

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

Children Looked After and Safeguarding

The role of health services in Havering

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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 Havering. 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 Havering, 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 78 children and young people.

Context of the review

The majority (96.1%) of Havering residents are registered with a GP practice that is a member of NHS Havering Clinical Commissioning Group (CCG).

Published information from the Child and Mental Health Observatory (ChiMat) 2016 shows that children and young people under the age of 20 years make up 24.0% of the population of Havering. There are 29.8% of school children that are from a minority ethnic group. The number of children (under 16) living in poverty in Havering is 18.4% which is just below the England average of 18.6%.

On the whole, the health and wellbeing of children in Havering is generally better than the England average. Out of 30 applicable indicators Havering was significantly better than the England average for 14 (46.7%). They were significantly worse off than the England average for two indicators; obese children aged four to five years was 10.4% with the England average scoring 9.1%; Accident and emergency attendances for those aged under four were 653.4 per 1,000 with the England average scoring 540.5 per 1,000.

The Department for Education (DfE) provide annual statistics of outcome measures for children continuously looked after for at least 12 months. The DfE reported Havering had 120 children that had been continuously looked after for at least 12 months as at 31 March 2015 (excluding those children in respite care). As at 31 March 2014, there were 10 children aged five or younger who had been looked after for at least 12 months.

A strengths and difficulties questionnaire (SDQ) was used to screen the emotional and behavioural health of looked after children within Havering. The most recent average SDQ score is considered to be borderline cause for concern and is above the England average of 13.9.

The percentage of looked after children whose immunisations were up to date is 87.5% which is slightly lower than the England average at 87.8%. The percentage of looked after children having their annual health assessment completed (90.5%) and their teeth checked by a dentist (87.5%) is higher than the England average.

Commissioning and planning of most health services for children are carried out by Havering CCG. Some of the governance and administrative functions of Havering CCG are part of a three-way arrangement with the neighbouring Barking and Dagenham CCG and Redbridge CCG (known as BHR CCGs) and the relationship with each local authority. This report will mostly refer to simply Havering CCG throughout unless it is relevant to report on the three-way arrangement.

Commissioning arrangements for looked-after children's health are the responsibility of Havering CCG and the London Borough of Havering local authority. The looked-after children's designated roles are provided by the CCG with operational looked-after children's nurses, and interim arrangements for the named nurse for looked-after children provided by North East London NHS Foundation Trust (NELFT).

Acute hospital services are provided by Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT).

Health visitor and school nurse services are commissioned by the Public Health department of the London Borough of Havering and provided by NELFT.

Contraception and sexual health services (CASH) are commissioned by the Public Health department of the London Borough of Havering and provided by BHRUT.

Child substance misuse services are commissioned by the Public Health department of the London Borough of Havering and provided by Young Addaction. We did not visit this service as part of this review.

Adult substance misuse services are commissioned by the Public Health department of the London Borough of Havering and provided by Westminster Drugs Project.

Child and adolescent mental health services (CAMHS) and adult mental health services are commissioned by Havering CCG and provided by NELFT. Universal CAMHS is partly funded by Havering Local Authority. Specialist children's mental health facilities are provided by NELFT.

The last inspection of health services for Havering's children took place in September 2011 as a joint inspection, with Ofsted, of safeguarding and looked after children's (SLAC) 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 or carers to whom we spoke, or whose experiences we tracked or checked. A number of recommendations for improvement are made at the end of the report.

What people told us

We heard from new parents on the maternity ward. They said:

“Everybody has been fantastic, they are so busy but they have done everything they need to do, I feel bad asking for help because they are so busy but I can’t fault anybody”.

“Everybody has helped us all so much, they have taken time to deal with and answer any questions”.

“It has been really good care here, everyone has been totally brilliant”.

We heard from care leavers who told us:

“If I had a health problem it was always sorted out quickly and help is there”.

“I have had a problem with my teeth since I was young. The doctor told me that my mum must have taken some pills that affected my teeth and so now they are like that. I was being seen by a dentist before I was 18 and then when I turned 18 I was told I would have to pay but it is too expensive. I don’t feel I can be myself, people stare at me. At least they could have tried to do something”.

“The process for me having my vaccinations could have been improved. I needed more than one but then after the first one I was told I would get a letter and I still haven’t got anything and that was 6 months ago now”.

“It was nice knowing my exact height and weight”.

“I had my looked after children’s review in July and there was someone from health there. Even though they have all been saying for the last two years, that they definitely need to look into counselling for me, it has just been done because I am about to leave care. It’s too late now, I have had to deal with things myself”.

“As a looked after child you do have lots of opportunities.”

“I found the questions that were asked in my health assessments quite silly – ‘Have you ever thought about harming yourself?’ Even if I had self-harmed, I would have said no to that question because of the way it was asked. I don’t know that person who is asking the question and it is daunting and you don’t know the consequences. It should be more of a general conversation such as ‘have you ever felt you have had no-one around to support you?’ ”

“The questions around mental health should be more subtle to start off with.”

“Queens A&E is not the best, they are very slow and they treat you like what you have is not an emergency.”

“I am moving to my own flat on Monday and no-one has sat me down and helped me – apart from my foster carers. No-one has told me what services I can access or how much rent I will have to pay, I’ve never had to deal with paying bills”.

Young people’s views of CAMHS:

“You can talk to people, they are supportive in the sense that if you feel you have depression or you are sad”.

“If something happens, they understand you, someone gets where I’m coming from and understands what I’m trying to say.”

“CAMHS sessions were difficult as they dug really deep into my life and I wasn’t expecting it.”

We talked to foster carers and they said:

“I have a good relationship with my health visitor, she is always available and easy to contact. I know if I leave a message I will get a response.”

“We have to push to get health appointments, for example follow up checks at the hospital. I don’t think he would have been given an appointment if I hadn’t contacted them.”

“There was a time when he told me he felt depressed and I was concerned so I contacted CAMHS and his appointment was brought forward to the following day.”

“[Name] has one to one support in school and the school have been marvellous too.”

“Appointments to follow up health needs can sometimes be a bit slow.”

“Access to counselling for older children is difficult as it is a different process and a long wait. They are left in the lurch when they are older. Everything seems to take so long.”

“CAMHS work hard to engage with those who are initially reluctant.”

“I feel listened to, even as a foster carer.”

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 We heard from the CCG, local authority representatives and providers of acute and community services that the growing population in Havering is contributing to an increased demand for services. However, this does not correlate with the available resources in provider services which may impact on capacity and their responsiveness. For example; we heard about the construction of two new schools in Havering but this has not resulted in an increase in the numbers of school nurses or other health services in the local area.

1.2 Children in Havering who need urgent care can attend the 24 hour paediatric emergency department (ED) at Queens Hospital. Children benefit from an environment, facilities and emergency care pathways that are appropriate for their age. There is a dedicated paediatric waiting area separate from the main ED waiting area with its own reception operating between 9.30am and 10pm. This is staffed by a paediatric trained nurse who sits alongside the receptionist in order to have an initial, first look at any child to identify any features of the child's presentation that would indicate a need for them to be seen straight away. At this point children can be 'streamed' into several different routes. Children can be seen by the triage nurse who prioritises their treatment according to need whilst those with a minor illness or injury can be seen by an urgent care GP based on site. They can also be seen and treated quickly by a paediatric emergency nurse practitioner. Although the role of 'streamer' is currently only covered around half of the time due to the availability of staff, the arrangements are nonetheless flexible and enable the most appropriate, timely care to be provided to children according to their need.

1.3 The paediatric ED have good arrangements in place to maintain oversight of those waiting for assessment and treatment whilst in the department. The triage nurse carries out a physical observation of the waiting area every 15 minutes and the number of children waiting is recorded each time. A clear glass door into the treatment area aids the identification of a child should their presenting condition deteriorate. These arrangements also afford an opportunity for staff to observe and note the interaction between children and those accompanying them; this can aid the identification of concerning behaviour that would enable staff to respond and intervene in order to safeguard the child.

1.4 ED staff identify the hidden child well in those adults that attend with concerning behaviours by using an adult safeguarding trigger tool. This practice allows clinicians in the department to consider the hidden child and respond to needs. However, existing arrangements at Queen's ED to inform community practitioners such as health visitors and school nurses of children's attendances, or concerns about hidden children are not effective. There has been a recent change in the information sharing agreement between BHRUT and NELFT which limits effective information sharing preventing health visitors and school nurses receiving notifications of all children's ED attendance. As a consequence health visitors and school nurses are not given the opportunity to consider every child's attendance at the ED in the context of what they may already know about the child or family. The matter has therefore been escalated for service managers to negotiate and resolve, but this presently remains on the health visitor risk register. Whilst GPs receive discharge notifications of all children's attendances it cannot be assumed by the trust that GPs would routinely share this information with community teams. This review has identified that links between GPs and community teams are not strong. Therefore, opportunities to routinely discuss children are hindered. This approach limits the opportunity for health visitors and school nurses to respond to emerging or identified needs and provide early help that would benefit the child and family. (**Recommendation 1.1**).

Case example

An adult had attended the ED following ingestion of alcohol and domestic abuse was disclosed. Staff had identified that the person was a parent and made an appropriate and effective referral to children's social care.

The referral documented the risks to the children who were reportedly staying with a grandparent.

Whilst this demonstrates proactive child safeguarding practice the information was not shared with the school nursing service.

This prevented the offer of additional support being initiated to help this vulnerable family.

1.5 The majority of pregnant women access maternity services at Queens Hospital through their GP practice although they can self-refer into the service. We saw evidence that midwives have a flexible approach to conducting antenatal appointments in a variety of settings, although most contact is made at midwifery antenatal clinics held within the community. This ensures midwives are visible which can help to engage women in their care.

1.6 GPs complete referrals for pregnant women using a 'maternity care referral form for antenatal care' which includes the notification of identified vulnerabilities. However, in the notes we reviewed, the 'social or additional risk factor' section was often left blank. This is a missed opportunity for GPs to share pertinent information at the point of referral to maternity services to aid ongoing care planning and timely access to additional support early in pregnancy if required. (**Recommendation 5.5**)

1.7 At Queens Hospital maternity unit there is a small specialist team of midwives for vulnerable women. These midwives have case holding responsibility for high risk cases, and are available to advise and support midwifery colleagues with medium to low risk cases. We saw good evidence of their 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.

1.8 The arrangements to routinely share information about a woman's pregnancy from midwifery to health visiting are not consistent. BHRUT are aware of this and have taken action to review a pathway to strengthen the liaison between the two services. In the absence of any formal arrangement for midwives, health visitors, school nurses and GPs to meet and discuss vulnerable families, information sharing is reliant on individual practitioners contacting professionals to exchange concerns. We saw individual case evidence of liaison by maternity staff with other health professionals such as substance misuse and mental health services. Good information sharing provides opportunities for services to work collaboratively to ensure women's needs are met to help secure the best start for babies and their families.

