health economy to support other professionals and their agencies on all aspects of safeguarding and child protection.
- 5.1.2 The CCG has set up a quarterly named and designated safeguarding professional forum to provide opportunity for local safeguarding children professionals to network, share reflective learning and identify safeguarding issues. The CCG has also developed a quarterly safeguarding newsletter to disseminate pertinent local and national safeguarding information across the local health economy.
- 5.1.3 The CCG works closely with GSCB to support improvements in practice and ensure that safeguarding and promoting the welfare of children and young people is embedded within the duties of commissioned provider organisations across the health economy.
- 5.1.4 The CCG's safeguarding priorities are in line with the GSCB priorities and are appropriately informed by the emerging needs of the local population, research and SCRs.
- 5.1.5 The co-location of the CCG, children's social care, MASH and GSCB aids good partnership working at a strategic and operational level. Working together is essential in the safeguarding and looked after children arena and having face to face contact helps promote professional challenge as well as professional respect.

- 5.1.6 Resourcing and contractual arrangements for the designated nurse for children looked after are inconsistent with the position adopted by the Royal College of Nursing (2015). There is no service level agreement between the host NHS provider who employs the designated nurse and the CCG where statutory responsibility for the post is held, and as a result of this and the positioning of the designated looked-after children's nurse in the provider rather than the CCG, the role is not sufficiently strategic.

The designated nurse for looked after children role is intended to be separate from any responsibilities for individual looked-after children, being a monitoring and quality assurance role rather than managerial. In Greenwich the role has only eight dedicated hours per week and is held by the looked-after child health team leader who also carries a caseload of looked-after children. The lack of designated nurse capacity to lead and develop the looked-after child health service is mitigated by the active involvement of the trust's head of nursing who is taking on some aspects of the role more usually undertaken by a designated nurse. There is however, a lack of objectivity as the designated nurse is monitoring, quality assuring and overseeing her own work as the operational team manager and this arrangement does not best support effective governance by the CCG. We are aware that this issue is on the CCG's risk register.

(Recommendation 10.1)

- 5.1.7 The post of designated doctor has been vacant since April 2016. The CCG are about to advertise the post and advised us that there have been expressions of interest so they are confident the post will be filled shortly.

Meanwhile, although the designated doctor's role is not officially being covered, there are designated doctors in nearby boroughs who are able and willing to provide advice and guidance if required. However, more formal arrangements will be needed if the post continues to remain vacant following advertisement.

- 5.1.8 The named GP demonstrates good leadership across primary care. He is experienced and committed to taking primary care engagement in safeguarding and child protection forward and is currently a member of the GSCB. He also takes a lead role in ensuring lessons learnt from SCRs pertinent to primary care become routine practice, such as recording a child's school when they newly register with a GP practice.
- 5.1.9 The GP resource pack has recently been revised and updated by the named GP and designated nurse and is due to be published imminently. This comprehensive pack encompasses a wide range of protocols and guidance as well as topical and local issues such as FGM, private fostering and CSE. It sets out practice standards for lead GPs and is a rich resource for primary care practitioners and the GP safeguarding leads.

5.1.10 Although we understand that there are plans to develop regular forums between the primary care safeguarding leads and the CCG to provide support, promote best practice and discuss local and national learning, safeguarding lead GPs in Greenwich do not currently benefit from the opportunity to attend such meetings. Where established in other areas, these facilitate continuous improvement in GP child safeguarding practice and help to embed consistent good practice across primary care. The named GP acknowledges this as an area for development along with the distribution of an updated list of designated post holders, key safeguarding contacts and lead officers which would be beneficial to practitioners.
(Recommendation 7.2)

5.1.11 Greenwich CCG has a duty to support improvements in the quality of primary care and its safeguarding functions, which it does by delivering level three safeguarding training to GP practices. The designated nurse and named GP carry out monthly quality assurance visits to GP practices and report to the joint safeguarding group and quality committees. The CCG's safeguarding team also provides safeguarding advice and guidance to GPs on request. However, they have no direct oversight of GPs' safeguarding practice, the monitoring of compliance with safeguarding children statutory requirements in Greenwich remains the function of NHS England.

