

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

Children Looked After and Safeguarding

The role of health services in Bromley

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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 Bromley. 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 Bromley, 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 90 children and young people.

Context of the review

Bromley is located in South-East London and is the largest London borough in the city. Bromley has a population of over 326,000 (2016). Children and young people under the age of 18 years make up around 24% of the population. Estimates show the black and minority groups to be approximately 19%.

Although Bromley is a relatively prosperous area, the communities within Bromley differ substantially. The North-East and North-West of the borough indicate higher levels of deprivation and disease prevalence comparative to those found in the London Boroughs bordered by Bromley, while in the South, the borough compares more with rural Kent.

The health and wellbeing of children living in Bromley is generally better than the England average. The infant mortality rate is better than England average and the child mortality rate is similar to the England average. Whilst the level of poverty is better than the England average the level of homelessness is worse.

The number of children looked after (CLA) has remained reasonably static over recent years ranging between 250-286 children. The rate of 38 CLA per 10,000 for under 18yrs is lower than national data.

The majority of residents Bromley are registered with a general practice that is a member of Bromley Clinical Commissioning Group (CCG).

Commissioning and planning of most health services for children are carried out by Bromley Clinical Commissioning Group.

Looked after children services are provided by Bromley Healthcare operationally, and strategically Bromley CCG.

* Looked After Children to be known as Children Looked After within the report.

Acute hospital services are provided by Kings College NHS Foundation Trust.

Community based services for children under 5 years are commissioned by London Borough of Bromley and provided by Oxleas NHS Foundation Trust.

Health support for schools service is commissioned by London Borough of Bromley and provided by Bromley Healthcare.

Child and adolescent mental health services (CAMHS) are provided by Oxleas NHS Foundation Trust.

Bromley Community Health and Wellbeing service known as Bromley Y is commissioned by London Borough of Bromley.

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

Child substance misuse services are commissioned by London Borough of Bromley and provided by Change Grow Live and known as Bromley Changes Service.

Adult substance misuse services are commissioned by London Borough of Bromley and provided by Change Grow Live and known as the Bromley Drug and Alcohol Service.

Bromley sexual health service are commissioned by London Borough of Bromley and provided by Bromley Healthcare and King's College Hospital.

Specialist facilities are provided by South London and Maudsley NHS Foundation Trust.

The last inspection of health services for Bromley children took place in October 2010 as a joint inspection with Ofsted. The overall effectiveness of the safeguarding services including for looked after children was judged as good with the contribution of health agencies to keeping children and young people safe as adequate. Progress against inspection recommendations have been considered in this review.

The report

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

What people told us

We heard from:

A family that described maternity care before and at the birth as “brilliant – we were very well looked after”. They said “we couldn't have had a better experience and staff go out of their way to help you, they genuinely care”.

Parents spoke very positively about the care received. “We felt cared for ...the staff go above and beyond”. They described how the midwives had explained risk and benefits to help them make decisions.

From a foster parent who said “A CAMHS trainee clinical psychologist has provided really helpful support. She is very experienced and insightful, supporting the children and myself. She involves other professionals and has ensured continuity. The direct work done with the children has enabled us as a family to work through some difficult issues.”

“There is a lack of flexibility in CAMHS. Even though our child expressed a preference for a worker of a specific gender, this couldn't be met and he didn't have any choice about where the appointments took place. If he had some choice, he might have continued to go to CAMHS. We did get great support from SLAM on a specific specialist aspect of his needs.”

“CAMHS have done a significant piece of work with her and it has taken over a year for them to get her to a place where she is ready for the service to be effective.”

“My GP has always been brilliant. He is extra sensitive to my looked-after child's issues and that really helps.”

“The CLA specialist nurse comes regularly and is always on time and is friendly. She engages well with the children and always sees them for a while on their own”.

“The specialist CLA nurse provided a whole training day two years ago which included CAMHS and other specialist presenters. This was great but has never been repeated. We need this at least annually.”

A foster carer reported “Social care training does include some aspects of health but much more in-depth health training is needed.”

We heard about:

On one record examined we saw how a CLA with severe disabilities had been placed into a family who were supported well to provide the child with care and support. Despite the child’s disabilities, the foster carers had involved them in holidays and were planning to take the child on a trip that would involve a flight. However, it was recognised that the child’s disabilities were severely hindering attempts to capture an image that would be suitable to meet the requirements for a passport. Recognising this difficulty, a request was made of the passport office to consider this when processing the application. The community paediatrician wrote to the passport office outlining the child’s disabilities and that it would not be possible to provide an image that would meet their requirements.