1.9 At Queens Hospital women are informed in their booking appointment letter that they will be seen alone for the first part of their appointment to discuss their personal medical history. This 'Time 2 Talk' approach facilitates discussion about domestic abuse and other social issues. Any concerns raised at this point are recorded on the electronic patient record in the maternity unit (E3). With consent, referrals are made to appropriate services to enable women to access early help and support. The trust currently has the benefit of an independent domestic abuse advocate (IDVA) from the Victim Support charity working in the hospital to help provide support to victims. Research widely recognises an increased risk of domestic violence beginning or escalating during pregnancy and we were assured that processes are being followed to support the identification of women who are experiencing domestic abuse.

1.10 The named midwife at Queen's hospital routinely receives police notifications of domestic abuse incidents involving pregnant women. Notifications are made by telephone from the health representative in the Havering Multi-Agency Safeguarding Hub (MASH). Furthermore, link midwives and the IDVA are engaged in local Multi-Agency Risk Assessment Conference (MARAC) meetings. This facilitates multi-agency information sharing and decision making which, in turn, informs the ongoing care midwives provide.

Case example

It is well evidenced that domestic abuse often starts or intensifies during and after pregnancy hence midwives and other health professionals have an important role in early identification and protection.

The completion of routine enquiry regarding domestic abuse aids the early identification of risks. A recent audit at BHRT demonstrated that midwives completed this for 92% of women sampled.

Furthermore, the midwifery team received professional recognition by the British Journal of Midwifery in June 2013 who awarded them second place in the 'best team' category for their work in the 'Time 2 Talk' routine enquiry into domestic abuse made at booking.

1.11 Teenage parents are offered bespoke antenatal classes or one-to-one sessions if this is more appropriate than the generic classes available for all other women. This sensitive young-person centred approach can help to engage this hard to reach cohort with access to maternity services and additional support that will contribute to achieving improved wellbeing.

1.12 There is a commissioned integrated Perinatal and Parent-Infant Service in Havering provided by NELFT. The Maternity Review (2015) reported improved outcomes that included the less likelihood of relapse in psychotic illness; less likelihood of the need for ongoing secondary mental health services upon discharge from the service; evidence of improved attachment security in many of the babies at 12 months. We were informed that robust mental health assessments and plans covering diagnosis, risk factors, triggers and strategies to manage any issues, are included in women's notes when appropriate. It is essential that specialist 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 newborn.

1.13 There are no specialist health visitor roles in Havering, however we were informed that most band seven health visitors have been allocated a topic of interest and act as an expert resource for colleagues; for example, in child sexual exploitation (CSE) or female genital mutilation (FGM); and most band seven health visitors are safeguarding children supervisors. One health visitor provides support to families from the Gypsy, Roma and Travelling community in Havering which means that these families can access timely early help and support from the health visiting team.

1.14 Health visitors are engaged in the maternity partnership meetings at Queens Hospital. This enables professional discussion and information sharing about families that are receiving specialist support including safeguarding. Regular caseload discussions improve information sharing, joint working and the early involvement of health visitors. Transition of care is better for families and it also ensures additional targeted support can help improve outcomes for families. However, those families with additional needs that are below the threshold for inclusion at the maternity partnership meetings are not included in the discussion yet may not benefit from this approach.

1.15 Health visitors in Havering do not offer the five mandated visits in accordance with the 'Healthy Child Programme'. Contacts consists of a targeted antenatal visit, a new birth visit, a targeted six week visit, a 12 month development check and a further review at two to two and a half years of age. The two and a half year development reviews are not yet fully integrated across Havering; however, we were informed that an integrated review is currently being trialled in one nursery setting. Healthwatch informed us of their concerns about some of these contacts and referred this through the Health and Wellbeing Board to the Children's Commissioner for review. We were told that the targeted health visiting offer to families in Havering was a commissioning decision made in response to health visitor capacity and increasing demand. This approach is not equitable and limits the opportunity for health visitors to search and respond swiftly to new or emerging health needs. *This issue has been brought to the attention of Public Health, as the commissioners of the health visiting service.*

1.16 The health visiting service demonstrated that good arrangements are in place to follow up families that miss appointments. Families in Havering are routinely offered two appointments with the health visiting team, prior to carrying out further investigation for those who fail to attend planned appointments. We saw within notes that practitioners made several attempts to contact non-engaging families using a variety of media, including letters and telephone calls. If the health visitor is unable to make contact with the family they liaise with key professionals including GPs and the children's social care team. This demonstrates that the health visitors are proactively working to support children to receive the care they require.

1.17 School nurses are not commissioned to undertake the full range of staged contacts outlined in the 'Healthy Child Programme' (five to 19) for children and young people in Havering. The National Childhood Measurement Programme (NCMP) is undertaken for reception and year six children with reception children further benefitting from an assessment of their health needs. However, no other universal health needs assessments are routinely offered to school aged children. This prevents school nurses from proactively searching, identifying and responding to needs of school aged children to ensure their needs are met.

1.18 In school nursing the existing arrangements to aid the identification of children that are home educated or other potentially hidden children such as those that are not in employment, education or training (NEET) are not robust. This reduces the visibility of these children and restricts the opportunity to offer early help or more specialist support if needs and risks had been identified. However, it was reported that some progress has been made to link a band seven member of staff from NELFT with the local authority virtual head to respond to this. *This issue has been brought to the attention of Public Health, as the commissioners of the school nursing service.*

1.19 The school nursing service is visible and accessible in both primary and secondary schools through the provision of drop-in's. This improves access to universal children's services enabling the offer of further assessment and access to additional support to help meet the identified health needs of school aged children. Achievement of this by the service is monitored through key performance indicators.

1.20 In high schools there is a move to provide young people with access to the 'C card' scheme with all school nurses becoming recently trained. However, the willingness of schools to host this offer in their establishment is reported to be limited. Where provided this will improve access for children and young people to sexual health support and services. This limited provision has resulted in school nurses' signposting children and young people to contraception and sexual health (CASH) services if this is appropriate for their needs.

1.21 School nurses provide support to children and young people experiencing emotional and mental health difficulties that do not meet the threshold for specialist child and adolescent mental health service (CAMHS). Clinical decisions about care planning for this cohort of children and young people are based on the professional judgement of individual staff and are not underpinned by the use of risk assessment tools. This may inhibit the provision of consistent practice and prevents the tracking of responses given to aid the recognition of improving or deteriorating mental health. School nurses have access to a primary mental health practitioner for consultation where they can discuss cases to aid their ongoing care and management of children and young people.

1.22 The school nurse service manager attends the virtual child sexual exploitation (CSE) and MASE meetings facilitating the exchange of information to inform multi-agency decision making to safeguard children and young people. School nurses are expected to use the NELFT CSE toolkit to rate the level of CSE risk in children and young people when they identify a concern. This relies on individual practitioner professional curiosity and judgement to identify risks in children and young people they support rather than a universal approach to risk assessment that includes CSE. This restricts the opportunity to proactively identify and safeguard children at risk of CSE. Furthermore, in the absence of any monitoring or spot checking of this practice the effectiveness is unclear. **(Recommendation 2.1).** *This issue has been brought to the attention of Public Health, as the commissioners of the school nursing service.*

1.23 We were told that approaches to enquire and assess for the risk of female genital mutilation (FGM) are not well developed in school nursing for children and young people they support. This is a missed opportunity to sensitively identify victims or those at risk of FGM given that 24.8% of school aged children are from minority ethnic groups (Child and Maternal Health Observatory 2016). **(Recommendation 2.2)**. *This issue has been brought to the attention of Public Health, as the commissioners of the school nursing service.*

1.24 Resources have been challenged recently due to episodes of sickness in the school nurse team. This has led to staff covering additional caseloads and the use of bank staff. Managers acknowledge that caseload sizes exceed the advice stipulated by Community Practitioners and Health Visitors Association (CPHVA) to commissioners. Staff reported that caseload size has had little adverse impact on children and young people.

1.25 The CAMHS service maintains links with local third sector organisations such as ADDUP (Attention Deficit Disorders Uniting Parents) and the Sycamore Trust (a local service supporting families with Autism) as well as with clusters of local schools through Special Educational Needs Co-ordinators. In this way the service identifies children who might benefit from early help by ensuring they have access to relevant local services.

1.26 Practitioners in adult mental health record the details of linked children in adult records in the electronic patient records system but this is frequently recorded in different parts of the electronic record. Furthermore, whilst the adult's progress notes are often detailed in recording concerns about children, this does not then consistently inform the risk assessment or the linked child safeguarding template. This reduces the visibility of escalating or de-escalating concerns to those accessing the record. Whilst it is evident that a think family approach underpins practice the use of consistent approaches will strengthen this further by ensuring children are highly visible to practitioners using the record. **(Recommendation 2.3)**

1.27 On the whole, in adult mental health we saw evidence of liaison with other agencies to facilitate collaborative working for the adult and linked children. The format of a shared record across NELFT services helps to inform ongoing care that different services may provide to families. However, this in itself is not a robust way to alert staff to safeguarding, or other concerns for children across the NELFT partnership as it relies on practitioners using the record in order to see this information. In the absence of tasking or other information sharing notification there is a risk that practitioners such as health visitors or school nurses providing a universal service and not actively working with these families may not be aware of a change in the needs of children. **(Recommendation 2.6)**

1.28 Westminster Drug Project (WDP) have developed assessment documentation that aids the identification of under 18s linked to the adults they support. However, records we reviewed demonstrated that practitioners do not consistently complete this field as part of the initial assessment. This reduces the visibility of children and young people and inhibits a robust 'think family' approach. As a consequence this may prevent access to additional support that would benefit the family. **(Recommendation 3.1)** *This issue has been brought to the attention of Public Health, as the commissioners of the WDP service.*

1.29 Westminster Drug Project do not routinely liaise with health visitors and school nursing services when they identify children that are linked to adults that use their service. Furthermore, WDP carry out home visits to families to assess safe storage of medications. A partnership approach with universal children's services would strengthen the delivery of safety information to families that could include issues such as safe sleep. The existing approach limits the opportunity to exchange information to ensure that any risks and additional needs for children are understood across these services and responded to effectively. It would also provide an opportunity to review any risks around lone working arrangements to support staff safety. **(Recommendation 3.2)** *This issue has been brought to the attention of Public Health, as the commissioners of the WDP service.*

1.30 Westminster Drug Project implement a timely and managed 'did not attend' and re-engagement policy. Whilst this includes the completion of a risk assessment, practitioners also update other services involved, such as mental health, GP, criminal justice system and children's social care. However, universal children's services are not routinely included in this contact. This is a missed opportunity to share information with health visitors and school nurses that are uniquely placed to engage with families and children that could facilitate some ongoing oversight of their needs whether escalating or de-escalating. **(Recommendation 3.2)** *This issue has been brought to the attention of Public Health, as the commissioners of the WDP service.*

1.31 Young people in Havering currently have access to a fully integrated contraception, sexual health and genitourinary medicine (GUM) service, in various generic clinics as well as one community based young person specific clinic. However, the existing provision is the subject of re-organisation with the planned arrangement set to see the service become more streamlined available through one central hub location. It is not clear what impact this will have on young people's ease of access to CASH services.

