

Review of health services for Children Looked After and Safeguarding in City of London

Children Looked After and Safeguarding The role of health services in City of London

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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 City of London. 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 City of London, 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 63 children and young people.

Context of the review

The City of London has an estimated resident population of 8760 and a transient daytime working population of around 431,400. Of the resident population, 12% are children under the age of 18 years. It can be difficult to disaggregate published health and socioeconomic data between the City of London and Hackney, as more often than not the two areas are combined. For example, the latest published information from the Child and Mental Health Observatory (ChiMat) 2016 is combined data for both the City of London and the London Borough of Hackney. Further, as most of the children from the City of London attend school in different London boroughs, much of the combined data set out below will not accurately reflect the picture for children living in the City of London alone. We have stated below, where appropriate, if combined data has been used.

The population of the City of London is characterised by areas of affluence and poverty. The Barbican West and East residential areas are among the 20% most affluent areas in England. Portsoken ward, however, is among the 40% most deprived areas in England. According to the national figures, 110 City of London children (14%) were living in poverty in 2011, with Portsoken ward having the highest levels of child poverty. An estimated 78% of the City of London population is white British; however, approximately 40% of children are from black or ethnic minority groups compared to 21% nationally.

There is one maintained primary school, and there are no maintained secondary schools in the City of London. According to Department for Education 2016 data, 19.6% of primary school children are eligible for and claiming free school meals. This is lower than neighbouring inner London boroughs.

Combined data for City of London and Hackney shows that dental health is worse than the national average across both local authority areas with 31% of five year olds having one or more decayed, filled or missing teeth. Children in Hackney and City of London have worse than average levels of obesity. There are 11.7% of children aged four to five years and 25.7% of children aged 10-11 years classified as obese although there is no robust data available for the City of London alone.

The City of London has reported no teenage pregnancies between 2012 and 2015. Infant mortality for City of London and Hackney is significantly worse than the England average although the City of London has reported no infant deaths in the last five years.

Attendance at accident and emergency for children under four years old for City of London and Hackney together is worse than the England average. Breast feeding uptake rates at birth are significantly better than the England average and admissions to emergency departments for self-harm are significantly fewer than the England average.

The number of City of London children and families requiring statutory social care interventions is low compared with other local authorities. There were fewer than 10 children and young people with disabilities known to the City of London Corporation in 2013. The majority of City residents (73%) are registered with just one GP practice in the City of London. At the time of inspection there were nine children and young people looked after in the City of London. Eight of these young people were unaccompanied asylum seekers and all nine children were placed out of area.

NHS City of London and Hackney CCG are responsible for commissioning children's health services in the City of London. The CCG are also responsible for commissioning the looked-after children's medical team which is provided by the Homerton University Hospital NHS Foundation Trust (HUFT) whilst the looked after children nursing team is commissioned by the City of London Corporation public health team and provided by the Whittington Hospital NHS Trust (WHT).

Acute hospital services, including emergency and maternity care, are commissioned by the CCG and provided, predominantly, by University College London Hospitals NHS Foundation Trust (UCLH) and by Barts Health NHS Trust (BHT) at The Royal London Hospital (RLH).

Community children's health services such as health visiting, targeted school nursing and the family nurse partnership are commissioned by the Public Health Team at the City of London Corporation through a service level agreement with the London Borough of Hackney. These services are provided by the Homerton University Hospital NHS Foundation Trust, whereas a bespoke safeguarding school nursing service is provided by the Whittington Hospital NHS Trust.

The City of London Corporation also commissions young people's contraception and sexual health services (CASH) and substance misuse services. CASH services are known locally as 'CHYPS plus' and provided by the Homerton University Hospital NHS Foundation Trust. There is also an integrated sexual health and genito-urinary medicine (GUM) service within Barts Hospital that we did not visit as part of this review.

Young people's substance misuse services are provided by Young Hackney. We did not visit Young Hackney as part of this review.

Adult substance misuse services provided by the Westminster Drug Project (WDP) are also commissioned directly by the City of London Corporation.

The CCG commissions Child and Adolescent Mental Health Services (CAMHS). Specialist community CAMHS and adult mental health services are provided by the East London NHS Foundation Trust (ELFT). The City of London Corporation public health team and children's social care have commissioned an enhanced CAMHS specifically for looked after children. A lower level CAMHS early intervention psychology service for children and young people which aims to intervene before difficulties become chronic and enduring is provided by the Homerton University Hospital NHS Foundation Trust under the branding 'First steps'.

The previous safeguarding and looked after children inspection published in April 2012 rated the contribution of health agencies to keeping children and young people safe as 'good', and health outcomes for children looked after as 'good'. Progress against the previous report's recommendations has been considered in this review.

The report

This report follows the child's journey reflecting the experiences of children and young people or parents and 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 the father of a newborn infant on a postnatal ward:

“The level of care has been excellent, from start to finish”

The mother of a newborn infant on a postnatal ward said:

“I think the care has been excellent, I would recommend the UCLH, they provide an incredible service”

A Foster carer told us:

“The looked after health team are fantastic, they write the reports so the young person can understand”.

Another Foster carer said:

“CAMHS were excellent, we were very late for an appointment once but they fit us in. CAMHS really helped, they made the young person feel welcome”.

A Young person accessing CHYPS plus service told us:

“I don’t know what I would have done without them. I’ve had a really difficult time and they have been like a family to me. You can drop in and they will see you they have really helped me with my mental and sexual health”.

A young person living in care said:

“The CHYPS staff are really friendly. They allow you to speak about things in a comfortable way. You can speak to them about anything that you wouldn’t speak to other people about.”

Another young person living in care said:

“I get enough information. There are lots of leaflets and I and feel very involved in my health”.

The child's journey

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

1. Early help

1.1 The Royal London Hospital (RLH) employs a full-time paediatric liaison nurse who reviews the records of all children who visit the emergency department on a daily basis. Where a child's record shows concerns, risks or any features which indicate the need for a child to be followed up after discharge, the community child health teams are informed by telephone straightaway. Information about all children's attendances is routinely sent to the community child health teams every day whether there are concerns identified or not. This means that, GPs, health visitors and school nurses can consider the attendance in the context of what they know about a child or family to enable opportunities for early help to be taken.

1.2 Children booking in to the ED at the Royal London hospital are not routinely being asked about their ethnicity and the information is not being consistently recorded. This means that staff are unable to demonstrate that they have considered culturally sensitive care. (**Recommendation 1.1**)

1.3 Midwives at the University College of London Hospital (UCLH) ask all women from at-risk groups about female genital mutilation (FGM) at the time of booking their pregnancy care. There is a FGM pathway in place, a specialist FGM midwife and clinics are held at UCLH which promote early identification of need and psychological support for women. Furthermore this process helps to identify any potential risk to unborn children or children and young people within the family.