Bromley Changes received a referral from children’s social care in relation to a young person’s alcohol use and binge drinking. The young person was autistic so the worker looked at the best way to adapt the sessions to meet the young person needs, such as delivering very short focused sessions. There has been a very positive outcome for this young person with greatly reduced binge drinking. The worker is now supporting the young person as they prepare to apply for a job.

We heard of a young person of 18years who had spent most of his life in care who suffered an episode of mental health psychosis and on discharge from a specialist unit had come to live in Bromley. The adult mental health worker recognised the lack of certainty about the security of his accommodation that was negatively impacting on his ability to pursue further training and build his social network in the local area. The worker was relentless in her challenge and support to enable the young person to attend college and develop marketable skills. The case demonstrated excellent patient centred care through advocacy by a mental health professional who ensured a vulnerable young person placed in the area following his discharge from hospital had the help and support needed to support his recovery and improve his life chances.

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 Children and young people benefit from timely assessments of their clinical need when attending for urgent or emergency care at Princess Royal University Hospital (PRUH). There is one main reception desk managed by the urgent care centre (UCC) which provides a single booking point for all patients. The UCC staff stream children and young people using agreed guidelines to the emergency department (ED) or UCC.
- 1.2 The administrative processes and checks in the UCC and emergency department that facilitate the identification of children with child protection plans or children looked after by the local authority are not robust. There is a reliance on paper based checks completed at booking rather than highly visible flags or alerts that follow the child's journey through services. If this check is missed there is a risk that assessments may not safeguard vulnerable children and that full information about the level of risk to a child is not shared effectively. Alerting systems identify increased vulnerability of the child and can inform care through liaison with agencies already supporting the family. (**Recommendation 4.1**)
- 1.3 The paediatric ED waiting area provides a safe and welcoming environment for children and families. The unit is currently fully staffed with paediatric trained nurses ensuring children are assessed and treated by appropriately trained staff.
- 1.4 We saw variability in the completion of the ED casualty cards. The recording of social and family history on the ED casualty cards in PRUH were often incomplete. In addition, the safeguarding proformas were not being routinely completed by the clinician either at admission and/or discharge. This information is important to contributing to the practitioner's overall assessment. (**Recommendation 4.2**)

- 1.5 A well-established multi-agency meeting in PRUH reviews and reflects on the management of children and young people needing early help and those with safeguarding concerns who attended the ED the previous week. Participants include Children’s Social Care, CAMHS, Bromley Changes, UCC and safeguarding professionals. This supports reflective practice from the unit and promotes a collaborative approach to making decisions about further help that could be made to the child and family. It was noted by the ED practitioners that the long term vacancy of the liaison health visitor role and their absence from this meeting hindered the discussions and feedback to community practitioners.
- 1.6 The emergency department and ward area at PRUH have a longstanding vacancy for a Bromley HealthCare liaison health visitor. This limits information sharing between PRUH and health visitors about children’s attendances which could inform their ongoing care and support to families. (**Recommendation 5.1**)
- 1.7 Effective arrangements are in place to respond to the needs of expectant women in Bromley. The most vulnerable expectant mothers with mental health concerns benefit from a well-developed perinatal mental health service that is compliant with NICE guidance. There is clear referral criteria and good multi agency working, delivered through joint weekly clinics, that supports a cohesive approach to engaging women and families with services. This provides strong “team around the family” working to help protect and improve outcomes for unborn and new born babies.
- 1.8 Expectant women with increased mental health needs receive specialist mental health midwifery care through direct or joint work with community midwives and the LINKS team (a specialist community midwifery team for vulnerable women). We saw care plans which were comprehensive and provided a clear picture of professional roles and accountabilities. This supports vulnerable women needs being met through a cohesive care approach.
- 1.9 The lack of shared IT means that midwives and adult mental health practitioners are unable to access patient records of expectant women that both services are working with. It is important that vulnerable expectant women with mental health concerns receive a co-ordinated approach to their care and that risk is managed appropriately. (**Recommendation 7.1**)