The CCG are seeking reassurance from NHS England that GP services have effective safeguarding arrangements in place, however this has not as yet been provided. In order for the CCG to support improvements in the quality of primary care's safeguarding functions, the CCG needs to be clear on areas for development and improvement as identified by NHS England.
(Recommendation 2.3)

5.1.12 The lead GP within the UCC exercises strong leadership and support for the wider team of GPs, underpinned by regular communication and information sharing to ensure the required standards of practice are jointly understood and met.

5.1.13 ED staff at the Queen Elizabeth hospital are supported well by the trust's safeguarding team and departmental safeguarding champions who help to develop staff knowledge and confidence in safeguarding issues and procedures.

5.1.14 As mentioned within this report there are significant concerns at the Queen Elizabeth hospital around the impact the short notice decommissioning of the PLN role has had on the trust in relation to its safeguarding children work, as well as its impact in terms of ongoing partnership working.

Work is required to agree a new shared pathway, policies and procedures for information sharing which meet the needs of both Lewisham and Greenwich NHS Trust and Oxleas NHS Foundation Trust.
(Recommendation 1.1)

- 5.1.15 The experienced named midwives within the Lewisham and Greenwich NHS Trust lead on developing and promoting good safeguarding practice. At the Queen Elizabeth hospital the named midwife has developed good working relationships with multi-agency professionals leading to good information sharing and joint working to improve outcomes for vulnerable women.
- 5.1.16 Strong operational and safeguarding leadership is supporting continuous development and improvement in the safeguarding practice of health visitors and school nurses.
- 5.1.17 Structurally there is good provision of focused safeguarding leadership for CAMHS across Oxleas NHS Foundation Trust.
- 5.1.18 There have been a number of CAMHS service changes and developments as a result of a recent local SCR. One direct outcome is the delivering of training to health visitors and school nurses by CAMHS. This demonstrates that Oxleas NHS Foundation Trust is strengthening operations and practice as a result of local lessons learnt.
- 5.1.19 Clinical 'In-Reach' sessions have been introduced to a range of services across Greenwich. These surgeries enable YOT, children's social care and other practitioners to discuss cases with a CAMHS practitioner who visits their service to provide advice and guidance. This has evaluated well in the YOT and with social workers. A report evaluating the first six months of In-Reach, its impact and outcomes will be shared with commissioners.
- 5.1.20 The Oxleas NHS Foundation Trust's head of nursing provides good leadership to the specialist looked-after child health team. She is knowledgeable about the service and has clear vision about how the service needs to develop. Since taking up this post last year, one of the key improvements she has made has been to establish substantive posts for the two looked-after children's nurses, replacing the previous secondment arrangements. The development of a stable workforce facilitates the establishment of consistent standards of practice and promotes continuous improvement in achieving good outcomes for looked-after children and young people.
- 5.1.21 The CAMHS operational manager and the head of nursing in Oxleas NHS Foundation Trust have discussed the referral pathway from looked-after child specialist nurses to CAMHS and have agreed that from this point, direct referrals to CAMHS can be made when a looked-after child or young person is in need of CAMHS assessment and intervention. Prompt action was taken by Oxleas managers to rationalise the referral pathway and ensure ease of access to looked-after children with mental health needs to appropriate support.
- 5.1.22 The sexual health service has been 'You're Welcome' accredited since 2009 which demonstrates consistent service standards and provision for young people to help meet their sexual health needs.

5.1.23 Whilst all case records seen in CGL Greenwich Aspire recorded the names and dates of birth of children and whether they had a social worker; focus on the 'voice of the child'; recognition of their needs and analysis of parental capacity to meet their needs was limited. We acknowledge that the social worker post of parental substance misuse co-ordinator, jointly funded by Royal Greenwich's health and adult services and children's services is a positive step in developing joint working practices between substance misuse and social care professionals. However, the service would benefit from being involved in wider partnership discussions around child neglect.