1.32 The reach of sexual health services into Havering secondary schools is reportedly limited due to capacity within the sexual health service despite several schools requesting their input. This is a missed opportunity to ensure that young people can have access to sexual health advice and support in a range of locations and venues that are easily accessible for them.

1.33 Sexual health staff report good working relationships with the teenage pregnancy specialist midwife at BHRUT. This is leading to the development of a pathway to improve access to contraception for postnatal teenagers while they are still in hospital. Furthermore, there are good links with the Young Addaction youth worker in Havering which has improved this client group's access to sexual health services. However, the Young Addaction youth workers post was disbanded recently and the effects of this on limiting accessibility for young people is yet to become evident.

1.34 The under 18s risk assessment tool used by sexual health practitioners aids the identification of children and young people that would benefit from additional support or safeguarding. However, the quality of risk assessments is hindered by practitioners continuing to use the same individual risk assessment tool for several years. As a consequence practitioners are reviewing information that is two or three years old and may not wholly reflect children and young people's current risks. **(Recommendation 1.2)** *This issue has been brought to the attention of Public Health, as the commissioners of the CASH service.*

1.35 Formal liaison between the community child health teams and GPs in Havering about vulnerable children and families is underdeveloped. . Neither practice visited has regular liaison meetings with the school nursing, health visiting or the maternity service other than receiving routine pregnancy booking notifications. In these practices GPs are unsighted in much of the key information and discussions about vulnerable families. Neither are they routinely contributing to colleague's decision making discussions. As a consequence there is a risk that information is not effectively being shared to help inform ongoing care to children and young people with additional needs and vulnerabilities. **(Recommendation 4.1)**

2. Children in need

2.1 Any child attending the ED at Queens Hospital identified as having additional unmet needs or who is otherwise at risk is subject of a referral to the children's social care through the multi-agency safeguarding hub (MASH). We learned that there had been a significant increase in referrals to the MASH over the last 18 months, evidence of an increasing insight and capability of staff in identifying additional needs brought about by more intensive management oversight. Referrals are made using the local safeguarding children's board multi-agency referral form (MARF).

2.2 Children and young people attending the ED who have harmed themselves, either physically or through medicine overdose, are treated as meeting the locally defined threshold for child in need or child protection and are subject of a mandatory referral to the MASH. This ensures that children's social care is aware of the additional vulnerabilities of the child and, has the opportunity to consider their family, environmental and social situation alongside any work with the CAHMS service as part of their response.

2.3 Children who are anxious or in mental health distress remain in the paediatric ED until they receive a mental health assessment unless they require admission for medical treatment. One-to-one supervision is arranged for children and young people who are more acutely distressed with access to a room in either the paediatric or adult ED that can be quickly adapted to create a less harmful or anxiety provoking environment. Those aged under 16 requiring medical treatment are admitted to the paediatric ward, whilst 16 and 17 year olds are admitted to an adult medical ward. Mental health assessments are carried out by the CAMHS service between the hours of 9am and 5pm and by the hospital based Psychiatric Liaison Service (PLS) out of hours. The PLS have on-call, 24 hour access to a paediatric psychiatrist in order to assist them in making their assessment.

2.4 An IDVA has a permanent, accessible presence in the Queens Hospital during week days. Staff can call upon the IDVA for advice to support their decision making in relation to families for whom there are concerns about domestic abuse. This raises the profile of domestic abuse to staff as an effective resource they can utilise in order to respond to and support vulnerable families.

2.5 At Queens Hospital maternity unit there is a small 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 medium to low risk cases. We saw good evidence of their 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.

2.6 Referrals to community children' services provided by NELFT, including CAMHS, are made through a single point of access. This approach facilitates access to the most appropriate service to meet the needs of children which helps to prevent delays in accessing support.

2.7 When a Havering health visitor transfers a vulnerable family to another health visitor team, where possible a face-to-face meeting will take place within 48 hours. The minimum expectation in these cases is a telephone call to the receiving health visitor to notify them verbally of the transfer and any ongoing concerns. A formal 'transfer out' form is also completed and forwarded to the new health visitor team. In records, we saw that this was a comprehensive summary record of relevant information which aids continuity of care and support for families. We saw in records evidence of Havering health visitors making timely contact with vulnerable families transferring in to the area which helps to keep families engaged with the service.

2.8 In health visiting, maternal mental mood assessments based on the 'Whooley' questions are generally conducted at the first postnatal visit and reconsidered as necessary at subsequent contacts. We saw evidence of questions relating to maternal mental health being routinely asked and recorded within notes reviewed. We were advised that health visitors have good working relationships with the perinatal mental health team and they share the same electronic patient record system which aids good information sharing, communication and joint working.

2.9 Health visitors conduct routine enquiry around domestic abuse at the new birth visit when possible, if not addressed at this contact this is recorded and opportunistically followed up when the woman is seen alone. It is important that all health visitors are routinely assessing maternal mental health and facilitating disclosure of domestic abuse as both can have a significant impact upon parenting capacity. Compliance with undertaking routine enquiries about domestic abuse would benefit from being audited to ensure that women subject to domestic abuse are adequately being identified and offered access to relevant support services at the earliest opportunity.

2.10 All GPs in Havering have a group of health visitors assigned to their practice that they can contact when necessary and we were informed that relationships with GPs in the area are generally good. However, health visitors do not attend any meetings with GPs to discuss families and share relevant information. This is a missed opportunity to ensure that vulnerable and complex families receive a co-ordinated approach to their care and also that families who would benefit from early help and support are identified. Therefore, more work needs to be done to ensure that health visitors have an opportunity to meet with their allocated GP practice to share information about safeguarding cases and vulnerable families. *This issue has been brought to the attention of Public Health, as the commissioners of the health visiting service.*

2.11 Health visitors and school nurses in Havering flag the electronic patient records of vulnerable children and families on their caseloads, including children subject to a child protection or child in need plan. The completion of such alerts ensures that vulnerable children are highly visible to practitioners using the electronic patient record with this then helping to inform their ongoing care.

2.12 Referrals to CAMHS are triaged by gathering information from parents, schools and GPs in order to determine the most appropriate pathway and within a timescale governed by the child or young person's needs. For example, children who are looked after will be seen within two to four weeks of initial referral whilst those with more acute need will be followed up within five days. This approach enables the prioritisation of work based on the needs of children and young people referred.

2.13 Clinicians in the CAMHS service effectively identify children in need and contribute to child in need processes. In one of the cases we were tracking across services we noted ongoing involvement of the CAMHS clinician with a young person who was subject of a child in need plan, including attendance at child in need meetings. The needs of the young person as they related to their mental health were documented in detail in the patient record. In this case the clinician had articulated risk well and clearly explained how this risk had led to a challenge to the social worker's plan to step down the level of intervention from child in need. This degree of analysis of risks means that the young person's emotional needs are a key feature in ensuring they receive the most appropriate level of service.

2.14 CAMHS provide children and young people in Havering with good access to a range of dedicated provision specific to their needs. As well as a specialist mental health clinician for children who are looked after, the CAMHS service also has additional specialist clinicians for children who are involved with the youth offending team, those with a learning disability and children and young people with long term medical conditions. This approach provides families with support from appropriate professionals at their time of need that can contribute to improved outcomes.

2.15 NELFT acknowledged that there is more to do in formalising transition arrangements to support children and young people that require adult services. Adult mental health services and CAMHS are developing transition pathways to aid planning for young people approaching 18 that require adult services. This will help to ensure that the needs of children and young people can be met through appropriate services. The existing arrangements involve monthly meetings between CAMHS and adult services from around the age of 17 and half years. Furthermore, NELFT have identified a gap in provision for young people experiencing emotional disturbance that do not meet existing adult criteria for support. Managers are actively engaged in seeking a solution to meet the ongoing needs of this vulnerable cohort of young people.

2.16 BHR CCG have set out transition arrangements amongst other matters in The Transforming Care Partnership three year plan (2016) to support children, young people and adults with a learning disability or autism, who display behaviour that challenges (including those with a mental health condition). Whilst this document sets out progress that has been made it also acknowledges areas for further development that will benefit children and young people with these specific needs such as joining up commissioning, decision-making and their care.

2.17 We learned that Healthwatch had supported BHRUT in the development of a number of approaches to caring for vulnerable children with learning disabilities. These include the development of appropriate literature about services; changes to registration processes to aid the identification of these vulnerable children; development of a lead nurse role for learning disability and the development and implementation of a training programme for staff. This supports services to respond effectively to children and young people with learning disabilities.

2.18 Adult mental health staff do not routinely alert universal children's services when they are supporting adults linked to children with their mental health. Whilst crisis and contingency plans are recorded in the adult's electronic patient record these are not routinely shared to inform health visitors and school nurses of the early warning signs of worsening mental health of the adult. This hinders joined up working in supporting the family and misses the opportunity to raise awareness of what those changes in the mental health of the adult are to help initiate a swift response that limits the impact on children.

2.19 WDP have implemented an approach that sees children linked to adult clients routinely referred to the MASH. This timely information sharing process offers an opportunity to safeguard children and establish a culture of communication early in the client's journey. However, we found that information sharing with children's social care was weak for pregnant clients unless they were in their third trimester. This approach is underpinned by views held by WDP that children's social care will not accept referrals for unborn babies earlier in pregnancy. This arrangement delays the provision of effective joint working and care planning with the specialist substance misuse midwife to help secure improved outcomes and safeguard the unborn child. **(Recommendation 3.3)** *This issue has been brought to the attention of Public Health, as the commissioners of the WDP service.*

2.20 Universal children's services and the sexual health service are represented at the weekly 'virtual CSE and children missing' meeting. This is a multi-disciplinary meeting where new referrals are discussed, information is shared and joint decisions made about further action taken. In sexual health this means that information gathered is placed within a young person's sexual health records if they are active to the service. We also saw information entered onto the electronic patient record of a school aged child. This enables health practitioners to have access to meaningful intelligence, which can support their decision making about risks during client interactions.

3. Child protection

3.1 There is a well-established health presence in the MASH; however, their expertise is not fully utilised to aid effective multi-agency decision making for all referrals made to children's social care. Referrals into the MASH, including those from health professionals are red-amber-green (RAG) rated by social workers with the health practitioners having no involvement in the ratings awarded to those children and young people. Cases triaged by social care as amber and red are passed to the health practitioners for full research of health information. They can access the electronic patient records system used by the NELFT mental health and community child health teams and to the system used by BHRUT for processing attendances to the ED; but, they do not have access to the electronic patient records system used in the midwifery service. Therefore, maternity information can only be obtained through a telephone call to the midwifery safeguarding team, sometimes resulting in a delayed response. Case evidence demonstrated that this information is collated and summarised well by the MASH health staff with risks properly highlighted ready for scrutiny by the social work practitioner.