1.4 Maternity services at UCLH do not currently use a child sexual exploitation (CSE) screening tool to help identify young pregnant women at risk. Although we were advised that the hospital has very low numbers of teenage pregnancies this is an area for further development. (**Recommendation 2.1**)

1.5 Most City of London resident women choose the UCLH for their maternity care. 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 or hospital. For City of London residents the hospital does not provide any community midwifery care, so in cases where vulnerabilities or concerns have been identified the majority of women will be seen by the specialist safeguarding midwives in their weekly hospital based clinics. This allows vulnerable women to receive continuity of care by specialist safeguarding midwives.

1.6 When GPs make maternity referrals to UCLH they make use of the Pan-London midwifery referral forms that contain a medical and social risk assessment. Otherwise, GPs are routinely informed by letter when a woman has booked for maternity care at the UCLH. Currently this is a one-way information sharing process and GPs are not routinely asked to share any known relevant, medical, social or safeguarding information with the hospital. This is a missed opportunity to ensure key information is shared at an early stage in pregnancy to enable vulnerable women to be offered additional support during their episode of care and safeguard the unborn baby. We are advised that there are plans to strengthen and promote information sharing at this early stage by adding a request into the notification letter to GPs. (**Recommendation 2.2**)

1.7 A social risk assessment is completed when a woman books for maternity care at the UCLH, although the risk assessment is not formally revisited during pregnancy. It is important that emerging changes in women's lives are captured as early as possible to help identify appropriate services and support as early as possible. Furthermore, the content of the midwifery social risk assessment is an area for further development. For example, practitioners are not prompted to ask about any paternal or partner's mental health or substance misuse which would help to inform future care planning for the newborn infant. (**Recommendation 2.3**)

1.8 Only 57% of mothers living in the City of London benefit from an antenatal assessment by a health visitor. There is no formal face-to-face discussion between midwives and health visitors for the City of London. This limits the health visiting team's ability to deliver health promotion advice in the antenatal period and inhibits the early identification of, and plans to meet, additional support needs. (**Recommendation 5.1**). *We have drawn this to the attention of the public health team at the City of London Corporation.*

1.9 Children with additional health needs are supported well by the Homerton University Hospital targeted school nursing service. Health care plans for children with complex health needs or children needing additional health care support at school are compiled in partnership with the school nurse, the child, their parents or carers and the Special Educational Needs Co-ordinator (SENCO). The health care plans seen were of good quality, with clear allocation of responsibilities for ensuring the success of the plan. These are child focussed and shared appropriately between the school, health services and the family. We saw evidence of good joint working leading to improved outcomes for both the health and the education of the child.

1.10 The targeted school nursing service and health visiting service do not receive copies of all domestic abuse police notifications. We understand that a City of London social worker informs health professionals of police interventions but only when a certain threshold is reached (as described by the All London Child Protection Procedures). Practitioners we spoke with felt that this limits the opportunity for health services to explore any underlying risks that may impact on the child's health and the overall ability to provide any early help support to families and children. We acknowledge that engagement with such vulnerable families and the navigation through safeguarding processes is the remit of the separately commissioned safeguarding school nurses. However, restrictions on the extent that important information, such as that which relates to domestic abuse, about children and families might be shared with health professionals who work closely with families often inhibits the ability of those staff to effectively identify and assess additional need. Our view is that the current arrangements for sharing domestic abuse information might be strengthened to support the contribution of those health professionals in assessing additional need and in safety planning measures described by the procedures. (**Recommendation 13.2**). *We have drawn this to the attention of the public health team at the City of London Corporation who are the commissioners of school nursing and health visiting services.*

1.11 For those children aged 11 to 19 needing additional support over and above the universal service but where the level of need is not at the safeguarding threshold, the offer for early help is provided by another public health commissioned service. This service offers emotional health and wellbeing support, sexual health education and healthy lifestyle promotion such as smoking cessation or healthy eating. However, there is no similar offer for younger children provided by a school nursing service. This is a missed opportunity for a public health commissioned school nursing service to provide early intervention to children comparable to that in other parts of England. *We have drawn this to the attention of the public health team as the commissioners of this service.*

Case example:

A child was identified as being significantly overweight by the health visiting team at 27 months. Three years later she was found to be above the 99.6th centile for her BMI at her school entry height and weight review. The targeted school nursing team referred the child to the dietician, who advised that the child should increase her activity levels and she was discharged from the dietician service. The school nursing team also discharged the child. The school nursing service have advised that they are not commissioned to provide anything other than the national child measurement programme, meaning the child would not be reviewed again until school year 6. This long gap between interventions will have a significant impact on her ability to manage her obesity.

1.12 City and Hackney Young People's Services (CHYPS Plus) has recently been recommissioned from 1st November 2016. The service will continue to be a 'walk-in' service based on a hub and spoke model. The central location will remain in Hackney with three spoke locations and a clinic in the youth offending team. Although it is acknowledged that the number of young people from the City of London currently using the service is comparatively low, with effect from the 1st November 2016 there will be no service provision for them within the City of London locality other than a once-a-term temporary arrangement that has yet to begin. This may limit the accessibility of sexual health services to young people in the City of London and means their specific needs may not be adequately met locally. *We have drawn this to the attention of the public health team at the City of London Corporation who are the commissioners of contraception and sexual health services.*

1.13 Vulnerable families benefit from the effective interagency working by health visitors and other professionals working across the City of London Health visitors have strong links to other services and this provides more opportunities to consider and co-ordinate additional support. For example, health visitors attend fortnightly liaison meetings at the local primary school which enables early identification of need and prompt support for families. They also complete an integrated two year development review with local nurseries. The City of London health visitor also has strong links with the local GP where they attend monthly vulnerable families meetings to exchange information. This effective multi-agency working supports the identification of additional need and promotes the offer of early help.

1.14 As part of a local initiative in the City of London, multi-agency risk assessment forms for those families in need of early help are completed by the health visiting and targeted school nursing services. A family support worker is then assigned to the family to complete the common assessment framework (CAF) and coordinate a 'team around the child' (TAC) meeting which the health visitors and school nurses actively contribute to. This is an effective arrangement because it ensures continued support by health practitioners who know the family best.

Case example:

A family of five who were living in a one- bedroomed flat and where English was not their first language were very promptly supported. A multi-agency risk assessment form was completed by the health visitor and a family support worker was assigned by the local authority to complete a CAF. A team around the child meeting was held. The family support worker assisted with application for benefits and appropriate accommodation and the health visitor was able to provide appropriate health advice and liaise with the GP. This resulted in improved health and social outcomes for the mother, father and all three children.