Partnership working at an operational level between CGL Greenwich Aspire and wider child health partnerships is limited. CGL Greenwich Aspire is not adequately linked into safeguarding children strategic partnerships including the work of the GSCB and its sub groups. (**Recommendation 9.2**)

5.2 Governance

- 5.2.1 Arrangements are in place to provide assurance to the CCG that providers are compliant with evidence based and locally agreed safeguarding children practice in the form of quarterly assurance reports. The designated nurse also attends providers safeguarding committee meetings which ensures CCG oversight and enables a level of challenge across the health economy. It is acknowledged that there is further work to do to fully engage smaller providers in this process, including for example the UCC although we understand actions are nearing completion to address this.
- 5.2.2 The CCG maintains a safeguarding children work plan amalgamating all required actions and recommendations from section 11 audits, GSCB and CCG audits, the accountability and assurance framework as well as actions from safeguarding work streams and the GSCB subgroups. This ensures that progress can be effectively monitored and improvements in practice across the area can be demonstrated.
- 5.2.3 Joint working between the UCC and ED at the Queen Elizabeth hospital is an area for development in order to provide a clear, shared approach to the delivery of care and safeguarding arrangements.
- Although there are forums in place to strengthen partnership working between the UCC and ED; there remain issues to be addressed in relation to information sharing and alignment of care pathways to effectively meet the needs of children, young people and their families.
(Recommendation 11.1)
- 5.2.4 Whilst concerns about patient's emotional and mental wellbeing are included in a generic streaming assessment on arrival in the UCC, questioning is undertaken in a public area. This is a key concern in relation to the dignity and privacy of young people and adults presenting to the UCC. **(Recommendation 8.2)**
- 5.2.5 At Queen Elizabeth hospital maternity department there is a clear governance structure and regular meetings to ensure safeguarding issues within maternity services are reported appropriately to the trust's senior management and board.
- 5.2.6 The head of safeguarding in Oxleas NHS Foundation Trust has good oversight of strategic and operational issues and is supported by a well-established safeguarding team and a robust governance structure across all services. However, the trust recognises that they are currently unable to provide assurance on all safeguarding activities and this is on the trust's risk register. The merging of three IT systems has challenged the process of extracting data. Work is ongoing to address the situation.

5.2.7 Record keeping in CAMHS and the adult mental health service is not sufficiently robust. Practitioners do not routinely record all activities and actions taken in relation to cases to ensure a client's record is complete. For example, discussions and decisions made about a case in supervision or by the multi-disciplinary team are not consistently noted on case records. We saw loose and inaccurate recording of dates, an unclear record of a client's pathway into hospital and missing information, such as copies of referrals into the MASH in case notes. It is imperative that records are clear, comprehensive and accurate.

We also saw too many case record entries in adult mental health that were not validated to prevent retrospective record editing. Managers in Oxleas NHS foundation Trust are not ensuring that case recording is contemporaneous, accurate, complete and validated.

Managers recognise a need to strengthen their oversight of practitioners' case recording and record management. An annual audit is improving practice in the short-term, but regular and routine oversight and dip sampling of cases by frontline managers would help to embed improved practice. (**Recommendation 6.14**)

5.2.8 Use of alerts on the IT system in the sexual health services requires development. There is an alert facility on the current IT system and we saw that it is used to highlight vulnerable young people appropriately. However its use is inconsistent as we also saw examples of records where young people were clearly vulnerable but no alert had been generated. Although we appreciate that the sexual health service is adopting the trust's main IT system in a few months, better use of the alert system could be made on the current IT system meanwhile.