3.2 Information is sought from GPs by the MASH social care business support officers with no additional input by the health practitioners. This means that the GP information is not generally considered in the context of other health information by an assessor with clinical insight. These arrangements could be strengthened to enable the MASH health practitioners to consider all health information together before the initial decision is made about which level of intervention the case requires. (**Recommendation 2.4**)

3.3 Information sharing arrangements with universal children's services are not strong for those referrals to children's social care that have been rated green. These cases are passed by the social worker directly to the early help team for lower level intervention. There is an assumption that health visitors or school nurses will be involved at a later stage as part of a team around the family, but this relies on the case being accepted by the early help team. However, we know from our site visits in the local area that this does not routinely happen. As a consequence child health teams cannot consider referral information, or lone worker issues, at an early stage in the context of what they may already know about a family. This is a missed opportunity to take early steps towards improving health outcomes for children linked to the referral. (**Recommendation 2.4**)

3.4 Children known to be subject of a child in need, child protection plan or who are looked after are visible to ED staff through an alert placed on the electronic record keeping system. This can heighten the clinician's awareness of additional vulnerabilities that helps inform their assessment of the child or young person. However, this does not extend to include those that are the subject of early help that universal children's service may have oversight of. In the absence of robust information sharing arrangements with health visitors and school nurses (as outlined in 1.4) these children's attendances do not go on to inform multi-agency planning or their care in the community. (**Recommendation 1.1**)

3.5 The ED have developed trigger tools to aid the identification of child safeguarding concerns for under 18s attending the department. However, this approach is not being fully utilised effectively by clinicians to inform their care of children and young people. The electronic record keeping system uses a mandatory safeguarding 'trigger' tool that governs the questions that staff consider when they are first seen by the triage nurse or the clinician that first assesses them. These questions include whether there has been an unexplained delay in seeking medical attention, the consistency of the history given by the adult who accompanies the child, the interaction between the child and the accompanying adult and whether the history has been given directly by the child. This supports staff in assessing whether there are any safeguarding concerns that require escalation and also reminds staff to seek the child's voice. The robustness of the safeguarding trigger tool is weakened at the point of the secondary safeguarding screen. This is expected to be undertaken when children are first seen by the doctor or just prior to discharge; however, patient notes demonstrated this was not well embedded and therefore not consistently completed by staff. (**Recommendation 1.3**)

3.6 Whilst we saw evidence that ED clinicians complete appropriate referrals to children's social care, this did not include how information about parenting or caring capacity had been established. This could challenge the validity of the assessment and furthermore does not underpin the professional judgement of the practitioner making the referral. As a consequence of the absence of this information there is a risk this may delay access to timely support that families would benefit from.

3.7 All safeguarding referrals made by the ED staff are monitored by the trust safeguarding team using a database. Referrals are followed up so that the outcome is known in every case and fed back to the practitioner who made the referral. Along with the previously mentioned psychosocial process, this provides robust quality assurance, support and learning for staff in relation to their initial decision making and fosters a culture of good practice.

3.8 Standards of record keeping were variable with some notable gaps in some of the information in the ED records themselves. Commonly, details of parents or carers were inconsistently recorded. In one case on the paediatric ward, entries in the patient record about a child's family members had been scored through and were illegible. This does not meet with professional record keeping standards and hinders clear understanding of parental responsibility for matters of consent. Furthermore, the absence of this information will impede professional curiosity of the appropriateness of the adult child relationship. (**Recommendation 1.4**)

3.9 The ED have implemented additional measures that sees all under 18s that attend benefitting from a retrospective screening of their attendance the next working day by the paediatric safeguarding nurse. This is carried out against a non-exhaustive checklist of features that include, for example, the presence of domestic abuse, risks of CSE or other harmful behaviours, injuries where there are concerns over the history given and the risks of self-harm. Any referrals to the community child health teams through the paediatric liaison nurse, and any referrals to the MASH are made at this point if they have not already been done by the ED practitioner who treated the child. This provides additional assurance that ED safeguarding processes and documentation are completed properly and that appropriate and timely referral action has been taken to safeguard children and young people effectively.

3.10 BHRUT have implemented an additional layer of scrutiny that helps to ensure that where concerns are identified that appropriate action is taken by staff. This involves a two-tier review process known as a 'psychosocial' meeting. An initial internal meeting involving the on-duty paediatric consultant, a paediatric ED senior staff member and a member of the trust's safeguarding team carry out a further screen of the records of the children in the previous week (or adults with access to children) for whom safeguarding concerns were identified. This is over and above the screen carried out by the safeguarding nurse. The list of cases is filtered so that the most concerning are taken forward to a second stage of the psychosocial process attended by multi-disciplinary or external partners such as children's social care, CAMHS, the IDVA, child and family psychotherapy and substance misuse. The purpose of this meeting is to consider the validity of action taken, the quality and standard of decisions and records made about those children and to trigger any additional or follow-up actions. These meetings are minuted by the safeguarding secretarial team so that a formal record is maintained of the discussion and review of those cases.

3.11 Queens hospital maternity department appropriately record pre-discharge planning meetings and resultant plans for ongoing postnatal support; however, the information is not fully transferred to the electronic discharge summary which is shared with health visitors, GPs and community midwives. In records seen the electronic discharge summary contained minimal safeguarding information, even when a newborn baby was subject to a child in need or child protection plan or required planned additional postnatal support. This is a missed opportunity to ensure community colleagues, including GPs, are fully aware of all safeguarding issues and also that their safety as lone workers is considered (**Recommendation 1.15**)

3.12 In maternity, electronic patient records were generally of a good standard. We saw evidence of appropriate challenge to children's social care decisions and tenacious work to ensure women, the unborn or newborn baby was protected. Where relevant we saw clear plans for around the time of birth within a woman's electronic record; however, these plans are not immediately identifiable as they are within the narrative of the notes. This reduces the visibility of this important information and there is a risk that an up to date plan may be missed, could inadvertently placing an unborn baby at risk of harm. (**Recommendation 1.5**)

3.13 At Queen's hospital we were informed that there is a locally agreed process in place for women who disclose during pregnancy that they have been subject to FGM. If there are females aged under 18 in the household or if the woman delivers a female child, a referral to the MASH is completed so that the risks can be considered fully?

3.14 Arrangements to support midwives to assess for the risks of CSE in those they are caring for are not well developed. Whilst midwives have received training about CSE they do not have access to a dedicated risk assessment tool within maternity records. This may impact on their ability to consider or exclude this as part of their ongoing care. Furthermore, midwives also reported difficulty in referrals being accepted where CSE has been identified as a risk. (**Recommendation 1.6**)

3.15 At Queens Hospital maternity unit active safeguarding cases are discussed at monthly maternity partnership meetings. These are multi-disciplinary and help to promote good interagency working and sharing of information in the antenatal period. These meetings also ensure all professionals working with a family have an up to date overview of cases. Furthermore, the named midwife ensures safeguarding or social issues are appropriately flagged on the electronic patient record system which increases the visibility of these vulnerable families to maternity staff.

3.16 The quality of the referrals we saw from Queens hospital midwifery services to children's social care were of a variable standard. Whilst they shared basic information there was limited analysis of the safeguarding risk and the potential impact of parenting behaviour on a newborn baby was not articulated clearly. The expected outcome of the referral was not included and they did not relate or refer to the threshold document. In the absence of a benchmarked standard to support midwives to consistently complete robust referrals to children's social care there is a risk this may impact on families receiving timely support. (**Recommendation 1.7**)

3.17 Child safeguarding documentation is not held in women's hospital maternal record but stored separately. This reduces the accessibility and visibility of information such as; referrals to children's social care, invitations to initial child protection conferences, reports for conference, and minutes from safeguarding meetings. This is a noticeable gap and does not provide midwives with access to a complete record. Whilst the electronic patient record contained up to date child safeguarding entries this is not easily linked to the underpinning documentation that is held separately. (**Recommendation 1.8**)

3.18 Health visitors and school nurses informed us that they are aware of the process to follow when referring children and families to children's social care via the multiagency referral form (MARF). Referrals to children's social care were of a good quality, clearly articulating and analysing risk and were outcome focused. A MARF completed by a school nurse demonstrated good knowledge and understanding of the child and captured the child's voice to evidence their wishes and feelings. However, there currently appears to be no formal quality assurance or oversight of MARF referrals or safeguarding reports. We were advised this is to be rectified in the near future but some monitoring in the interim period to prevent a decline in standards would be beneficial.

3.19 Health visitors in Havering prioritise attendance at all safeguarding children meetings and actively participate in the safeguarding processes. They are confident in sharing their professional opinions and will challenge other professionals and escalate concerns when appropriate.

3.20 School nurses are well engaged in safeguarding work and implement a new approach to ensure their involvement is based on need and having an identified role in child protection arrangements. This ensures effective use of the nurses' time and avoids the additional burden to families of additional professionals being involved when they have no identified role. This approach is freeing more time for school nurses that will aid the development of their public health role around prevention and health protection.

3.21 In records reviewed, both in health visiting and school nursing, reports for child protection conferences were of a good standard; they were comprehensive and outlined risks and protective factors from the viewpoint of the professional. This ensures that their expertise can go on to inform effective child protection multi-agency decision making that benefits the child.

3.22 The CAMHS service makes referrals to the MASH using the MARF whenever they encounter concerns. We also saw that the service routinely contributes to child protection processes by attending strategy meetings where they are involved in providing care to children or young people. However, we have seen that practitioners do not always effectively record safeguarding risks that reflect their actions in children's records. In one particular case a CAMHS clinician had a pivotal role in getting the local authority to revisit an earlier assessment that at the time may have warranted a child protection investigation. However, the impact of the clinical opinion was diminished as risks were not sufficiently articulated in the child's record or the chronology to underpin their decision making. Furthermore, the record did not contain entries that related to case discussions the clinician made with the school. This does not conform to professional record keeping standards and does little to inform the child's record of escalating concerns and the safeguarding actions taken by staff. (**Recommendation 2.5**)

3.23 In adult mental health, records are held on the electronic patient records system but those adults accessing improving access to psychological therapies (IAPT) have an additional record. In one complex case, the main electronic record clearly evidenced that there were multi-agency safeguarding arrangements in place for the family. It was not evident that this information was referred to by the practitioner to inform their decision to discharge the client or why this did not facilitate liaison with other professionals involved with the family. We were not able to scrutinise the IAPT record to clarify its alignment with the child safeguarding information held in the main electronic record. Where there are additional record keeping systems there is a risk that information can become fragmented causing poor access to information that does not inform ongoing care or safeguard children and young people.

3.24 Managers expect adult mental health staff to engage in multi-agency child safeguarding processes including their attendance at child protection conferences and the submission of reports. We saw a completed MARF that did reflect the practitioners concerns well; however, there was no evidence that this was proactively followed up to clarify the outcome of the referral. We also saw information shared to contribute to another child's looked after children review relating to the adult. It is positive to see adult services engaging in looked after children's reviews as this ensures their expertise forms part of the arrangements for the child.