1.15 There are good opportunities for children and young people to access early help and intervention through a combined offer known as the 'CAMHS Alliance'. This is a collaboration between the specialist community CAMHS provided by East London Foundation Trust (ELFT) and the 'First Steps' service for mild to moderate mental health problems and the CAMHS Disability Service provided by Homerton University Hospital NHS Foundation Trust and 'Off Centre' a local voluntary sector agency. We learned that the alliance has a 'no wrong front door' approach and ensures that children and young people who are referred for CAMHS will be seen without the need for re-referral even if the initial contact is made with the team that will not provide the follow-up. The practical effect of this is that, through interdisciplinary discussion, young people can receive a specialist service or can be directed or signposted onwards to other local services that provide community and family support that will meet their needs more effectively.

1.16 The specialist CAMHS provided by ELFT deploy a staff member as a 'liaison and diversion' worker. This post works alongside the police and courts service to ensure young people with identified mental health needs who come into contact with the courts can be given opportunities for diversion as opposed to exposure to the justice system. For some young people this means that they will be supported with an intervention that better enables their rehabilitation.

1.17 Within the City of London, the co-location of professionals such as health visitors, the safeguarding named nurse, speech and language therapists, first steps, CHYPS plus and targeted school nursing helps to promote joint working. We saw examples of improved outcomes for families as a result of this approach.

1.18 The 'think family' approach is underdeveloped in the adult mental health service provided by ELFT. In all case files we looked at we saw that the demographic information section of the electronic patient record was marked as 'no data' in relation to whether the clients had dependants. Further, on reviewing patient records we noted that the existence of families, children and grandchildren were apparent but there was no evidence that they featured in any risk assessments. There is potential for the needs of children associated with adults with mental ill-health to be overlooked by the service and, in some cases, risks to children not adequately identified. (**Recommendation 6.1**).

1.19 The Westminster Drug Project (WDP) provides City of London substance misuse services. The service recognises the diversity of their population and provides tailored services to sensitively meet the community's needs. The project's City of London team have services to support rough sleepers and also a proactive preventative substance misuse service. There is a full-time dedicated staff member who provides health promotion and advice to the daytime population of city workers. This service has been sensitively branded to appeal to business workers to reduce the stigma attached to accessing mainstream NHS drug and alcohol services. An example of its success was a father working in the City of London who had accessed support for alcohol misuse. Westminster drug project supported him in attending a detox programme and a worker from the family service in Hackney provided support for his wife and two children and liaised with his GP from the area in which he lived.

1.20 The absence of “Think Family” is evidenced further in the lack of information sharing and involvement with other health professionals supporting vulnerable families by adult mental health and substance misuse professionals outside of formal child protection processes. Neither midwives at UCLH, nor the health visiting, targeted school nursing or the safeguarding school nursing teams receive any relevant information or referrals from adult health services, such as adult substance misuse or mental health services. This is a missed opportunity for adult services to share relevant information such as relapse indicators or risk assessments to aid the effective assessment of a child’s needs, which despite the clinical presentation may be caused or aggravated by deteriorating parenting capacity. For example, in one case we looked at we saw that a mother with sporadic engagement with substance misuse services had a school age child. The mother’s reported concerns about the child’s emotional health and school attendance were not shared with the school nursing service and there was no evidence of joint working to secure a good outcome for the child. (**Recommendation 3.1**). *We have drawn this to the attention of the public health team at the City of London Corporation who are the commissioners of the adult substance misuse services.*

2. Children in need

2.1 Children and young people who have emotional health needs that relate to a medical condition have access to a paediatric psychiatry liaison service. This is a separate service to the CAMHS that supports young people who might have harmed themselves. This means that all children and young people with additional emotional health needs are properly supported and not just those with self-harming behaviour.

2.2 Children from the City of London who attend the RLH benefit from a well-equipped and, child friendly children's ED. The waiting environment of the department is decorated appropriately and has sufficient activities to ensure that any distress experience by children during their attendance at hospital is minimal. This includes the deployment of a play specialist during the day time as is recommended in the relevant guidance. This positive environment is, however, let down by the paediatric ED booking in area. The dedicated children's reception area has a glass screen extending the full height of the reception desk and there are microphones built into the screen at adult height; this is at odds with the welcoming nature of the rest of the waiting area. (**Recommendation 1.2**)

2.3 Effective processes are in place to ensure the health and wellbeing of children waiting to be treated in the children's ED. Waiting times in the children's ED at RLH are monitored to ensure that children are not kept waiting longer than necessary. There are also processes in place to ensure that staff can identify a deteriorating sick child in the waiting area. The waiting area is subject of a visual check every 15 minutes by the staff and this check is logged to ensure it is completed. This also affords the opportunity of noting any concerning behaviour by those accompanying the child.

2.4 Appropriate arrangements are in place to ensure that children and young people who harm themselves are seen and assessed by CAMHS professionals. Children and young people who harm themselves are seen in the ED at RLH for their presenting medical condition and are then assessed by a CAMHS clinician. 'Children and young people are admitted to and remain in one of the paediatric wards if they still require an assessment from CAMHS or there is on-going medical treatment required for a physical need.' However, there is no mechanism in place to enable an effective risk assessment of the child's risk to themselves and others or of the environment. This is a significant gap as it means staff are not clear about what action they should take to ensure the child or young person is safe during their stay on the ward. (**Recommendation 1.3**).

2.5 At UCLH there is an expectation that midwives will discuss issues around domestic abuse with pregnant women at least three times during their period of care. However, women are not routinely offered the opportunity to be seen alone to discuss any sensitive medical or social issues. Women are seen alone on an *ad hoc* or opportunistic basis which may mean that domestic abuse is not discussed until the woman is admitted to hospital. This arrangement could be strengthened by informing women in the antenatal appointment care plan that at identified appointments they will be seen on their own for a proportion of the appointment. This standardises the care plans for all women and enables women to disclose and discuss sensitive issues in private. (**Recommendation 2.4**)

2.6 Expectant women, who are booked to deliver their babies at UCLH, who are subject to domestic violence, benefit from good information sharing between the police and the midwifery teams. Files seen demonstrated appropriate information is transferred to health records following police notification and that the woman is discussed at the weekly multi-disciplinary team safeguarding meetings where any actions are agreed to safeguard her and the unborn child.