The IT system should aid practitioners and accurately inform them of any current social or safeguarding concerns, as well as help prevent young people having to re-tell their story unnecessarily. Currently there is a risk that known vulnerabilities could be missed. *This issue has also been drawn to the attention of Public Health, as the commissioners of the sexual health service.* (**Recommendation 6.4**)

- 5.2.9 Performance on the timeliness of initial health assessments is poor. Partners have only recently started to measure performance from the date on which a child enters the care system rather than the date on which health receive documentation requesting an IHA from children's social care. Previous data collection and scrutiny will therefore have been giving false assurance.

The partnership is taking positive action to address the situation. For example, weekly exception reports setting out performance data on IHAs are now being generated by the looked-after child health team and sent to the director of nursing, the CCG and the local authority. The designated nurse for looked after children also meets managers in children's social care to address difficulties which are impacting on performance. An escalation process has been put in place to enable any frontline sub-optimal practice or delay to be addressed and resolved promptly. Databases have been developed for children under and from five years of age so that due dates and progress on the RHA process can be monitored closely.

While these actions are positive and there is an indication that there may be some slight improvement in the most recent performance report, this is far from being a sustained upturn. (**Recommendation 6.15**)

- 5.2.10 There is no multi-agency 'health of looked-after children' group as part of a multi-agency governance arrangement. Such a group might include representatives from relevant partners such as the looked-after child health team, CCG, children's social care, CAMHS and an Independent Reviewing Officer. The absence of such a group does not help partners to move toward the establishment of a whole system approach, working together to improve all aspects of the provision of healthcare for looked-after children.
- 5.2.11 Managers and specialist nurses are not able to identify specific cohorts within the looked-after child population, such as those who are UASC, substance misusers or at risk of CSE. This also means that the CCG is unable to identify these cohorts and understand their health needs to inform the joint strategic needs assessment (JSNA), workforce development and future service configuration and planning. (**Recommendation 6.16**)
- 5.2.12 It is of benefit to health services in Greenwich that Oxleas NHS Foundation Trust has introduced an integrated electronic case recording IT system. This enables information from health visitors, school nurses, CAMHS, adult mental health and the specialist looked-after child health team to be shared through a single case record for individual children. However, this also means that a child's record is long. Some practitioners reported that it is difficult to find information about a child or young person quickly as there is no separate section for all users to record concerns, vulnerabilities or specific safeguarding information including non-attendance at appointments. (**Recommendation 6.17**)

- 5.2.13 Oxleas NHS Foundation Trust and the operational managers have an overview of the population of children within its service. However, this data is not broken down to identify the cohorts of child in need or child protection cases. This does not facilitate effective operational management oversight of safeguarding practice within the services. Nor does it help to inform caseload management, workforce deployment and development. It is also a missed opportunity to inform future service planning through the JSNA.
- 5.2.14 CGL Greenwich Aspire has an open learning culture and is working to embed its safeguarding systems; but assurance arrangements are still at an early stage and have yet to have the required impact in being able to evidence a consistently high standard of practice. 'Think family' approaches are under developed and the voice of the child was weak in almost all case records reviewed. (**Recommendation 9.3**)
- 5.2.15 The Quality of CGL Greenwich Aspire's practice requires strengthening in relation to its processes where children within a family are subject to child protection plans. In particular we noticed gaps in effective joint working, information sharing and in understanding and prioritising the need to produce reports and routinely attend relevant safeguarding and child protection meetings. CGL Greenwich Aspire's governance and management oversight of safeguarding children work is still at an early stage of development. (**Recommendation 9.1**)