3.25 In adult mental health whilst case records demonstrated that practitioners are identifying children linked to adult clients this was recorded in different parts of the electronic record. Furthermore, whilst the adult's progress notes were often detailed in recording concerns about children this did not then consistently inform the risk assessment or the linked child safeguarding template. This reduces the visibility of escalating or de-escalating concerns to those accessing the record. Whilst it is evident that a think family approach underpins practice the use of consistent record keeping will strengthen this further. (**Recommendation 2.3**)

3.26 Children that miss appointments with NELFT services benefit from a policy to guide professionals on how to respond. Whilst we did not see this applied in specific cases we saw evidence in health visiting that appropriate action was taken to meet the needs of a child who missed an appointment. This approach affords children that miss appointments with robust and proactive follow-up to ensure their needs are met.

3.27 We saw evidence that WDP engage in child safeguarding processes with minutes of child protection conferences seen in case records. Practitioners effectively articulate the risk and impact of the parent's or carer's substance misuse on the child to inform multi-agency decisions. However, reports for child protection conference are not routinely being shared with parents or carers prior to conference in accordance with best practice.

3.28 The existing record keeping arrangements in WDP do not facilitate the achievement of effective record keeping. In several cases that we reviewed, the paper records contained electronic print-outs that were not dated or signed and it was not clear what their purpose was for care planning. This does not adhere to record keeping guidance. Furthermore, the use of two record keeping systems increases the chances of essential information being missed, especially when considering and presenting risk to help safeguard children and young people. (**Recommendation 3.4**) *This issue has been brought to the attention of Public Health, as the commissioners of the WDP service.*

3.29 WDP have good arrangements in place that can help to keep children visible in their ongoing work with adults. However, the impact of this is diminished as actions and decisions made by the team at their safeguarding meetings are not recorded in client's records. This does not conform to professional record keeping standards and does not inform the client's record of agreed actions and outcomes to aid future care and planning. (**Recommendation 3.5**) *This issue has been brought to the attention of Public Health, as the commissioners of the WDP service.*

3.30 The alert facilities on the electronic records used by CASH are underdeveloped; whilst under 18s are flagged there are no alerts to aid the identification of looked after children or those subject to child in need or child protection plans. Furthermore, practitioners do not consistently have access to a complete record that contains risk assessments as a consequence of dual record keeping systems and the provision of care in different locations. As a consequence there is a risk that known vulnerabilities could be missed by practitioners; and, for children and young people they may have to unnecessarily keep telling their story. **(Recommendation 1.9)** *This issue has been brought to the attention of Public Health, as the commissioners of the CASH service.*

3.31 We were informed that sexual health practitioners are only occasionally invited to attend and contribute to safeguarding meetings. This is a missed opportunity for sexual health practitioners who may hold important information to routinely contribute to the health and wellbeing of young people.

3.32 Practitioners in the sexual health service are aware of the process to follow if they have any safeguarding concerns for a young person. MARFs are completed and a copy of the referral is sent to the trust safeguarding team, the safeguarding lead nurse within the sexual health service and a copy is placed in the young person's notes. The quality of the MARFs we reviewed was variable; some articulated and analysed risk well whilst others were vague and missing essential professional insight and opinion. All could be improved by being more outcome focused. A robust quality assurance process would aid the recipient of the referral to better understand the concerns being raised. **(Recommendation 1.7)** *This issue has been brought to the attention of Public Health, as the commissioners of the CASH service.*

3.33 Generally, GPs in Havering are unable to attend initial or review child protection conferences due to clinical commitments. We were informed that a report is always submitted to ensure that the relevant health history of children and their families can be taken into account by conference.

3.34 GPs respond to requests for information from children's social care for child in need or child protection enquiries. Staff in the MASH reported that GPs respond to these requests in a timely manner. However, the quality of the information passed to children's social care is of a variable standard. Information that is simply copied from the electronic patient record of chronological attendances is not acceptable and prevents any professional analysis of the significance of these attendances and any risks. There is more work to do to ensure GPs present information in a structured and analytical way which will aid effective and timely decision making by other professionals who have no medical knowledge. **(Recommendation 5.1)**

3.35 GPs we spoke to were confident in how to access appropriate advice and guidance if they had concerns about a child or young person and also in how to refer a child or family to children's social care. They have access to a primary care safeguarding handbook to aid their practice; this contains key contact numbers, templates for MARF and team around the family and guidance on information sharing.

Case example

We saw the adult mental health team respond appropriately to safeguarding concerns that had been reported to them about a 15 year old. The concerns related to the parent's substance misuse that was impacting on their ability to care for and keep their child safe.

Practitioners responded appropriately; having established that the child was safe, they completed a referral to children's social care. This reflected the level of professional concern and was sufficiently detailed.

The practitioner updated their internal risk assessment to high risk and the case was discussed in zoning meetings where this RAG rates cases of concern and provides additional internal scrutiny. A referral was made for the parent to WDP.

However, practice could have been strengthened by sharing this information with the school nurse to ensure an alert was placed on the child's record to flag escalating safeguarding concerns and to facilitate effective partnership working.

Furthermore, there was no evidence that adult mental health staff proactively followed up the referral made to children's social care to clarify outcomes for the child that would inform their ongoing care.

4. Looked after children

4.1 Designated looked after children professionals, commissioners and providers have demonstrated their commitment to improve the health offer to looked after children of Havering. This has come as a result of internal and external scrutiny of the health provision to looked-after children in Havering that found weak practice and unclear contractual arrangements for initial health assessments. Prior to February 2016 GPs completed initial health assessments but the quality was variable and monitoring of this work was ineffective. This has resulted in a new service level agreement for initial and review health assessments that sets out clearly the standards expected in providing this service. This is in draft format at present as there continue to be some contractual arrangements being considered. Nonetheless, since February 2016, the responsibility for undertaking initial health assessments has lain with community paediatricians in NELFT.

4.2 NELFT are also the providers of review health assessments for looked after children with health visitors undertaking those for children aged under five years of age, and specialist looked after children school nurses for those aged five to 19. However, this does not extend to include those looked after children that attend schools in neighbouring boroughs or those placed out of borough. Whilst some of this work was undertaken by the previous specialist nurse for looked after children and young people the current interim arrangements do not support the same level of provision. The designated doctor is pursuing negotiations regarding this matter with commissioners and providers in September 2016. (**Recommendation 2.7**)

4.3 The timeliness of both initial and review health assessments remains an area that could be strengthened as outlined by the designated doctor for looked after children in their draft annual report. Whilst the current provider has responded well in ensuring there are adequate community paediatric resources and clinics to undertake initial health assessments there continues to be a lag in their timely completion. On the whole, this was as a consequence of delays in receiving notifications of children entering care from the local authority looked after children team. Furthermore, we noted that the looked after children service routinely measured the timescale for completion of the health assessments from the point that they received the request, not from the time the child came into care. This is contrary to the relevant guidance. This is not acceptable practice and it means that looked after children are subject to unnecessary and avoidable delay in having their health needs assessed and met. (**Recommendation 2.8**)

4.4 On the whole, case files indicated that consent to undertake looked after child health assessments had been sought in most cases we sampled. However, for two cases there was no consent recorded on Part A of the health assessment yet the health assessments were completed. Obtaining appropriate consent ensures health staff have appropriate permissions to assess and examine the child and can also support consideration for children's wishes and feelings. (**Recommendation 2.9**)

4.5 There is a notable variation between the quality of initial and review health assessments seen in the patient records. Review health assessments are child-centred and age appropriate. Health care plans are measurable and there was evidence throughout the records that actions are completed and appropriately documented.

Case example

In one review health assessment gross motor delay was the child's identified health need, we saw that the health visitor offered developmental strategies to the foster carer. The health visitor followed up the intervention with a planned home visit four weeks later to assess the outcome of the intervention.

Creating care plans that are child centred and measurable such as this maintains the clinical focus on the child and provides clear expectations for the child, parents and carers and professionals involved in meeting the child's needs.

4.6 There is an effective quality assurance approach that is well embedded for review health assessments. This ensures that all review health assessment are subjected to further scrutiny by the interim specialist nurse for looked after children and young people using an agreed template to monitor the quality overall. We saw this completed for all review health assessments we looked at. In one case, this had identified that the standard had not been met and required the individual practitioner to review and improve this. This ensures that Havering's looked after children benefit from consistently robust assessments that accurately review their health needs.

4.7 The quality of initial health assessments seen completed by both the previous and current providers was much weaker with generally limited or illegible information. For example, one health assessment completed by the new provider was rendered ineffective as it was virtually illegible; this important information was of little value as it was not clear how it then went on to inform the health action plan to benefit the child in improving their health outcomes. Furthermore, its relevance in informing practitioners completing subsequent review health assessments was limited. Whilst NELFT report that this information is not used by partner agencies the standard of this record keeping is poor. (**Recommendation 2.10**)

4.8 We also noted that there was a lack of professional curiosity in the consideration of risks the clinician identified in initial health assessments. In one case this related to a child's sexual health and in another the potential impact of maternal substance misuse on the child, both of which showed poor further exploration. This limits the identification of additional health or support needs that may benefit from being included as part of the health action plan. (**Recommendation 2.11**)

4.9 The existing arrangements to quality assure initial health assessments are not effective. Whilst we were informed that there are quality assurance approaches in place where all initial health assessments are reviewed, we saw no evidence of this in children's records. This limits the ability to see how weak practice has been identified and improved ensuring a higher standard of initial health assessments can lead to improved health outcomes. (**Recommendation 2.12**)

4.10 The trust use a database to aid the tracking of individual children's initial and review health assessments. This helps to maintain some administrative oversight of timescales for completing this work. However, we could not review information held relating to children aged under-five on the day we visited as the staff member that maintains this was off and other staff do not have access. (**Recommendation 2.13**)

4.11 The arrangements for review health assessments when children have a pre-adoption medical require clarity. In two cases of children under five, a pre-adoption medical took place and then the children did not have their health needs reviewed again for a year. The children had remained in the care of foster carers and had not been adopted. There was no information recorded in the progress notes of the children's records to reflect actions and decisions made about planning for their next review health assessment. An audit of health assessment processes after pre adoption medicals may provide more insight into current practices to ensure that children's health needs are assessed in accordance with statutory guidance. (**Recommendation 2.14**)

4.12 The voice of the child was evident in review health assessments but was not as strong in initial health assessments. Where this was captured, the case records demonstrated that it was undertaken sensitively, contributing to a child-centred approach which helps to develop greater co-production. (**Recommendation 2.15**)

4.13 GPs do not effectively contribute to the health assessments of looked after children in Havering and, completed health assessments are not routinely shared with the GPs. This is not compliant with statutory guidance and limits the ability for health reviews to be a continuous cycle that fully informs the child's complete health record held by the GP. (**Recommendation 2.16 and 5.2**)

4.14 We were told that the designated clinical officer has made links with the looked after children team to enable stronger partnership working for those looked after children that are being assessed for education and health care plans. Whilst we did not see any evidence of the impact of this on children it is encouraging that this is developing as this will help work towards the 'tell it once approach'.

4.15 Looked after children benefit from access to a dedicated CAMHS worker that is co-located with the looked after children health team. Referrals are made via the social worker and waiting times are reported not to exceed four weeks. We heard about the flexible approach taken by the CAMHS worker in their efforts to try and engage looked after children with their support. This is a positive development as prior to October 2015 Havering was the only NELFT borough without dedicated looked after children CAMHS provision.