- 1.10 The CCG and Mind are working jointly to facilitate peer to peer support for mothers who have had mental health difficulties during their pregnancy/post-natally through the Mindful Mum volunteer befriender scheme. The service offers additional capacity in supporting the peri-natal team to provide a comprehensive, targeted package of support to vulnerable women and their unborn/new born babies.
- 1.11 Health visitors and early years' settings are developing partnership working to support families but have not yet formally established the integrated two year check. Where children are engaged with nurseries, practitioners use the Early Years assessment to which health visitors are able to contribute and both disciplines work together to make positive use of the personal child health "Red Book". Integrated working increases opportunities to provide a cohesive approach to families and maximise opportunities for identification of developmental needs and other vulnerability.
- 1.12 Vulnerable families are benefitting from an improved relationship between their GP practice and the health visiting service. All GP practices have a linked health visitor and most practices host three monthly safeguarding meetings. Health visitors and GPs report that the meetings are working well and are facilitating the early identification of safeguarding concerns and vulnerability in families and promoting a joined up approach to care and support.
- 1.13 The health service for children aged five to 19 years has been commissioned in a structure not seen during this type of review previously. The remit of the health support to schools service (HSSS) is to undertake specific safeguarding work and offer strategic management support in relation to health needs for children in school. This has meant we are unable to report on a five to-19 years' service that identifies and supports children and young people within a universal early help model as this is not part of the commissioned service.
- 1.14 Bromley Health Care provides a comprehensive sexual health service across the Borough. The service is available six days a week at different clinics to maximise availability to service users. A young person clinic (under 25yrs) operates on a Saturday in central Bromley. This gives those young people needing to access the service a degree of flexibility in receiving contraceptive and sexual health advice.

- 1.15 More young people who attend ED for care where alcohol or drugs have been a factor are being supported by Bromley Changes, a service for children and young people with drug and alcohol concerns. Bromley Changes have undertaken work with ED practitioners to strengthen the referral pathway between the two teams. A referral form for use by ED staff has been adapted and training sessions on substance misuse have been delivered by the service.

Child C is 15 attended the hospital ED. During the consultation it was found that the young person's use of alcohol was a factor and the treating clinician also established that Child C was not in school. A referral was made to Bromley Changes.

Child C was initially very reluctant to engage with services but the Bromley Changes worker worked creatively and persistently to engage them. The worker successfully built up a rapport with Child C who then felt confident in making a disclosure of self-harm. The worker subsequently identified that Child C was at risk of CSE.

A successful team around the child network was formed with children's social care, Child C's school and the practitioner from Bromley Changes all working together to support Child C, who is now back in school and is engaging well and making more positive choices.

- 1.16 Bromley Changes is working successfully with primary care to embed their referral form into the GPs IT system so that the GP can easily find and complete the referral form. This has resulted in Bromley Changes starting to routinely receive GPs referrals with a subsequent increase in the number of young people that can benefit from specialist help.
- 1.17 Bromley Changes work effectively with schools. Satellite sessions are held in various schools across the borough, delivering "drop in" clinics and hosting sessions on health promotion and preventative work often through school assemblies. In particular ,the school "drop ins" have been effective in engaging young people with the service and in one school 23 young people signed up for a group programme demonstrating evidence of good engagement.

2. Children in need

- 2.1 There is sufficient oversight by PRUH safeguarding team of safeguarding concerns raised in ED. The safeguarding nurse based on site reviews the forms daily and follows up any safeguarding issues, raising datix incidents when required. The safeguarding information sharing forms completed in the ED contained relevant and sufficient detail of risk factors to support decision making and the recommended treatments/actions going forward. A senior staff member is assigned from the ED to ensure the recommended outcomes are followed up on a daily basis, this included calls to the agencies/professionals. This ensures that where safeguarding concerns have been identified by the ED practitioner the information is shared in a timely way to support assessment of risk to the child.
- 2.2 Arrangements to identify the risk of domestic violence in pregnant women require strengthening. Expectant women are asked about whether they are at risk of domestic violence at the beginning of their pregnancy. A routine, dedicated, woman only element to the first ante natal booking appointment is in place which supports enquiry and exploration of matters of a sensitive nature including domestic abuse. This positive practice is supported by mandatory recording on the electronic patient record. We saw evidence of midwives using a positive response to carry out an assessment of risk. However, given the under reporting and known dynamics of domestic abuse the exploration of risk of domestic abuse would be improved by the routine enquiry by the midwife on more than one occasion in line with NICE guidance. (**Recommendation 4.3**)
- 2.3 We saw good practice in how the maternity booking documentation and social assessment ensures routine gathering of risk related to partners during pregnancy. This effectively contributes to an overall risk assessment and prompts midwives to consider partners with regard to behaviours such as substance misuse that may impact on the pregnant women and unborn.
- 2.4 Assessments of a child's home environment and their safety carried out by health visitors are not always robust. Case records seen demonstrated that practitioners concerns did not always articulate strongly enough the impact of the home environment on the child or reflect the child's voice. Recording of the information can assist the practitioner to identify emerging or existing signs of neglect. (**Recommendation 6.1**)