5.3 Training and supervision

- 5.3.1 Single agency provider safeguarding training is not currently ratified by the GSCB, however the training materials are reviewed by the designated nurse in the CCG to ensure the training is compliant with intercollegiate document competencies. This approach helps to promote consistency in the quality of training provision to practitioners. The GSCB learning and development group are considering how they can implement a ratification process.
- 5.3.2 The expectation of the CCG is that providers and GPs meet their safeguarding children training compliance figures, which are currently between 80% and 85% depending on individual contracts. Compliance is monitored by the CCG and some providers have work to do to meet their contractual obligations. The CCG plan to standardise the compliance percentage requirement across the health economy during the next round of contract discussions.
- 5.3.3 The designated nurse receives appropriate safeguarding supervision and is compliant with safeguarding training requirements. Peer support is provided by quarterly designated nurse meetings.
- 5.3.4 UCC staff have received appropriate training in relation to their safeguarding roles and responsibilities. Quarterly safeguarding supervision is in place to enable reflection on current practice and address areas for further learning.
- 5.3.5 The Lewisham and Greenwich NHS Trust has ensured its learning and development programme is aligned to intercollegiate document requirements with a strong focus on the acquisition of knowledge and skills and demonstration of improvements in practice. The trust has work to do to meet the required compliance targets set by the CCG around safeguarding children training, particularly for level three training which is low.
(Recommendation 3.8)
- 5.3.6 The Lewisham and Greenwich NHS Trust have recognised that their safeguarding supervision arrangements require strengthening and a new operational policy is being drafted. **(Recommendation 3.9)**
- 5.3.7 The safeguarding supervision offered to the specialist team of midwives at the Queen Elizabeth hospital is good. This comprises one-to-one sessions every four to eight weeks, which appropriately reflects the high risk case-loads of this specialist team.

- 5.3.8 The provision of safeguarding supervision for the remainder of midwifery staff could be strengthened. As case load holders community midwives would benefit from regular in depth one-to-one supervision sessions rather than the mandatory one hour annual group session currently offered. Likewise, maternity ward staff would also benefit from an increase in group supervision provision from the one hour mandatory session per year currently offered

This would help to ensure a degree of professional challenge in cases where increased support or intervention for vulnerable women is identified. It would also help ensure that potential risk or drift is not overlooked and that staff are supported in fulfilling their safeguarding responsibilities.

(Recommendation 3.9)

- 5.3.9 SMART actions resulting from midwifery safeguarding supervision discussions are not currently recorded in women's records. Women's notes are therefore not a full and complete record of an episode of care and not compliant with record keeping standards. **(Recommendation 3.9)**
- 5.3.10 Midwives at the Queen Elizabeth hospital are expected to fulfil the learning hours specified within the intercollegiate document by accessing in house mandatory training, relevant local training, e-learning and GSCB sessions. Training compliance is recorded in a training passport which is signed off by the named midwife and compliance is monitored.
- 5.3.11 Oxleas NHS Foundation Trust's staff spoke positively of the accessibility to advice and guidance from the trust's safeguarding team. The growing network of safeguarding children champions across the trust also helps promote safeguarding children practice with frontline practitioners. The trust supports the champions in their roles by providing additional training on key topics such as FGM, a twice yearly Greenwich based forum and an annual safeguarding children's champion forum. This is a positive approach to raising awareness of safeguarding issues, ensuring dissemination of information across the trust and supporting and developing staff in their safeguarding practice.
- 5.3.12 The arrangements for safeguarding supervision for health visitors are good. This comprises one-to-one sessions every three months. A new template is in use which supports a comprehensive approach to analysis of risk and of monitoring progress towards the achievement of required outcomes.
- 5.3.13 Health visitors have good access to an appropriate range of safeguarding children learning and development opportunities to support their continuous professional development, safeguarding knowledge and competences.
- 5.3.14 The safeguarding supervision offer to school nurses is a one-to-one session every term and attendance is monitored. As in health visiting, the template in use supports reflective practice and a record of the supervision session along with any resultant actions are placed in children's records.