Case example

We saw that the specialist looked after children CAMHS clinician had collaborated with the local authority in the planning of the care and support offered to two very young children and their foster carer.

The clinician had provided extensive CAMHS support to the children and the foster carers to help manage the significant emotional and behavioural delay arising from neglect by their birth parents.

This sensitive approach has enabled the children to access and engage more with services.

4.16 The designated doctor reported she is seeking to provide looked after children placed outside of the three (BHR) CCG's footprint with equitable and timely access to CAMHS to that which is provided within the three corresponding boroughs, including Havering. For looked after children placed in Essex a service level agreement is in the process of being finalised that will see an independent provider provide CAMHS support to these children rather than the existing NHS provider arrangements.

4.17 Minutes from the looked after children health sub-group (April 2016) indicate that the health needs of those Havering children placed out of borough are not well known. As a consequence it is difficult to ascertain if children's needs are being met effectively. There is an intention to undertake discussion on this matter at a strategic and operational level but progress regarding this unclear. (**Recommendation 2.17**)

4.18 In review health assessments, on the whole we saw the specialist looked after children school nurses refer to strength and difficulty questionnaires (SDQs) to help inform their assessment when they had been completed. However, some of these had been completed sometime before the health assessment which saw professional concern that the SDQ score and the child's presentation were not congruent. SDQs can help children and young people to track their emotional and mental health but are of little value if they are not undertaken around the time of the health assessment. (**Recommendation 2.18**)

4.19 Care leavers benefit from the recent introduction of health passports for use across the BHR CCG's area, including Havering. We were told that looked after children and care leavers did have some input in the development of the passports but this was less so in Havering than the other two boroughs. This passport provides looked after children with information about their past and current health history which is important when they require healthcare in their adult years.

Case example

A 19 day old baby was having their initial health assessment completed which appropriately recorded maternal health concerns about substance misuse. However, there was no evidence of any consideration about the impact of this on the wellbeing of the baby.

The developmental assessment was not age appropriate. For example, despite the baby being 19 days old, we saw comments such as 'good weight bearing', 'alert, happy baby'.

This level of superficial enquiry does little to identify and respond to health needs of children entering care to ensure their health needs are met.

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 safeguarding management structure for Havering CCG is part of the three-way arrangement with the neighbouring Barking and Dagenham CCG and Redbridge CCG (BHR CCGs). The BHR CCGs have a robust approach to developing and improving safeguarding practice across the health services it jointly commissions. Designated professionals are placed in the BHR CCGs with identified lead areas that link in with NELFT, BHRUT and other health services. This provides clear lines of accountability to the nurse director.

5.1.2 Health services in Havering participate in the local and pan-London safeguarding management arrangements. Havering CCG, designated professionals, NELFT and BHRUT are engaged in the functions of the Havering local safeguarding children board (LSCB). The nurse director of the CCG is the vice chair of the LSCB. Providers are engaged in sub-groups reporting on quality and effectiveness. Following the completion of deep dives and risk assessments NHS England do not routinely attend the Havering LSCB but prioritise the London Safeguarding Children Board meetings.

5.1.3 There are some interim arrangements for key safeguarding posts in Havering such as the designated nurse for safeguarding children and the named looked after children nurse. Whilst it is clear that there are imminent plans to recruit into these key posts the interim arrangements should be well defined to enable ongoing effectiveness. The CCG recruited a designated nurse for adults into the safeguarding team and have plans to re-configure designated posts across the three CCGs to create joint designated nurse and looked after children nurse posts for each CCG area.

5.1.4 The named GP also undertakes this role in a neighbouring borough. He has good links with the forum of named GPs in London that has led to the development of a safeguarding handbook that is aiding primary care child safeguarding practice in Havering. Furthermore, he is well engaged in the safeguarding assurance group and is developing links with NHS England in relation to local safeguarding practice and with the interim designated nurse in improvement initiatives. For example, minutes of this meeting held on 6 July 2016 indicate that the named GP is prominent in the plans to develop report writing guidance based on a local case study.

5.1.5 BHRUT is strengthening its safeguarding functions and has agreed additional resources to support this. Recruitment into key posts is underway and this, for example, will see the ED have dedicated safeguarding nurses. This will strengthen safeguarding activity in ED and the trust in general.

5.1.6 The named midwife leads on developing and promoting good safeguarding practice at Queen's hospital. She has developed good working relationships with multi agency professionals leading to good information sharing and joint working to improve outcomes for vulnerable women. There are capacity issues with her fulfilling her role; however, this is recognised and is on the trust safeguarding risk register. There are active plans to recruit additional resources to the maternity safeguarding role and therefore improve capacity.

5.1.7 An unacceptable culture emerged in maternity services that are at times seeing the delayed discharge of women and babies due to social reasons. We were informed that it is not unusual for a mother and newborn to be placed on the postnatal ward for up to seven days to await the outcome of an interim care order. Extended in-patient stays for medically fit women and babies for social reasons are not appropriate. (**Recommendation 1.10**)

Case example

A mother abandoned her newborn baby on the postnatal ward despite the efforts of staff trying to encourage her to remain and speak to a social worker.

The police were notified to conduct a welfare check.

The social worker arrived on the ward after the mother had left and advised staff they had been unable to find a temporary foster placement for the baby so far. A maternity care assistant looked after the baby while they remained on the postnatal ward.

The maternity unit continued to advocate for the baby in their active liaison with children's social care in trying to secure a placement.

The baby remained on the ward for seven days until they could be discharged into a foster placement.

5.1.8 We have consistently heard about the increase in the population that is contributing to increased demand for health services in Havering. We have seen that this is not leading to any increase in resources in universal children's services. As a consequence families receive some health visiting provision that is targeted rather than universal. The joint SLAC inspection in 2011 recommended that resourcing for community practitioners matched the complexity of families they supported. It is clear that this continues to be a challenge in both health visiting and school nursing and is recognised as a risk yet no effective solutions have been identified to address this. It is not acceptable for health visitors to be the caseload holders for over 600 children. This far exceeds guidance issued by the Community Practitioners and Health Visitors Association (CPHVA). *This issue has been brought to the attention of Public Health, as the commissioners of the health visiting and school nursing service.*

5.1.9 Young people contribute to the evaluation of the quality and impact of the CAMHS service through an active participation group. The group meets weekly and analyses the latest findings from the service's patient outcome measures – a patient questionnaire carried out on discharge. Findings from their analysis are then fed back into team meetings to ensure staff are aware of any identified shortfalls in routine practice. In addition, the group produce occasional resources to improve the way the service communicates with clients, for example, a patient information leaflet about the services CAMHS provides was on display in the reception of the CAMHS centre.

5.1.10 In adult mental health managers have a clear view that 'think family' is an approach that is seen across adult and children's services and is not limited to safeguarding practice. The adult mental health service are piloting an approach for adults called 'Open Dialogue' that further supports the think family model. This is reported to be having a positive impact in the adults receiving this approach. NELFT are sharing this across the strategic partnership at the Health and Wellbeing Board who are interested in being part of this. This demonstrates that adult mental health seek to transform and develop their offer to clients to help achieve better outcomes that will benefit adults and children linked to them.

5.1.11 The service manager at WDP is engaged in safeguarding work as they attend a six weekly safeguarding forum. WDP are also in the process of setting up a drug and alcohol forum in Havering to look at ways to work together. These are positive steps that will help make WDP visible and effective as a new service provider in the area.

5.1.12 We were informed that the contract for BHRUT to provide sexual health services has expired and although we were told that discussions are taking place between the commissioners and the trust we are concerned that no formal contract has been in place for several months. Without a formal arrangement there are no contractual performance standards for commissioners to monitor a service against and ensure the needs of the local service users are being adequately met. **(Recommendation 1.11).** *This issue has been brought to the attention of Public Health, as the commissioners of the CASH service.*

5.1.13 Each GP surgery is reported to have a dedicated safeguarding lead and an additional identified contact to aid the dissemination of information for child safeguarding. This has enabled the named GP to share, for example, links to or learning from serious case reviews. We have seen the benefits of providing dedicated safeguarding forums for GP leads as an additional way to strengthen access to information that will enhance primary care practice.

5.2 Governance

5.2.1 Havering CCG were the subject of an NHS England deep dive into safeguarding in December 2015. This identified areas of good practice and made recommendations to include training, supervision and assurance from health providers. NHS England shared findings with the LSCB and this will also be used in the completion of a London wide report regarding CCG assurance of safeguarding practice.

5.2.2 BHR CCGs have produced a set of safeguarding children's standards (2016 to 2017) that providers are required to comply with. The intention is for this to be overseen by the designated nurse for safeguarding children (currently an interim post) who will also advise and monitor areas of non-compliance identified. This approach will facilitate the CCG to have a good oversight of the child safeguarding performance in health services they commission.

5.2.3 The CCG can further evidence that they have an effective oversight of the safeguarding performance of BHRUT and NELFT in a number of ways, including updated section 11 (Children Act 2004) audits that are submitted to the LSCB and through monthly reporting of these providers set against contractual agreements. Safeguarding matters that arise from the providers' monthly clinical quality review meetings (CQRM) are shared at the CCG's monthly safeguarding assurance committee. This is chaired by the interim deputy nurse director and attended by the nurse director, designated professionals, the named GP and the children's commissioners. The committee sends minutes of the monthly meetings to the quality and safety committee including any exception reporting and identified safeguarding risks. This arrangement ensures that child safeguarding and looked after children arrangements in Havering and the neighbouring two CCG areas receive appropriate scrutiny and challenge.

5.2.4 Primary care in Havering is not afforded the same level of scrutiny regarding their child safeguarding effectiveness as highlighted in the above two points. The approach taken by the CCG involves maintaining some oversight through the use of a database of practices that have received a CQC inspection where the safe domain required improvement or were inadequate. Minutes from the Primary Care Commissioning Committee (6 July 2016) include a Local Action Plan that is proposing the adult and children's designated nurses will support and develop appropriate safeguarding training for primary care. It is positive this work is to be undertaken however, the role of designated professionals extends beyond that (RCPH Intercollegiate Guidance 2014).

The view of the CCG is that as they have not signed a memorandum of understanding with NHS England they do not monitor or oversee primary care child safeguarding practice. NHS England reported they monitor GPs performance and take action if required, undertake appraisal, and maintain their registration. Whilst reportedly there are established links between NHS England and the CCG nurse director that facilitates joint working should a safeguarding matter emerge this demonstrates an approach that is reactive in nature.

In our discussions with both GP practices and the named GP they could not evidence the presence of any ongoing operational or strategic oversight of primary care performance of child safeguarding, or looked after children effectiveness in Havering. Therefore, we could not be assured that good practice is appropriately recognised and that weak practice is challenged, developed and improved. This is a significant deficit given the vital role GPs have in safeguarding children and young people. (**Recommendation 5.3**)

5.2.5 The CCG are well engaged and maintain an oversight of the improvement plans in relation to BHRUT being in special measures, NELFTs closure of the Brookside unit, the looked after children service, initial health assessments and health visitor caseloads. The CCG are maintaining oversight of the progress of these issues through their risk register.