- 2.5 Some high risk first-time mothers up to the age of 24 are now able to benefit from support by the family nurse partnership (FNP) service in Bromley. The upper age limit has been extended with the agreement of the FNP National Unit. This is a positive step in extending care and support to vulnerable young mothers recognised as facing increased challenges in their parenting role due to their own experiences.
- 2.6 Bromley health visitors do not routinely use chronologies or genograms to support their safeguarding activity. In Oxleas, there is not a consistent approach across commissioned health visiting services. Management accept routine use of chronologies is an area for development in health visitor services in order to ensure effective risk assessment and oversight of a child's vulnerability. (**Recommendation 6.2**)
- 2.7 Inspectors are not assured that the health needs of electively home-educated children are effectively overseen and met. HSSS are commissioned to support vulnerable children including those electively educated at home. However, practitioners told us this is not a role they currently carry out as they do not have access to data to identify this cohort of children. *This has been brought to the attention of London Borough of Bromley Public Health.* (**Recommendation 5.2**)
- 2.8 The HSSS is not routinely made aware of, or asked to contribute to, children being assessed for Education, Health and Care Plans (EHCP). This limits assurance of compliance with the Special Education Needs & Disability (SEND) Code of Practice as required under The Children and Family's Act 2014. *This has been brought to the attention of London Borough of Bromley Public Health.* (**Recommendation 5.3**)
- 2.9 Arrangements for children presenting to the PRUH in severe mental health crises do not meet the needs of the young person. Children and young people often wait for too long for a CAMHS assessment and subsequent discharge or transfer to a specialist setting. It is reassuring that the ED and the ward use registered mental health nurse to look after the children and young people when they are at their most vulnerable. (**Recommendation 6.3**)

- 2.10 The commissioned service arrangements, increased demand and staff capacity affect the ability of the CAMHS out of hour's service to respond to children and young people in crisis in a timely way. There is no commissioned young people's liaison service providing support for young people admitted to acute paediatric beds or those awaiting transfer to mental health in-patient beds. A business case for a tri-borough mental health liaison service for children and young people at QEH and the PRUH has been submitted by Oxleas to the CCG. Although we were satisfied there is a process to manage risk both for the child and that staffing arrangements are in place during these admissions, it is not as child focussed as it should be.
- 2.11 Care pathways between Bromley Community Health and Wellbeing service (Bromley Y) and CAMHS remain an area for development. Current arrangements do not consistently support a smooth and timely response for children and young people with more complex/longer term needs. New arrangements for strengthening handover to CAMHS tier 3 are still being embedded and referrals seen did not demonstrate consistent use of the referral form, or evidence it is being used to best effect. We saw examples of requests for additional information being needed to support decision making and identify the appropriate treatment pathways, this can then impact on the timeliness of the child or young person accessing the right care at the right time. (**Recommendation 8.1**)
- 2.12 The Oxleas adult mental health service has strongly promoted the 'think family' approach across teams, with clear guidance to practitioners to enable them to better recognise the needs of children. The Local Children's Safeguarding Board (LSCB) has endorsed an information sharing document which provides clear guidance to strengthen liaison and information sharing between midwives, HV and adult mental health practitioners. The quality of multi-agency referrals by adult mental health practitioners to children's social care was good.
- 2.13 Bromley Drug & Alcohol Service (BDAS) and adult substance misuse practitioners demonstrate a good understanding and application of the 'think family' model. From the point of initial assessment and throughout their work with clients, there is a focus on the vulnerabilities of children and young people with whom adult clients might have contact with.

We heard of a 20 year old pregnant woman who was leaving care whose unborn baby was on a child protection plan referred to Bromley Changes. The care planning was tailored to support the focus on the young person and the unborn baby through joint working with the perinatal mental health service. A transition plan to the adult substance service was developed with the young person that delayed the transfer and supported the consistency of care at a time of increased complexity in their life.

- 2.14 Bromley Changes and the youth offending service work effectively to keep young people safe. Information sharing arrangements and the co-location of these services supports joint working. We heard how information sharing is appropriately based on risk and individual assessment. The impact of this was seen in relation to young people who are part of gangs. Individual risk assessments are developed with the young person on where they consider it will be safe for them to meet. This enables the young people to be kept safe and still receive support.