- 5.3.15 The safeguarding children training offer to school nurses is good with practitioners meeting the intercollegiate guidance requirements. Managers stated that school nurses access multi-agency training via the GSCB and attend mandatory internal single agency training. All school nurses have completed FGM e-learning training and a bespoke face to face training session to ensure they have sufficient knowledge to support their work in this area.
- 5.3.16 The safeguarding supervision offer to CAMHS practitioners is strong. All practitioners receive routine one-to-one clinical and managerial supervision with safeguarding as a standing item. All cases that involve child in need or child protection issues are routinely discussed in each supervision session.
- 5.3.17 All CAMHS frontline practitioners receive level three safeguarding children training and compliance with this and with the uptake of supervision sessions is rigorously monitored by Oxleas NHS Foundation Trust management.
- 5.3.18 CAMHS is planning to strengthen their support to paediatric staff in acute hospitals in their area and are working with the Queen Elizabeth hospital to help meet the mental health training needs of their paediatric staff.

The Oxleas Bexley CAMHS psychotherapist is to run a supervision group regularly on the paediatric ward to help staff develop their understanding and response to supporting young people with mental ill health.

Nurses in the later stages of training who are to work in ED, UCC or paediatric settings benefit from a CAMHS training module delivered by CAMHS practitioners. This is helping to upskill and increase knowledge within this cohort of staff at the outset of their careers and is one of a range of positive developments helping to support good outcomes for young people.

- 5.3.19 However, young people who are experts by their personal experience of CAMHS services and of being in-patients on paediatric wards have not been given the opportunity to participate in the delivery of training to paediatric staff to date. This is a missed opportunity for young people to directly increase knowledge and understanding by virtue of their first-hand experience of what is helpful or unhelpful while being cared for in these environments.
- 5.3.20 Safeguarding supervision arrangements for the looked-after child team nurses are good with regular one-to-one supervision sessions enabling the practitioners to reflect on and challenge their practice.

- 5.3.21 The medical lead in the sexual health service receives two-monthly one-to-one safeguarding supervision sessions from the designated doctor. The sexual health clinicians receive group safeguarding supervision every six months from the trust's named nurse. This is in line with Oxleas NHS Foundation Trust's safeguarding supervision procedures, however in view of the lead nurse's and youth worker's caseloads, more frequent in depth one-to-one supervision may be beneficial to ensure a degree of professional challenge in cases where increased support or intervention with vulnerable young people is identified. It would also help ensure that potential risk or drift is not overlooked and that staff are supported in fulfilling their safeguarding responsibilities. *This issue has also been drawn to the attention of Public Health, as the commissioners of the sexual health service. (Recommendation 6.18)*
- 5.3.22 All sexual health practitioners access the Oxleas NHS Foundation Trust level three safeguarding children training. In addition, practitioners have accessed topical training relevant to their role including CSE and FGM.
- 5.3.23 Sexual health practitioners are also regularly involved in the provision of education and training to other services, for example health, education and foster carers. This helps to widen the awareness and understanding of young people's sexual health issues.
- 5.3.24 While frontline adult mental health practitioners undertake safeguarding children training at level three and compliance is rigorously monitored across all trust services, the training is single agency only. Adult mental health practitioners are therefore not benefitting from multi-agency child safeguarding training as stipulated in the intercollegiate guidance unless they also access GSCB training sessions.
- 5.3.25 Adult mental health teams all have a safeguarding champion who meets regularly with the adult mental health safeguarding lead for updates and peer support. Additionally, the bi-annual safeguarding champions' forum and annual safeguarding conference are helping to maintain and develop safeguarding knowledge and understanding across the mental health service. Champions act as additional sources of advice and guidance to team colleagues
- 5.3.26 All CGL Greenwich Aspire staff have recently received updated safeguarding training (CGL framework). However, the quality of practice seen indicates that targeted workforce development is required to ensure all adult substance misuse professionals are competent, fully grasp their accountabilities and consistently and effectively use the organisation's and partnerships established safeguarding children tools. *(Recommendation 9.4)*

5.3.27 GPs told us that the Amber project delivered in the past by Barnardos had been helpful in raising awareness across primary care about the experience of children living with domestic abuse. Primary care practices across Greenwich also make good use of the protected learning time hours, although we understand that these are coming to an end.