5.2.6 Safeguarding activity in BHRUT is supported by the trust's safeguarding team and overseen by the Safeguarding Children Operational Group. Activity is monitored through an annual safeguarding work plan which is rated according to its level of risk. There are clear lines of accountability to the trust's board through the Safeguarding Strategic and Assurance Group and this ensures effective governance through exception reporting.

5.2.7 Safeguarding performance in the BHRUT is monitored through a safeguarding audit schedule which sets out key topics for monthly review and the identity of the staff member responsible. For example, completion of the multi-agency referrals forms and use of the safeguarding trigger tool. The outcomes of audits are discussed at the Safeguarding Children Operational Group from which actions are directed to deal with any shortfalls. For example, as reported above, our review of records indicated that the use of the secondary safeguarding trigger tool was inconsistent. The trust's audit report for this of April 2016 accords with our findings and also identifies this as a shortfall. There are 37% of children and young people under 16, and 85% of young people aged 16 and 17 who are not being subject of this additional safeguarding screen. As a result of this audit the trust's named doctor is currently carrying out work to ensure the use of the screening tool by ED clinicians is reinforced.

5.2.8 There are clear and accountable governance arrangements in place for safeguarding within NELFT. Compliance, quality and standards of safeguarding work is overseen by the trust's safeguarding team. Reporting processes to the trust board through the Divisional Performance Quality and Safety Group and the Integrated Safeguarding Group ensure safeguarding accountability of operational managers and service leads. The trust safeguarding team are represented on the Havering Safeguarding Children Board.

5.2.9 Governance arrangements in NELFT are further strengthened by the use of a high risk reporting protocol. Significant risks to people, staff or the organisation are reported to the trusts' weekly senior leadership meeting for monitoring and directing any action. Although we did not see any examples of this during our review we are aware that currently there are four cases subject to this oversight.

5.2.10 The NELFT safeguarding team reported that they undertake audits of safeguarding documentation with the most recent one evidencing an improved picture. It is positive that records are scrutinised as this helps to create benchmarked standards to practice and record keeping. However, through case discussions it became apparent that the safeguarding team were not aware that IAPT professionals use an additional record keeping system to the electronic patient records system used by community teams. Future record audits would be more robust with the inclusion of IAPT records.

5.2.11 In NELFT, advice provided by the safeguarding duty desk is logged and monitored on a database. This enables the trust to have oversight of safeguarding concerns and to track the progress of recommended actions arising from the advice, such as a direction to make a referral or to bring the case to safeguarding supervision. The trust can also identify any common themes for future learning events. For example, we saw that the trust had recently audited the calls to the duty desk and had identified historical sexual abuse and domestic abuse as themes for inclusion in the next round of safeguarding training.

5.2.12 The functions and effectiveness of services for looked after children are afforded some scrutiny through the monthly looked after children Health Sub Group. Furthermore, the LAC service report on their activity and progress to the Havering Corporate Parenting Board and Safeguarding Assurance Committee. It is encouraging that the looked after children service has recognised the need to improve their offer to children and young people in care to work towards the timely completion of health assessments. This has seen the CCG and designated professionals actively engaged in seeking solutions across the partnership.

5.2.13 All safeguarding referrals made by the ED staff are monitored by the trust safeguarding team using a database. Referrals are followed up so that the outcome is known in every case and fed back to the practitioner who made the referral. Along with the previously mentioned psychosocial process, this provides robust quality assurance, support and learning for staff in relation to their initial decision making and fosters a culture of good practice.

5.2.14 At Queens Hospital maternity department there is a clear governance structure and regular meetings ensure safeguarding issues within maternity services are reported appropriately to the trust senior management and board.

5.2.15 In maternity a flexible approach is used by staff to record and share concerns or vulnerabilities about women with the named midwife; midwives share information either by email or telephone calls. The benefits of information sharing are well evidenced. However, the use of a standardised proforma or template to record this important information would give greater structure and create a stronger auditable process to oversee this practice.

5.2.16 Although the CAMHS service actively contributes to child in need and child protection meetings, such as core groups and conferences, records of these meetings are not always available or uploaded to the electronic patient record. This means that records are incomplete and do not provide practitioners who might use the record in the future with relevant information. Furthermore, the absence of this vital information from records means that there is no effective audit trail of actions attributed to practitioners from those meetings. This does little to inform the ongoing care of vulnerable children and young people. **(Recommendation 2.20)**

5.2.17 Managers in WDP do not have a complete oversight of the child safeguarding work which practitioners may be contributing to. The current pathways for the child safeguarding information coming into and out of the team are not measurable. As a consequence, managers cannot be assured of response and attendance rates and therefore how they are contributing to safeguarding children in these processes. **(Recommendation 3.6)** *This issue has been brought to the attention of Public Health, as the commissioners of WDP service.*

5.2.18 In the GP practices we visited there was considerable variation in the standard of record keeping on patients' electronic record systems and in the storage of safeguarding information received. This included the flagging of vulnerable children on patient electronic record systems and the storage of child protection plans. This fragmented approach reduces the visibility of vulnerable children to primary care staff and prevents access to safeguarding documents to help inform their ongoing care. This indicates that existing governance arrangements require strengthening to ensure this vital information is managed effectively in primary care settings to benefit safeguarding children in Havering. **(Recommendation 5.4)**

5.2.19 Access to relevant safeguarding policies and information and guidance for staff within the practices was available. It is beneficial for all staff working in a practice to have access to the same up to date information. The Havering GP safeguarding Handbook was seen to be a useful resource to aid decision making and a prompt response to a variety of safeguarding issues.

5.2.20 The existing arrangements in the MASH for health practitioners restrict opportunities to have an effective oversight of the quality of the information completed and submitted by health staff. Therefore, they are not able to carry out any routine audit of activity in relation to the standard and quality of referrals from health providers or the information submitted by GPs. This is an important function as it ensures that shortfalls in practice can be fed back to providers to inform learning and raise standards of practice.

5.2.21 A consistent finding that is impacting on effective governance arrangements is in those services that operate and have in place dual record keeping systems. This hinders access to complete records of children and young people to inform their future and ongoing care and can limit the effectiveness of safeguarding practice that may delay access for children and young people to timely support.

5.3 Training and supervision

5.3.1 The CCG and provider services of NELFT and BHRUT have outlined the importance of having a workforce that is skilled in safeguarding the children of Havering. The requirements for this are set out clearly in both NHS providers safeguarding children training strategy. Both providers have achieved the CCG requirement of 85% compliance for level three safeguarding training; however, this has been reset to 90% for 2016 to 2017. The data supplied is not fully reflective of the hours that frontline staff have completed at level two and three. A stronger oversight of this would provide more meaningful assurances.

5.3.2 Learning from serious case reviews is reportedly disseminated across the health economy to inform frontline practice. For example, we heard that BHRUT produced guidance about safeguarding meetings to support staff to understand their responsibilities for attending and contributing to child protection processes. In NELFT we heard that they undertook a table top activity based on fabricated or induced illness that was open to the multi-disciplinary workforce. We are aware that learning from an ongoing case is underway that has identified weak information sharing arrangements between maternity and ED and this continues to receive high profile attention at the Safeguarding Assurance Group.

5.3.3 All ED staff at Queen's hospital receive training that meets the requirements of level three of the relevant guidance. This training is delivered on a single agency, multi-disciplinary basis within the trust and compliance is monitored through the trust's training dashboard. Recent training has included risk assessment and referral processes, the management of allegations against staff, CSE, FGM, domestic abuse and trafficking. Access and attendance at multi-agency training would strengthen this offer further.

5.3.4 ED staff are aware of their role in relation to safeguarding children and they have access to supervision to support positive outcomes for children and their families. Furthermore, staff benefit from the visible presence of the paediatric safeguarding nurse (when they are on duty) as this provides an accessible point of safeguarding advice to staff.

5.3.5 Midwives are specifically identified within the intercollegiate guidance as requiring multi-disciplinary, inter-agency level three training at specialist level (a minimum of 12-16 hours over a three year period). Midwives at Queen's hospital do not currently fulfil the learning hours required and therefore training is not fully compliant. (**Recommendation 1.12**)

5.3.6 The existing model for safeguarding supervision for community midwives could be further strengthened to include the provision of one to one supervision. The current format of quarterly group sessions can inhibit the opportunity to professionally challenge practice 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. Furthermore, SMART actions resulting from safeguarding supervision 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 1.13**)

5.3.7 Health visitors and school nurses attend mandatory level three multiagency safeguarding training every three years, which is in line with the intercollegiate guidance. They have access to a range of additional training; including maternal mental health (health visitors), CSE, FGM, domestic violence, risk management, report writing and Prevent. This helps them to ensure that their safeguarding knowledge is up to date and they can provide families with appropriate support, guidance and advice.

5.3.8 The safeguarding supervision arrangements for health visitors and school nurses are well established and delivered quarterly on a one to one basis with caseload holding staff. Non caseload holding staff has access to group safeguarding supervision and additional advice and guidance as required. Case records in both services demonstrated that this is recorded in children's electronic patient records and actions are generally SMART. This is important for reviewing progress and informing ongoing practice.

5.3.9 Furthermore, health visitors receive monthly clinical supervision from the perinatal mental health team. This helps to ensure health visitors are able to discuss their practice and women they are supporting with appropriate specialists to inform their ongoing care.

5.3.10 School nurses have not received training to underpin their work with children and young people with emotional and mental health difficulties. This may impact on their ability to respond appropriately to emerging mental health needs using appropriate evidence based practice. However, we were informed at a later time that the CAMHS service has planned some training to help better equip the school nursing service to support children and young people.

5.3.11 There are strong mechanisms in place in NELFT to support practitioners with safeguarding activity from their clinical work. For example, the trust operates a 9am to 5pm safeguarding duty desk for each of its main geographical areas. This is staffed by specialist safeguarding advisers who respond to calls from staff and provide advice based on trust policy and local multi-agency safeguarding procedures. In the CAMHS service we noted that any advice provided by the duty desk is detailed on patient records and this is good practice.

5.3.12 CAMHS practitioners receive safeguarding training at the appropriate level of the relevant guidance. Initial safeguarding training at level two is delivered at induction on a face-to-face basis and repeated through an online programme every three years. All clinical staff receives training that meets the requirements of level three through a mixture of face-to-face events, either provided by the trust on a multi-disciplinary basis or provided by external trainers. Training attendance and compliance with the requisite number of hours set out by the intercollegiate framework is monitored by the trust's training department.

5.3.13 Practitioners working in the CAMHS undergo one-to-one safeguarding supervision at least every three months. This not only focusses on individual cases but practitioners are briefed on emerging learning from serious case reviews and updated guidance or practice. All case supervision for NELFT staff is monitored through a supervision database maintained by the trust's safeguarding team and this ensures effective oversight of actions. However, CAMHS practitioners' recording of safeguarding supervision was not as detailed as those seen for health visitors and school nurses; entries lacked the rationale for discussion and risks were not always recorded in detail. This may impact on the ability to review and analyse actions that had been taken to inform future safeguarding supervision sessions.