2.7 The safeguarding school nursing team is a separate school nursing service for children and young people who are identified as 'vulnerable'. Once a child is identified as such and meets the team's acceptance criteria, the child transfers from the targeted school nursing team to the safeguarding school nursing team. The case reverts to the targeted school nursing team once a child is no longer regarded as vulnerable. There are reportedly some differences of opinion between the team and referring services or agencies on what is classed as 'vulnerable'. Defined acceptance criteria for the team are being developed to improve wider understanding of the groups of children and young people the service is appropriate for although this was not in place at the time of our review. (**Recommendation 8.1**). *We have drawn this to the attention of the public health team at the City of London Corporation who are the commissioners of the school nursing services.*

2.8 It is positive that the WDP carries out home visits to check the safe storage of methadone and provide parents with an action plan to keep their children safe. However this action plan is not routinely shared with health visitors, school nurses or GPs. Sharing this information would allow other health professionals working with the family to assess risk to the child arising from the storage of methadone. (**Recommendation 9.1**)

2.9 Women who may have an existing mental illness or who become unwell during or just after pregnancy are able to access a consultant-led perinatal service from the mother and baby unit at Homerton Hospital provided by ELFT. Referrals are accepted from 32 weeks pregnancy and the service carries out joint work with community midwives from the hospital trusts who provide maternity services serving the City of London for women who are experiencing more severe illness. For those women whose mental health needs are described as mild or moderate, the offer is for additional support to be delivered through primary care providers such as GPs, health visitors and, for example, a prioritised initial appointment from the Improving Access to Psychological Therapies (IAPT) service. However, the thresholds were often unclear to practitioners with no clearly identified point of access and did not always lead to timely intervention. (**Recommendation 10.1**)

Case example:

A mother with a child under one contacted the health visitor feeling low in mood and angry. The health visitor made a referral to the perinatal mental health team at ELFT and provided listening visits while the perinatal service considered the referral. After a delay of two weeks the referral was passed back to the health visitor as the woman did not meet the criteria for access to the service despite a high score on the post-natal depression screening tool. It was not until eight weeks after the initial presentation that the woman's mental health needs could be assessed by the IAPT service and treatment could begin. Despite the listening visits offered by the health visitor this represents a significant period of delay during which the risks of the mother's mental ill-health to the young child were not formally assessed by a qualified mental health practitioner.

3. Child protection

3.1 Children attending the RLH ED are not being comprehensively assessed for safeguarding risk. Although there is an expectation that practitioners record the details of significant adults and other pertinent issues such as consistency of injury with history given and reasons for any delay in seeking treatment, most records seen did not describe that these issues had been explored and as such we cannot be confident that discussion did take place. We were consistently unable to identify the child's voice in records and found no evidence that children were asked to consent to treatment, where this was age appropriate. This means there is a potential for some risky cases to be missed at this early stage. (**Recommendation 1.4**)

3.2 At the RLH we noted some positive examples of good identification of children at risk arising from adult attendances at ED which were discussed at the weekly psychosocial meeting (see below under 'Leadership and Management' for a description of this medium). Despite this, however, the records template does not support this being done routinely. For example, there is no section on the record which allows practitioners to record whether there are children that an adult patient might have access to. Therefore, the identification of children and young people who might be at risk from an adult patient who demonstrates risky behaviour is reliant wholly upon the professional curiosity of staff. (**Recommendation 1.5**)

3.3 We looked at examples of referrals made by staff at the ED at RLH and maternity staff at UCLH and found these to be of a poor standard. There were numerous gaps in the demographic information of the child and their family, of the current legal status of the child and whether the family or child knew of the referral. The narrative sections of the referral forms were superficially completed with little or no analysis of risk shown. This means that the recipient of a referral might not be in possession of key information to enable them to get a clear picture of the child's situation or to assess risk effectively. (**Recommendation 11.1**)

3.4 At UCLH maternity department the named nurse and specialist safeguarding midwives ensure safeguarding or social issues are appropriately flagged on the maternity electronic patient record system. We saw consistent use of this, which supported midwives to easily identify vulnerable women and children.

3.5 Vulnerable expectant women and their unborn children are safeguarded well through the multi professional UCLH weekly safeguarding meeting. At UCLH maternity department all cases where concerns or vulnerabilities have been newly identified are discussed at a weekly safeguarding meeting. These meetings are multi-disciplinary, attended by a social worker, midwife and obstetrician and promote good interagency working with effective sharing of information and co-ordination of support in the antenatal period.

3.6 At UCLH midwives share all relevant safeguarding information with GPs, health visitors and community midwife through an additional discharge summary letter. This is an effective means of ensuring community colleagues are fully aware of any safeguarding risks of other vulnerabilities.

3.7 At UCLH maternity unit the specialist midwives for safeguarding take case holding responsibility for high risk safeguarding cases, and are available to advise and support midwifery colleagues with lower risk cases. We saw good evidence of their role in both multi-disciplinary and multi-agency liaison which helps ensure that vulnerable women are well supported and receive co-ordinated services throughout their period of care.

3.8 The safeguarding school nursing team have recently started attending City of London Multi-agency Sexual Exploitation (MASE) meetings. This will aid in the identification of those children who are at known risk of CSE as it will provide safeguarding school nurses the opportunity to contribute key information to support joint decision making in these cases. However, neither the targeted or safeguarding school nursing team have adopted a standard CSE screening tool which would refine and standardise their practice. Therefore, the service cannot be assured that they are identifying all young people at risk and there is potential that some young people at risk might have been missed. **(Recommendation 8.2)**. *We have drawn this to the attention of public health at the City of London Corporation who are the commissioners of the school nursing services.*

3.9 We were informed of, and saw within case records, that the safeguarding school nursing team are not routinely invited to safeguarding meetings such as case conferences, child in need and core group meetings for City of London children. They are often informed of these meetings through a third party such as a health visitor or SENCO. This is an issue as the safeguarding school nursing team is not always involved in early decision making and, therefore, do not engage or work with children at the earliest possible opportunity. **(Recommendation 8.3)**. *We have drawn this to the attention of the public health team at the City of London Corporation who are the commissioners of the school nursing services*

3.10 Children and young people access different school nursing teams depending on their need and will often transfer between teams at a time of identified vulnerability. The process of handing over a child or young person's case from the targeted school nursing team to the safeguarding school nursing team at the point of vulnerability may not be seen by the child or their family as in the best interest of the child or young person. We were not assured that the transfer between the two separate services considers the wishes or feelings of the child who will have to begin to build a level of trust at a vulnerable time and may have to repeat any concerning history more than once. *This has been brought to the attention of the public health team, the commissioners of school nursing services in the City of London.*

3.11 The use of chronologies and genograms within the targeted, safeguarding school nursing team and health visiting teams is an area for development. They are not routinely used to aid staff in the quick recognition of concerning behaviour or escalation of concerns such as disengagement with services or non-attendance at appointments. (**Recommendation 12.1**). *We have drawn this to the attention of the public health team at the City of London Corporation who are the commissioners of the school nursing and health visiting services*

3.12 The CHYPS plus service is represented at the local MASE meetings and information gathered is placed within a young person's sexual health records if they are active to the service. This is a good opportunity for sexual health practitioners to use meaningful information and intelligence to contribute to decision making about potentially vulnerable young people at risk of CSE.