Recommendations

1. Lewisham and Greenwich NHS Trust and Oxleas NHS Foundation Trust should:

- 1.1 Work together to agree and embed a robust risk management system and pathway to ensure timely sharing of information about children and young people and pregnant women who present at the Queen Elizabeth hospital.
- 1.2 Ensure arrangements for assessing the mental health of children and young people who attend ED out of hours are conducted in a timely manner. Continually monitor wait times and ensure that processes are jointly reviewed to improve timeliness as necessary.

2. Greenwich CCG and NHS England should:

- 2.1 Ensure GPs understand the importance of fully engaging with safeguarding processes and encourage them to share relevant patient information in a structured and analytical way with maternity services.
- 2.2 Ensure that GPs are informed of all children and young people who are subject to a child in need or child protection plan and who are accessing their services.
- 2.3 Implement joint arrangements and regular dialogue to ensure there is clarity about how safeguarding performance in primary care is monitored and assured.

3. Lewisham and Greenwich NHS Trust should:

- 3.1 Ensure that safeguarding and social issues are formally re assessed at intervals during a woman's pregnancy to identify emerging risks at the earliest possible opportunity.
- 3.2 Develop a robust risk assessment tool for use when children and young people are admitted to a ward with mental health issues and ensure this appropriately informs individualised care plans.
- 3.3 Ensure that all 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.
- 3.4 Ensure that relevant safeguarding information is captured in the maternity electronic discharge summary so that community colleagues, including GPs, are fully aware of current safeguarding issues.

- 3.5 Improve how safeguarding information and documents are retained in women's paper medical records to ensure they are easily identifiable, chronological and complete.
 - 3.6 Ensure that midwives are competent in identifying potential cases of CSE through training in the use of appropriate screening tools.
 - 3.7 Develop a robust quality assurance process to improve the standard of maternity 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.
 - 3.8 Develop an improvement plan with timescales to assure commissioners that contractual safeguarding training compliance figures will be achieved at all levels across the trust.
 - 3.9 Implement the trust's new operational policy for safeguarding supervision. Ensure the policy adequately reflects the safeguarding responsibilities of all staff groups in relation to professional scrutiny and challenge and record keeping.
- 4. Greenwich CCG, Lewisham and Greenwich NHS Trust, Oxleas NHS Foundation Trust and the Royal Borough of Greenwich council should:**
- 4.1 Strengthen and formalise arrangements for liaison between GPs, maternity and health visitors, to ensure that multi-disciplinary exchange of information takes place for vulnerable families, children and young people.
- 5. Oxleas NHS Foundation Trust and CGL Greenwich Aspire should:**
- 5.1 Develop partnership links between health visiting and adult substance misuse services to ensure services work together to support children within families where adults misuse substances.
- 6. Oxleas NHS Foundation Trust should:**
- 6.1 Continue to work with the local authority to ensure that a school nursing service is offered to the full cohort of home educated children.
 - 6.2 Develop partnership links between the sexual health service and young people's substance misuse services to ensure that these young people are offered a clear pathway into sexual health services.
 - 6.3 Improve practitioners' understanding of the importance of joint working and dialogue between all services about safeguarding matters to augment the use of the shared records.