3. Child protection

- 3.1 The MASH health safeguarding advisor is valued and respected by the MASH partner agencies. The safeguarding advisor is increasingly participating in MASH strategy meetings although further work is needed across MASH partner agencies to ensure consistency. Collaborative information sharing meetings allows the MASH specialist to communicate findings clearly in discussions, and ensure health input into decision making as part of the joint approach to safeguard children where resource allows.
- 3.2 The existing health resource in the MASH is not sufficient to ensure health partners consistently input into multi-agency decision making to safeguard children. Although plans have been put in place to increase capacity this was not in place at the time of this review. As a consequence the timeliness of health's contribution in multi-agency safeguarding decision making may be compromised. (**Recommendation 5.4**)
- 3.3 Health practitioners are participating in multi-agency and multi-disciplinary discussion by the use of teleconference facilities for strategy meetings. Prompt access to appropriate health expertise and clinical information is facilitating decision-making and the effective management of risk to children and young people. It is encouraging to see a local area taking advantage of technology to effectively support multi agency work.

- 3.4 The PRUH maternity service has robust arrangements to identify and record safeguarding risk. We examined electronic referrals made to children's social care by the service and saw that they were of a good quality and included detailed information on the potential impact of parenting behaviour on a new-born and the expected action of children's social care. This practice helps to safeguard those in their care, including the unborn child.
- 3.5 The PRUH have implemented robust multi agency arrangements for reviewing the care of vulnerable pregnant women in the final stage of her pregnancy. A maternity safeguarding planning meeting for high risk cases is held at 28 weeks gestation. This is a well-established multi-agency forum chaired by the safeguarding specialist midwife with formal minutes and actions recorded in the woman's record to support patient focused care. Social care routinely share agreed multi-agency pre and post birth plans and child protection plans. The collaborative working through well-developed professional relationships is providing a cohesive approach to supporting the women and protecting the unborn and newborn infant.

In maternity we saw a robust process in place in relation to nonattendance by a complex high risk pregnant woman who had also been the victim of domestic abuse.

The local process and flow chart for maternity services was followed and unannounced home visits and a multi-agency response was made to multiple DNA's.

The unborn became subject to a child protection plan and the midwife showed a good level of professional curiosity during her care of the woman and baby.

There was good evidence of procedures and practice that safeguarded the unborn baby effectively.

- 3.6 We saw comprehensive single electronic records of care in maternity services. All safeguarding and child protection meeting information is uploaded onto the maternal electronic patient record and there are highly visible alerts in women's hospital records. The internal processes and joint working facilitate effective information sharing and management of risk for the unborn baby and the mother.

- 3.7 Robust processes are in place in maternity to identify women who have been subject to female genital mutilation (FGM). We saw that enquiries about FGM are part of routine booking conversations and are documented in a separate mandatory section of the electronic record. There is also a specific pathway for young women less than 18 year old. This is supported by the use of the Department of Health risk assessment tool, which assists in the identification of those at risk, such as the unborn baby or siblings so they can be safeguarded.
- 3.8 In maternity, recording of exploration of child sexual exploitation risk requires improvement. Although we saw that CSE is referenced within routine documentation we did not see reference to, or use of a screening or risk assessment tool in the electronic record. (**Recommendation 4.4**)
- 3.9 Health visitors in Bromley are actively involved in, and prioritise, safeguarding and child protection. Practitioners are committed to attending and participating in information sharing meetings such as the maternity safeguarding forum. Health visitors see this as a valuable information sharing meeting, helping them to understand emerging concerns about unborn children at an early stage and supporting effective targeting of antenatal visits.
- 3.10 The health support to schools service (HSSS) practitioners within the safeguarding team have a good understanding of their roles and responsibilities to safeguard children and participate in child protection processes. The HSSS are diligent in participating in child protection strategy meetings as appropriate and attendance at initial child protection conferences are prioritised. The team also provides regular face to face support to young people with health needs who are engaged with the youth offending service and educational pupil referral unit.

Child A quickly identified the HSSS practitioner as a trusted adult. The practitioner showed skill in quickly establishing a rapport with the young person who felt able to disclose serious sexual abuse.

The practitioner took timely and appropriate action by informing the young person they would need to escalate the disclosure and ensuring the young person was kept safe following the disclosure.

The practitioner sought advice and guidance from the BHC safeguarding team and made a clear and good quality referral to MASH so that Child A was protected.