3.13 The WDP's initial and comprehensive assessment paperwork encourages staff to consider the needs of children. However, in the single case managed by the City of London adult substance misuse team where an adult client had a child we noted significant shortfalls in children's safeguarding practice. For example, record keeping did not show that the impact of parental drug misuse on the child had been considered and did not evidence any communication with other agencies. As it is the same provider, we dip sampled three cases from the Hackney children's team which showed a more positive approach with a high standard of practice; records were child focused and analytical with robust risk assessments. The difference in practices was acknowledged by the service as an area to be addressed. (**Recommendation 9.2**). *We have brought this to the attention of the City of London public health commissioners.*

3.14 The CAMHS and adult mental health services provided by ELFT actively participate in child protection conferences and core groups and ensure that written information is submitted in advance. The reports we reviewed in the CAMHS were detailed and set out an analysis of the young person's situation as it is affected by their mental health. Such detailed information supports good decision making by conference.

3.15 The work by the CAMHS to identify the risk of CSE and respond appropriately requires further development. There is no formal CSE risk assessment tool used. In one case we reviewed we noted that potential risks of CSE to a young person who had had a history of similar risks had been disclosed during a consultation. However, no action had been taken to explore these risks further by the use of an assessment tool or through more targeted questioning of the young person. It was only later, after more disclosures that the practitioner escalated the concerns and referred to children's social care. (**Recommendation 6.2**)

3.16 Safeguarding processes for referring matters of concern are not always followed in the CAMHS. For example, in one case we noted that a referral had been made verbally to the social care team. This was appropriate and decisive as the information needed to be conveyed quickly. However, the referral was not followed up in writing. Instead the referral was passed to the trust's safeguarding team through the use of an internal serious incident report on the trust's Datix system. The report we saw was completed in detail and set out the risks clearly; it also enabled the safeguarding team to apply some documented supervisory oversight. However, this report format was not placed on the child's patient record. This is contrary to the record keeping requirements of the All-London procedures and could potentially be lost over time. This limits the function of the patient record to be regarded as the principal historic, accountable record. (**Recommendation 6.3**)

4. Looked after children

4.1 The small number of children and young people who become looked after by the City of London are all currently placed outside of the Borough. They all now benefit from timely and comprehensive initial health assessments undertaken by a paediatrician. Most of the cohort of children looked after are unaccompanied asylum seeking children and the designated doctor has good insight into their specialist needs. For example, the designated doctor is working to establish pathways of care with the infectious disease service to ensure fast tracking of cases and this will meet the particular needs of this vulnerable group who may enter the country from areas where there is an infection risk. There are specialist care pathways already in place for those children and young people who need specialist advice for contraception and sexual health through CHYPS plus.

4.2 Children and young people looked after by the City of London are all seen by the specialist looked after children nurses for their review health assessments. The majority of review health assessments are carried out in a timely way by the specialist nurses who are commissioned to travel up to 75 miles to ensure continuity of care and accountability. All review health assessments we reviewed were completed within timescales.

4.3 The initial and review health assessments for unaccompanied asylum seeking children that we reviewed were completed to a high standard. The holistic assessments consider the child's journey to the UK, their traumatic experiences and their family history. This information is effectively used to determine the impact on physical and emotional health. Ethnicity and religion are consistently recorded and used to consider cultural needs and the impact on the child or young person's health. The looked after team record the implications for future health and these are worded in a way that can be understood by young people and carers.

4.4 Both initial and review health assessments could be strengthened further by ensuring the voice of the child or young person is present and reflected throughout the written assessment. Although health assessments seen were very detailed they lacked direct quotes from young people about their likes and dislikes or views on their own health. This personal approach engages children and young people to take ownership of their health needs and ensures the health assessment is very specific to their needs and beliefs. (**Recommendation 8.5**)

4.5 All looked after children benefit from a CAMHS assessment within 6 months of entering care. This is carried out in their placement and includes assessment for ADHD and Autism Spectrum Condition if required as well as an assessment of their mental health and emotional wellbeing; this is a strong offer. However strengths and difficulties questionnaires (SDQ) are not routinely obtained from the local authority to inform ongoing health assessments. SDQs are not used with young people as a tool to continuously assess and track emotional health needs and this is acknowledged by the team as an area for development. (**Recommendation 8.6**)

4.6 Care leavers receive a summary of their health history in the form of a letter. This is a comprehensive letter which gives all health history, including parental health history if known and also useful advice on registering with local services. A care leaver's passport is being implemented but it is important that this is coproduced and audited with young people to ensure it meets their needs. **(Recommendation 8.7)**

4.7 The looked after children health team do not use any specialist screening tools to assess for any emerging risks of CSE. It is recognised that children looked after are at a greater risk of exploitation during their time in care. The absence of a CSE risk assessment tool or practice prompts means that staff rely solely on professional curiosity and this is a missed opportunity to identify early concern. **(Recommendation 8.2)**

4.8 GPs are asked to contribute routinely to health reviews of children looked after, although this is often not possible for initial health assessments. This is because the majority of children looked after are unaccompanied asylum seeking children who do not have a GP at the time. GP registration is quickly facilitated by the social worker and this ensures that health summaries and plans can be routinely shared with the child or young person's GP to inform their ongoing health needs.

4.9 The designated doctor has undertaken an analysis of the health needs of the cohort of unaccompanied asylum seeking children across Hackney and the City of London and has shared the report of the findings with the local authority and health providers. The audit highlights the specific needs of this group of children; for example, the findings shows the burden of physical, mental and sexual health problems with a proportion of girls who reported sexual exploitation was high. The team are working to produce an action plan to reduce the health inequalities of children looked after by the City of London.

4.10 The use of audits is well embedded within the children looked after health team and strong analysis of findings to identify areas for improvement is a positive feature of the service. For example, improvements have been made in the timeliness of carrying out initial health assessments and of uploading health summaries and plans onto record systems. We have seen evidence that shows that this has been as a direct result of audit by the designated doctor and peer review of the specialist children looked after nurses which indicates a practice of promoting a continuous cycle of improvement. **(Recommendation 8.8)**

4.11 We have not provided any case examples from our review of looked after children records as with such low numbers the young people would be easily identifiable.

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 Health partners are an integral part of a successful, innovative and forward looking Local Safeguarding Children Board (LSCB) recently judged as outstanding in an OFSTED inspection. The LSCB have good oversight of the health and wellbeing of children and families living in the City of London despite the challenge of disaggregating data between Hackney and the City of London. The designated nurse uses data intelligently to understand where children and vulnerable families access health services and has used this to inform service development.

5.1.2 The LSCB takes an active interest in ensuring the partnership work effectively to maximise the life chances of these vulnerable children and young people. We saw that the LSCB are prepared to intervene directly to benefit looked after children. For example, in one case we saw that the LSCB had intervened in supporting a child who was looked after to access CAMHS services in an out of area placement.