- 6.4 Ensure that the current IT system in the sexual health service clearly identifies all vulnerable young people accessing the service.
- 6.5 Revise the quality assurance process to improve the standard of referrals from practitioners to children's social care to ensure information contained within referrals is complete, relevant, clearly analyses and articulates risk, relates to the local threshold document and is outcome focused.
- 6.6 Work with the local authority to ensure the full cohort of children known to be at risk of CSE are appropriately identified on the electronic patient record used across the trust.
- 6.7 Develop a template to ensure a robust handover of care when a child moves to universal services from the looked after child health team.
- 6.8 Ensure that health assessments for looked after children are a continuum so that issues identified in any previous assessments inform current health reviews.
- 6.9 Ensure the looked after child health team are involved in and are apprised of outcomes of strategy discussions for children and young people at risk of CSE so that they can consider their involvement if necessary in any follow-on work.
- 6.10 Provide all practitioners who conduct initial or review health assessments with looked after children with specific training to improve their understanding of the asylum seeking experience, particularly in relation to emotional wellbeing.
- 6.11 Ensure all health assessments are child or young person focused and fully capture the 'voice of the child' including where possible a child or young person's own words.
- 6.12 Review the quality assurance process for initial and review health assessments to ensure it is transparent, robust and drives improvement in the overall standard of health assessments being undertaken.
- 6.13 Expedite the development and provision of a health history or passport document for all young people leaving care.
- 6.14 Take measures to improve and embed a consistently high standard of record keeping for safeguarding purposes in the adult mental health service.
- 6.15 Continue to monitor the timeliness of initial health assessments to ensure that the assessments are completed within statutory timescales.

- 6.16 Ensure that specific cohorts of vulnerable children and young people can be identified from within the overall cohort of looked after children, such as those who are UASC, who are at risk of CSE or who misuse substances and use the data to inform service planning and workforce development.
- 6.17 Develop use of the IT system so all services centrally record specific concerns, vulnerabilities or safeguarding information, including non-attendance at appointments. Ensure all staff using the integrated system are aware of what should be recorded and where, to ensure standardisation of record keeping.
- 6.18 Review the safeguarding supervision provision in the sexual health service to ensure key staff have regular access to an appropriate level of professional scrutiny and challenge but also support in fulfilling their safeguarding responsibilities.
- 6.19 Ensure that the use of chronologies and genograms is routine within the health visiting service.

7. Greenwich CCG should:

- 7.1 Develop a perinatal mental health service in line with national guidance to strengthen the current provision of support for women with perinatal mental health difficulties.
- 7.2 Ensure that safeguarding lead GPs are supported in their role and better able to embed consistent good practice across primary care by developing regular safeguarding forums for lead GPs to attend.

8. Greenbrook Healthcare (Hounslow) Ltd should:

- 8.1 Develop a robust quality assurance process to improve the standard of referrals to children's social care from the urgent care centre. Ensure information contained within referrals is complete, relevant, clearly analyses and articulates risk, relates to the local threshold document and is outcome focused.
- 8.2 Revise the arrangements for carrying out an initial streaming assessment in the urgent care centre so that questions about mental health and emotional wellbeing are asked in an environment that ensures patients' dignity and privacy is appropriately respected.

9. CGL Greenwich Aspire should:

- 9.1 Establish robust operational governance and quality assurance processes to ensure practitioners understand and fulfil their safeguarding responsibilities in line with the service's procedures and national guidance.

- 9.2 Ensure that at a strategic and operational level the service is integrated and involved in the work of the local safeguarding partnership as well as with the work and priorities of the GSCB.
- 9.3 Establish a 'think family' approach in the adult substance misuse service that ensures staff consider the potential impact of an adult's substance misuse on children and that the 'voice of the child' is gathered and recorded when possible.
- 9.4 Conduct a training needs analysis to identify the safeguarding development requirements of staff and use this to formulate a safeguarding training plan to meet the identified need.

10. Greenwich CCG and Oxleas NHS Foundation Trust should:

- 10.1 Revise the role of the designated nurse for looked after children to ensure that the post holder remains independent of the provider and is able to carry out effective quality assurance and development work.

11. Greenbrook Healthcare (Hounslow) Ltd and Lewisham and Greenwich NHS Trust should:

- 11.1 Work together to develop better information sharing arrangements and align care pathways to improve the experience for patients moving between their services.

Next steps

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

Please submit your action plan to CQC through The plan will be considered by the inspection team and progress will be followed up through CQC's regional compliance team.