5.3.14 All adult mental health practitioners are expected to access four hours of level three safeguarding training every year, and this is reportedly delivered in different formats to include single and multi-agency. All staff have reportedly received training on Prevent. This meets the requirements set out in the intercollegiate guidance. Adult workers have an important role in child safeguarding practice as their expertise can determine the impact of parental behaviour on their capacity to care for children they have contact with.

5.3.15 There are different formats of safeguarding supervision that relate to the roles undertaken by adult mental health practitioners and their contact with children. The early intervention in psychosis team accept referrals for 14 to 35 year-olds and so receive quarterly face to face safeguarding supervision. Other teams are provided with group safeguarding supervision. However, we did not see evidence of effectiveness of this to review the quality and impact of this work.

5.3.16 Furthermore, adult mental health teams benefit from having an identified safeguarding link worker for adults and children. They provide accessible support and also disseminate safeguarding information to practitioners which is a useful resource.

5.3.17 In adult mental health, when cases are discussed at management supervision, safeguarding forms part of the discussion. This facilitates further analysis and professional challenge to child safeguarding cases. However, this is not routinely recorded onto the client's record hence any actions or outcomes identified are not seen to inform their ongoing care. This does not conform to professional record keeping standards. (**Recommendation 2.19**)

5.3.18 Whilst all WDP staff have received appropriate safeguarding training as part of their induction, it was less evident what additional updates and training was provided to existing staff. Managers were made aware of training expectations in relation to intercollegiate guidance (2014) and ensuring that the training was commensurate to their role. **(Recommendation 3.7)** *This issue has been brought to the attention of Public Health, as the commissioners of the WDP service.*

5.3.19 WDP staff have access to safeguarding supervision as part of monthly management meetings and on an ad hoc basis with the organisational safeguarding lead. However, practitioners do not routinely record the outcome of any safeguarding discussions or supervision in client records. As a consequence we were not able to review the robustness of these arrangements or consider how action plans were then used to inform any ongoing care and safeguarding practice. **(Recommendation 3.8)** *This issue has been brought to the attention of Public Health, as the commissioners of the WDP service.*

5.3.20 All nursing sexual health practitioners access BHRUT level three safeguarding training every three years. In addition, practitioners have accessed specialist training relevant to their role including CSE and FGM. However, health care assistants who work clinically in the sexual health service are only expected to complete level two training which is not compliant with the intercollegiate guidance. **(Recommendation 1.12)** *This issue has been brought to the attention of Public Health, as the commissioners of the CASH service.*

5.3.21 We were informed that the sexual health safeguarding lead and lead nurse practitioner for young people receive safeguarding supervision every three months from the trust's named nurse. Nursing staff in sexual health have access to two monthly, one hour group safeguarding supervision sessions. The mandatory requirement is that staff should attend a minimum of three sessions a year. However, if a specific case is discussed actions resulting from the discussion are not documented on the young person's records which are therefore incomplete. **(Recommendation 1.14)** *This issue has been brought to the attention of Public Health, as the commissioners of the CASH service.*

5.3.22 Learning and development for GPs is enhanced with the provision of protected time initiatives that take place 11 times per year with one full session dedicated to the safeguarding children's agenda. Pertinent child safeguarding information would be shared at other sessions if appropriate. However, the GP practices we visited had not accessed the protected time initiatives training and so it is not clear how accessible this training is across primary care establishments. All staff at both practices are trained to the appropriate level for their role to enable them to identify and respond to safeguarding children concerns in Havering.

Recommendations

1. **Havering CCG and Barking, Havering and Redbridge University Trust should:**
 - 1.1 Improve the information sharing arrangements with health visitors and school nurses to ensure that they receive the details of under 18s that attend the department or are of concern based on an adult attendance. This will facilitate greater oversight of children and young people in the community and support access to early help.
 - 1.2 Ensure there is a robust protocol that standardises the completion and review of under 18s risk assessment in the sexual health service to aid the early identification of safeguarding concerns.
 - 1.3 Improve operational governance of child safeguarding practice to ensure safeguarding trigger tools in the ED are completed and embedded in frontline practice. This will afford children the opportunity to have safeguarding concerns identified whilst they are in the department.
 - 1.4 Ensure that the name and relationship of adults that accompany or have caring responsibilities for children are recorded legibly. This will aid practitioners to analyse the appropriateness of those relationships to help safeguard children and young people effectively.
 - 1.5 Ensure safeguarding birth plans are easily identifiable and visible in records to inform ongoing care and to aid effective child safeguarding practice.
 - 1.6 Ensure midwives have access to CSE risk assessment tools to enable the early identification of risks that will help to safeguard those in their care.
 - 1.7 Improve operational governance of child safeguarding practice in maternity and CASH to improve the quality of referrals made to children's social care and other child safeguarding documentation.
 - 1.8 Ensure maternal records are complete and contain easily identifiable child safeguarding documentation; such as, copies of referrals to children's social care, child protection plans and reports to provide a robust account of the vulnerability of those in their care.
 - 1.9 Develop existing alert and flagging facilities to aid the identification of vulnerable children and young people that attend the CASH. This will help to inform their assessment and ongoing care.

- 1.10 Work with partners to develop a clear pre-birth protocol for expectant women to include robust plans for the timely discharge of mother and baby to prevent inappropriate hospital stays.
- 1.11 Ensure there are contractual arrangements in place to support the delivery of a commissioned CASH service.
- 1.12 Ensure midwives and health care assistants in CASH have received child safeguarding training that is commensurate with their role as outlined in the intercollegiate guidance (2014) to ensure compliant.
- 1.13 Provide community midwives with one to one safeguarding supervision to aid their managements of women with complex needs and vulnerabilities.
- 1.14 Ensure CASH staff accessing child safeguarding supervision record this in the client records to meet with professional record standards and to aid ongoing care and planning.
- 1.15 Ensure discharge summaries from maternity contain information about the ongoing care that a newborn baby and family require in particular if they have additional needs or are the subject of safeguarding arrangements.

2. North East London Foundation Trust should:

- 2.1 Develop and implement an approach that universally assesses for the risk of child sexual exploitation in children and young people that they are supporting to aid the early identification of risk.
- 2.2 Implement an approach that supports practitioners to enquire and assess for the risk of female genital mutilation in children and young people they support to aid the early identification of risk and harm.
- 2.3 Ensure adult mental health staff record information relating to children consistently to inform the required fields of the electronic patient record and reflect escalating or de-escalating concerns.
- 2.4 Work with local authority partners to ensure that the presence of health staff in the MASH is used effectively to inform multi-agency decision making and share information to community health staff so they are aware of referrals regardless of RAG rating.
- 2.5 Ensure standards of record keeping in CAMHS are in line with professional standards to ensure entries are complete and analytical to help underpin care planning and decision making to safeguard children and young people.

- 2.6 Strengthen and Ensure effective information sharing arrangements are in place where a shared electronic health record is used to ensure practitioners are appropriately alerted to escalating or deescalating child safeguarding risks. This will facilitate greater joined up multi-disciplinary working and ensure information is effectively exchanged.
- 2.7 Work with commissioners to address the gaps in service provision for looked after children that are resident in Havering but attend another local authority school, and those placed out of borough.
- 2.8 Work with local authority partners to improve the timeliness of both initial and review health assessments in line with statutory requirements to prevent unnecessary delay in children and young people having their health needs assessed.
- 2.9 Ensure that consent is obtained and recorded on looked-after child health assessment documentation prior to undertaking the assessment.
- 2.10 Ensure that the standard of record keeping for looked after children's initial health assessments meet professional standards and are legible so this can clearly inform the health action plan.
- 2.11 Ensure staff utilise opportunities to be professionally curious in their assessments of children and young people to aid the early identification of additional needs or risks that will safeguard and improve outcomes for the child.
- 2.12 Develop and improve the existing quality assurance arrangements for initial health assessments to aid the identification of weak practice; that will raise standards and afford looked after children with a robust assessment of their health needs as they enter care.
- 2.13 Ensure that the looked after children's database to include those aged under five is accessible to staff during the operational hours of the service.
- 2.14 Ensure that arrangements for adoption medicals and any ongoing review health assessments are well defined to ensure children continue to receive their statutory health assessments.
- 2.15 Ensure that the voice of the child is considered and recorded in initial health assessment documentation.
- 2.16 Ensure GPs are informed of looked-after children health assessments and action plans to support their contribution and stronger joined up working.
- 2.17 Strengthen arrangements to ensure looked-after children are identifiable in and out of borough to maintain an effective oversight of their health needs.

- 2.18 Work with the local authority to ensure that practitioners have access to SDQs that support effective tracking of the emotional and mental health of looked-after children to inform their health assessments and ongoing care.
- 2.19 Ensure child safeguarding cases discussed at management supervision have this recorded in client health records to meet with professional record standards and to aid ongoing care and planning.
- 2.20 Ensure that practitioners have access to a complete record that contains the details of children and child safeguarding documentation to help inform ongoing care.

3. Westminster Drugs Project should:

- 3.1 Ensure practitioners consistently record the details of children in the required fields of the linked adult's record. This will ensure children are visible to staff using the record and contribute to a think family approach.
- 3.2 Develop effective information sharing with universal children's services to aid collaborative working that helps to safeguard children and young people.
- 3.3 Ensure practitioners effectively share information of female clients known to be pregnant across the partnership to help safeguard and improve outcomes for the unborn.
- 3.4 Ensure that practitioners have access to a complete record that contains the details of children and child safeguarding documentation to help inform ongoing care.
- 3.5 Ensure safeguarding supervision and case discussions are recorded in the client's record to maintain professional standards of record keeping.
- 3.6 Improve operational governance of child safeguarding practice to ensure managers have an effective oversight of the child safeguarding practice staff are engaged with.
- 3.7 Ensure staff receive child safeguarding training that is commensurate with their role as outlined in the intercollegiate guidance (2014) to enhance their professional development.
- 3.8 Ensure child safeguarding cases discussed at management supervision have this recorded in client health records to meet with professional record standards and to aid ongoing care and planning.

4. Havering CCG, NHS England, BHRUT and NELFT should:

- 4.1 Improve links between GPs, midwives, health visitors and school nurses to promote effective collaborative working for vulnerable families.

5. Havering CCG and NHS England should:

- 5.1 Ensure GPs are supported to complete good quality information for child safeguarding purposes to aid effective multi-agency decision making.
- 5.2 Ensure GPs are informed and contribute good quality information to looked-after children health assessments and action plans.
- 5.3 Ensure effective arrangements are developed that provide assurance of the child safeguarding and looked-after children's practice in primary care.
- 5.4 Support GPs to develop effective information governance arrangements to increase the visibility of vulnerable children and access to child safeguarding documentation to inform ongoing care.
- 5.5 Ensure GPs record appropriate information in the social or additional risk factor section of referrals made for women when requesting antenatal care. This will help to inform midwives of pertinent information so they can effectively support women throughout their episode of care.

Next steps

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

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