5.1.3 The safeguarding team at Barts Health NHS Trust provides visible and active leadership across the trust's estate with a lead named nurse, a named nurse for each of the four sites and a team of three specialist advisors. This includes ready access for all staff to advice and guidance through a 24-hour on-call advice line, staffed on a rotational basis by each of the named nurses and the designated nurse for one of the CCG areas in the trust's footprint. Thereby, operational staff and managers are given timely guidance which supports good judgements about the safety of children and young people.

5.1.4 We learned that staffing in the children's ED at RLH is almost at full complement and that there is ongoing recruitment activity that is intended to maintain this. Encouragingly, the department is staffed entirely with qualified children's nurses. This is compliant with the relevant guidance on children's urgent care settings and was an area that we had identified required development at a previous inspection.

5.1.5 The named nurse and specialist midwives at the UCLH lead on developing and promoting good safeguarding practice. They have developed good working relationships with multi agency professionals leading to good information sharing and joint working to improve outcomes for vulnerable women and their newborn infants.

5.1.6 There is a real commitment by the health visiting team to ensure that the needs of City of London families and children are met. Performance data can be separated to ensure health visiting support meets the needs of this population. There is evidence that the use of audit is embedded within the health visiting service and this supports a continuous cycle of improvement. The health visiting managers have good oversight of the vulnerable children and families within their service by the use of a database which enables them to track child protection responsibilities and supervision.

5.1.7 During our review of records in the paediatric ward at RLH we noted that CAMHS practitioners from ELFT do not have access to the hospital electronic patient records system and so noting the outcome of any clinical or risk assessment that would benefit other staff is problematic. A work-around has developed whereby CAMHS practitioners use the access card (SMART card) belonging to a staff member in the ED or the paediatric ward at RLH to make entries in the patient record. This does not comply with professional record keeping standards or the information governance rules on use of such cards. Moreover, it does not support accountable safeguarding decision making and is an unacceptable practice. **(Recommendation 7.1)**

5.1.8 Where safeguarding children concerns are identified in the ED at RLH, an additional layer of scrutiny is in place to ensure appropriate action is taken. Each child for whom there are concerns or additional safeguarding needs is scheduled for further oversight at a weekly, 'psychosocial' meeting. This is over and above the screen carried out by the safeguarding advisor performing the paediatric liaison role. Included for discussion are children who are identified by virtue of the attendance at ED of an adult with potentially harmful behaviours. This meeting is attended by multi-disciplinary staff such as a paediatrician, a senior nurse from ED, CAMHS, the paediatric psychiatry liaison service and a safeguarding advisor. Attendance also includes external partners such as a social worker, and members of voluntary organisations, such as those who advocate in domestic abuse situations or who work with victims and perpetrators of crime. 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. This is a strong arrangement that ensures good decisions are made about children and young people and that opportunities to safeguarding them are not overlooked.

5.1.9 Although the targeted school nursing team are moving towards a 'paper-light' system they still have some children's records in paper format. Having both a paper and an electronic system in place does not support full information sharing and there is the potential for relevant information to be missed. **(Recommendation 4.1)**. *We have drawn this to the attention of the public health team at the City of London Corporation who are the commissioners of the school nursing services.*

5.2 Governance

5.2.1 The designated nurse meets with peers across a number of other London boroughs and interrogates quarterly dashboard returns to identify any breaches or trends in performance. This enables the designated nurse to have good oversight and hold providers to account. For example, we note that compliance levels for safeguarding training and supervision have improved at one of the health providers as a result of close monitoring and an action plan submitted through the formal provider clinical quarterly monitoring meetings. The provider is now on track to meet projected compliance and close monitoring continues.

5.2.2 The designated nurse is the chair of the LSCB training sub-group. This group effectively monitors and evaluates the local training offer by agencies and providers. We saw evidence of local and national serious case reviews informing development of the local training offer; for example learning from neglect and the need for local counselling services to be involved in local training opportunities. Health services are well represented at the Corporate Parenting Board and the Corporate Parenting Officers' group. This helps to ensure that the health needs of children looked after remain a priority within health providers and the corporate parenting team.

5.2.3 The role of designated nurse for looked after children is not resourced in accordance with the national model. This has the potential to lead to a blurring of the tiers in managerial responsibility. The CCG does not have full-time responsibility for the nurse carrying out the designated role, which continues to be employed by the provider, WHT. Both we and NHS England consider that this type of arrangement creates a conflict of interest. Furthermore, the arrangements do not meet the requirements of national intercollegiate guidance and professional nursing bodies. The CCG is aware of this potential conflict of interest and will be addressing this. **(Recommendation 13.1)**

5.2.4 Barts Health NHS Trust has undergone recent changes to their senior leadership team and this has resulted in a responsive approach that is broadly supportive of the trust's safeguarding functions. For example, the most recent CQC regulatory inspection resulted in the creation of separate site management teams for each location. Each site also has its own safeguarding committee, chaired by the sites' Directors of Nursing. The safeguarding committees report directly to, and are accountable to the trust's Integrated Safeguarding Assurance Committee chaired by the trust's Chief Nurse who has executive responsibility for safeguarding. This is a simple linear structure which supports clear lines of accountability between operational managers and the trust board.

5.2.5 At UCLH 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.

5.2.6 There are clear lines of accountability for safeguarding governance in the ELFT. The trust is represented at senior level on the City and Hackney LSCB. The ELFT Safeguarding Team's associate director and the named professional for City and Hackney also represent the trust on the Safeguarding Children Board's various sub-groups. The trust also manages safeguarding activity across the areas in its footprint through a bi-monthly safeguarding committee chaired by the Director of Nursing and attended by the Chief Nurse and Deputy Chief Executive who is the trust's board lead for safeguarding. This ensures that the trust board have oversight of the safeguarding performance of its operational teams.

5.3 Training and supervision

5.3.1 Barts Health have a monthly scheduled programme of one-day level three training delivered to class sizes of around 30 staff. This ensures that all staff who meet the criteria for level three training receive updates within the three year timescale described in the intercollegiate guidance. However, there are limited further opportunities for paediatric staff, including those who work in the children's ED, to receive the additional specialist level three training that is a requirement of their role. (**Recommendation 1.6**)

5.3.2 Whilst some additional staff in Barts Health have received specific training in providing safeguarding supervision, the managers in the ED and the children's services at RLH acknowledge that capacity to deliver safeguarding supervision requires further development. The trust policy requires all case holding staff to receive three-monthly one-to-one supervision. All other staff have access to *ad hoc* safeguarding supervision as and when it is needed but there is a requirement that they should all receive this supervision at least once every year. Currently the trust is not able to ensure this occurs. This means that staff in key roles dealing with children and young people do not have the opportunity to talk and reflect about their safeguarding practice and this may lead to drift in cases. (**Recommendation 1.7**)

5.3.3 Apart from the full day's safeguarding training at induction, the annual two hour updates, mean that the UCLH midwives undertake six hours safeguarding training over a three year period. Midwives are specifically identified as requiring multi-disciplinary, inter-agency specialist level three training; that is a minimum of 12 to 16 hours over a three year period. Although we are informed that some midwives are accessing additional learning opportunities these are not currently being fully captured. We cannot therefore be assured that all midwives at UCLH currently fulfil the learning hours and competencies required to meet the needs of their specialist role as stipulated in the intercollegiate guidance. (**Recommendation 2.5**)

5.3.4 The provision of safeguarding supervision for community midwives at UCLH could be strengthened. Caseload holding community midwives would benefit from frequent, in depth one-to-one supervision sessions rather than the quarterly group sessions currently offered. This would help to ensure a degree of professional challenge in cases where increased support or intervention for vulnerable women is identified. It would also help ensure that potential risk or drift is not overlooked and that staff are supported in fulfilling their safeguarding responsibilities. (**Recommendation 2.6**)

5.3.5 The safeguarding supervision in place for the named nurse and specialist midwives at UCLH for safeguarding is strong, they are provided with ten supervision sessions per year from an external provider. This appropriately reflects their high risk case-loads and safeguarding responsibilities.

5.3.6 Clinical staff in the safeguarding school nursing team receive a Good offer of one-to-one safeguarding supervision every three months from the trust's named nurse. Administrative staff have recently started receiving group supervision sessions in recognition of their involvement in predominantly safeguarding work. This is positive.

5.3.7 Clinical staff in the safeguarding school nursing team are required to undertake level three safeguarding children training. The current provision is a one day, in-house training session every three years. Additional *ad hoc* training is available through the LSCB with, for example, focused sessions on CSE, domestic abuse and FGM. However, staff are unclear as to how many hours of learning they are required to undertake over a three year period and they are not currently, formally recording any training other than the seven hours provided in-house. We cannot be assured therefore that safeguarding children training is currently meeting the needs of their specialist role. (**Recommendation 8.4**). *We have drawn this to the attention of the public health team at the City of London Corporation who are the commissioners of the school nursing services*

5.3.8 The targeted school nursing service do not benefit from regular in-depth one-to-one safeguarding supervision, instead they are invited to attend three monthly group sessions as well as monthly management supervision meetings where cases are discussed. The group sessions do not include case discussions and are educational events rather than safeguarding supervision. We acknowledge that the universal team no longer hold any safeguarding cases; however, the team is responsible for identifying safeguarding concerns and referring children to children's social care. Formal one-to-one safeguarding supervision would help to ensure a degree of professional challenge in such cases. It would also help ensure that potential risk or drift is not overlooked and that staff are supported in fulfilling their safeguarding responsibilities. (**Recommendation 4.1**). *We have drawn this to the attention of the public health team at the City of London Corporation who are the commissioners of the school nursing services*

5.3.9 The targeted school nursing team are required to undertake 12 to 16 hours of safeguarding training over three years and this is compliant with the intercollegiate guidance. The trust has developed a training passport to enable staff to capture the learning they have undertaken so that they can be assured of their levels of competence at any given time.

5.3.10 All of the staff in the adult substance misuse service have received updated level three safeguarding children's training. The offer of one-to-one and group supervision within the adult substance misuse service is good. However, we found that supervisors do not routinely review or record supervision decisions in client records, furthermore supervision records we looked at did not always demonstrate a clear child focus, and there is limited evidence of the impact of parental drug misuse on all children the client has contact with. This means that risks may not be properly understood by staff and included in risk management planning. (**Recommendation 9.3**)

5.3.11 Health visitors are well supported by effective supervision. They receive one to one quarterly safeguarding supervision and psychosocial group supervision every six weeks which is delivered by the first steps team. All supervision staff have undergone supervision training delivered by the NSPCC. The supervisors receive supervision by the named nurse and this allows themes and concerns from supervision to be identified to inform future learning. However, there is no consistent approach to recording supervision in children's records and supervision records are not easily identified in the child's record so that they can be used to inform day-to-day practice. (**Recommendation 4.2**). *We have drawn this to the attention of the public health team at the City of London Corporation who are the commissioners of the health visiting services*

5.3.12 There is a strong level three training offer for health visitors provided by the Homerton University Hospitals NHS Foundation Trust and compliance is closely monitored. Health visitors receive in-house and multi-agency training events including updates on learning from serious case reviews. This helps to keep practice current and supports staff in identifying risks.

5.3.13 CAMHS have an established risk rating system to identify the level of clinical supervision required for each child and the frequency of such supervision. Active safeguarding concerns are RAG rated as amber and these cases are discussed every three months with a supervisor or through multi-disciplinary review ensuring that actions taken to safeguard more vulnerable young people are monitored.

5.3.14 We acknowledge that most complex cases in CAMHS have a degree of additional scrutiny and oversight through clinical supervision, multi-disciplinary team meetings or the complex case forum. However, the absence of specific safeguarding supervision does not provide the mechanism for safeguarding or risk information to be isolated and considered separately from a person's clinical needs and limits the opportunity for professional challenge on a one-to-one basis. This is highlighted in the previous CSE case we have reported above under 'child protection' where the risks of CSE could have been considered separately to the young person's clinical needs. (**Recommendation 6.4**)

5.3.15 CAMHS practitioners receive training to level three alongside multi-disciplinary colleagues from other areas of the trust's services. This training takes place every three years and there are regular monthly sessions run by the trust's safeguarding team where practitioners can attend. CAMHS staff also receive additional level three specialist training, predominantly via the LSCB. Compliance with the requisite number of hours at Level 3 over the three year period is monitored by the trust safeguarding team.

5.3.16 Safeguarding supervision in the adult mental health service takes a variety of forms. The named professional visits each operational team in the City and Hackney area and carries out group safeguarding supervision for all clinical and managerial staff every month. During these sessions individual cases are discussed and team members benefit from the insight and learning taken from each of these cases. Decisions and actions from the supervision meetings are typed contemporaneously onto the client's electronic patient records and this is good practice. Managers receive monthly one-to-one supervision from the named professional for cases managed by their teams ensuring that there is an additional layer of oversight for individual cases. *Ad hoc* supervision is also available as and when practitioners require it.

5.3.17 Practitioners working in the adult mental health service receive level three training as part of the trust's mandatory training offer. This training takes place every month across the geographical area of the trust covering the East London Boroughs and the City of London. Delegates from each of the teams participate from a wide range of disciplines and attendance is monitored. Recent training has included FGM, CSE and the radicalisation of young people and this ensures staff are knowledgeable about current high risk issues affecting families

Recommendations

1. Barts Health NHS Trust should:

- 1.1 Ensure that the child's full demographic details including the child ethnicity is recorded in the booking at the RLH to support the delivery of culturally sensitive care.
- 1.2 Review the use of the glass screen in the booking area for children and young people within the emergency department at RLH to ensure the area is child friendly and welcoming
- 1.3 Ensure that children who are admitted to the paediatric ward at RLH and are waiting for a CAMHS review are kept safe and do not present a risk to themselves or others by carrying out a personal and environmental risk assessment and creating a subsequent plan
- 1.4 Improve the paediatric assessment template used in the ED at RLH to ensure it captures father's details and those of the accompanying adult and that it appropriately reflects the child's voice for all children up to the age of 18 years.
- 1.5 Ensure that systems and proformas are in place to prompt staff to consider and record the safeguarding risks to children of adults who present at ED with risk taking behaviours. This should include the recording of details of any children so that this information can be shared with health or social care professionals as necessary.
- 1.6 Ensure all practitioners who work with children attend appropriate Level 3 safeguarding children training so that their training is commensurate with the requirements of the intercollegiate guidance.
- 1.7 Strengthen the arrangements for regular planned safeguarding supervision which is monitored centrally for case holding staff or those who work closely with children or their families.

2. University College London Hospital NHS Foundation Trust should:

- 2.1 Improve the screening for CSE within maternity services to help identify risk of CSE in young pregnant women.
- 2.2 Ensure that plans to invite GPs to share any relevant medical and social history with midwives at the time of pregnancy booking are implemented so that the most appropriate support can be planned.

- 2.3 Improve the safeguarding risk assessment used within maternity services to ensure that expectant women benefit from a comprehensive and holistic assessment of their vulnerability. The trust should ensure that this safeguarding risk assessment is revisited throughout pregnancy.
- 2.4 Ensure that the routine enquiry around domestic abuse is made more than once during pregnancy as per NICE guidance.
- 2.5 Ensure that midwives attend sufficient level three safeguarding training which complies with the specialist levels of competence as described in the relevant intercollegiate guidance.
- 2.6 Develop and introduce effective supervision for community midwives

3. East London NHS Foundation Trust and Westminster Drug Project should:

- 3.1 Ensure that processes are in place to enable regular and effective sharing of information with maternity and health visitor and school nursing teams about risks to children arising from parental mental health or substance misuse.

4. Homerton University Hospital NHS Foundation Trust should:

- 4.1 Strengthen the arrangements for safeguarding supervision for targeted school nurses so that it includes regular, one-to-one, review of individual cases where there is cause for concern.
- 4.2 Develop safeguarding supervision for health visitors so that a record of supervision is made in children's records to enable action plans to inform day-to-day delivery of care.

5. Homerton University Hospital NHS Foundation Trust, Barts Health NHS Trust and University College London Hospital NHS Foundation Trust should:

- 5.1 Ensure that there are effective processes for informing health visitors about women who are resident in the City of London when they register for antenatal care so that health visitors can carry out the antenatal contact.

6. East London NHS Foundation Trust should:

- 6.1 Ensure adult mental health practitioners identify and record the details of children to whom their clients have access so that children feature in assessments of adult mental health risks.

- 6.2 Improve the capability of CAMHS practitioners to recognise and assess the risks to children and young people of CSE.
- 6.3 Improve record keeping within CAMHS to ensure that the child's record contains details of any referrals to children's social care, as well as any other safeguarding activity.
- 6.4 Strengthen the arrangements for safeguarding supervision for caseload holding CAMHS practitioners.

7. Barts Health NHS Trust and East London NHS Foundation Trust should:

- 7.1 With immediate effect, ensure that appropriate information sharing arrangements are in place to facilitate joint working between CAMHS staff working at the Royal London Hospital and the hospital teams. The sharing of SMART cards across health practitioners is not acceptable practice.

8. The Whittington Hospital NHS Trust should:

- 8.1 Work with partners to develop a clear threshold criteria and pathway for vulnerable children and young people accessing safeguarding school nursing
- 8.2 Improve the systematic identification of CSE within the safeguarding school nursing services and the children looked after health team to help identify emergent or existing risk of CSE in children and young people.
- 8.3 Work with partners to ensure the safeguarding school nurses are invited to, attend and contribute to child protection conferences and safeguarding meetings.
- 8.4 Ensure that safeguarding school nurses have opportunities to attend additional level three training that meets with the specialist nature of the role as defined in the relevant intercollegiate guidance.
- 8.5 Ensure the voice of the child is captured and reflected in initial and review looked after health assessments and informs final health action plans.
- 8.6 Improve the assessment and monitoring of the emotional health and wellbeing of children looked after by more effective use of the SDQ.
- 8.7 Ensure that the current development of the care leaver's passport incorporates true coproduction with young people and care leavers and is reflective of their views.

9. Westminster Drug Project should:

- 9.1 Share plans for the safe storage of methadone with relevant universal health services to enable them to contribute to safeguarding children against accidental overdoses.
- 9.2 Ensure that practitioners consider the impact that parental drug misuse has on children and communicate these concerns with other universal health services working with the family.
- 9.3 Ensure that records of safeguarding supervision are made on client records and that they remain child focused and that the impact of parental drug misuse on children is properly understood.

10. East London Foundation NHS Foundation Trust, Homerton University Hospital NHS Foundation Trust, University College London Hospital NHS Foundation Trust and the NHS City and Hackney Clinical Commissioning Group should:

- 10.1 Improve the multiagency pathway for peri-natal mental health across the City of London with clear guidance for thresholds and a single point of access so that all professionals working with mothers are clear about how clients can be supported and from whom that support can be obtained. .

11. Barts Health NHS Trust and University College London Hospital NHS foundation trust should:

- 11.1 Ensure that referral forms are completed to a satisfactory standard and that they include full demographic information and an analysis of the risks to enable children's social care to make an informed decision about the safety of the child.

12. The Whittington Hospital NHS Trust and The Homerton NHS Trust should:

- 12.1 Develop the use of safeguarding chronologies and genograms so targeted service staff and safeguarding school nurses can easily recognise concerning behaviour or escalation of concerns.

13. NHS City and Hackney Clinical Commissioning Group:

- 13.1 Ensure that the role of designated nurse for looked after children is commissioned and provided by a person who meets the requirements of the intercollegiate guidance and professional nursing bodies.

13.2 Work with the local safeguarding children board, the police and the local authority to enhance the understanding of health visitors and school nurses of domestic abuse risks in individual families and thereby their involvement in domestic abuse safety planning.

Next steps

An action plan addressing the recommendations above is required from NHS City and Hackney 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.