- 3.11 The multi-agency referral forms completed by CAMHS provided a good overview of current risks, protective factors and actions required to safeguard children. We saw cases where the voice and experiences of the young person were well considered in relation to high risk behaviours and managed effectively through joint work with children's social care.
- 3.12 CAMHS professionals have started to use the CSE tool to help inform their assessment of risks for the safety and wellbeing of children and young people but practice is not yet sufficiently embedded, or effectively used to inform referrals to children's social care. (**Recommendation 6.4**)
- 3.13 GPs are increasingly effectively sharing information for case conferences through the use of a standard template introduced by the named GP. In one practice we visited we saw good practice where all child protection reports were routinely quality assured and feedback provided to the author. However, further work is still required by GPs so that they can better use information held on their records to consider the impact of the lived experience of the child. This supports the findings of an audit last year by the named GP which identified an action to support GPs with submitting robust case conference reports. (**Recommendation 1.1**)
- 3.14 Young people who access Sexual Health Bromley are safeguarded well. Practitioners have good safeguarding knowledge, especially in respect of particular risks, such as CSE and domestic abuse, that may present in their cohort of clients. Completion of an electronic safeguarding young person's template is mandatory for all under 16's and quality assurance is built in. The service also has a number of access points to electronic records and links to the MASH health advisor to support information gathering and inform a comprehensive assessment of the young person. We saw an example of where this had supported keeping a sexually active child, who was also looked after and at risk of CSE, safe.
- 3.15 The changes in commissioning arrangements for the five to-19 year service has reduced the opportunity for the sexual health advisors to refer young people to a 'school nurse' for more universal focused health advice or ongoing support within the school setting. It is too early to say if this will have any longer term impact on the interdisciplinary working and supporting young people with their health needs. *We have brought this to the attention of Bromley Public Health Commissioning Team.*
- 3.16 Sexual health Bromley participates in assessing risk and sharing information through membership of the Multi Agency Planning meetings (MAP) and links to the ATLAS team. This forum and team undertake work on children at risk of CSE, missing from home and those involved in gang activity. This recognises the role sexual health services can have in identifying and supporting young people at risk of child sexual exploitation.

- 3.17 Children and young people who access Bromley Changes and need safeguarding benefit from good quality referrals to children's social care. Referrals seen included detailed information on risk related to the young person's substance misuse. Key information, such as the analysis of risk and the potential impact on young people, is part of the referral. This assists partner agencies in MASH to make fully informed decisions.
- 3.18 The BDAS has clear processes for effectively managing escalation in cases where there are unresolved child protection issues. We saw two cases where comprehensive letters written by the service safeguarding lead to children's social care outlining their concerns led to further action being taken by social care to safeguard children.
- 3.19 Information sharing protocols between the BDAS adult substance misuse service, Bromley Changes young person's substance misuse service and the MAP meeting are underdeveloped. Although both adult service practitioners and their young person's service counterparts have received training which makes them aware of the risks of CSE to young people in Bromley, no direct links have yet been established and this is a gap. We are aware that service managers are to investigate potential relationships with ATLAS in due course. (**Recommendation 9.1**)
- 3.20 We saw a number of CSE screening tools available to practitioners across the provider services which adequately addressed key areas of risk to support an initial assessment. However, these are ratified within individual organisations and there is currently no process for oversight and cross referencing to the Bromley LSCB CSE screening tool to ensure consistency of approach within the screening tools being used across the health economy. (**Recommendation 1.2**)
- 3.21 Quality assurance processes to support learning and identify trends was variable across provider services. A robust quality assurance process would provide oversight of referrals and support a consistent standard to better meet thresholds when considering actions to protect vulnerable children and young people. (**Recommendation 4.5, 5.5, 6.5 and 9.2**)

4. Looked after children

- 4.1 The Bromley Health Care Children Looked After (CLA) team is well led and specialist practitioners are striving to improve standards for looked after children. Service managers are members of appropriate CLA forums and reporting processes are in place to the CCG and, jointly with social care, to the LSCB.

- 4.2 Children looked after do not always benefit from the timely completion of initial health assessments as children start their care journey. Work is ongoing to ensure IHAs take place within statutory timescales. Data from quarter two demonstrates an increase in compliance and this is encouraging. It is recognised that more needs to be done to ensure partner agencies promptly notify CLA health team when a child becomes looked after and reporting and monitoring by BHC and the CCG are in place. It is disappointing that trajectories have not been set to monitor and report on improvement. These would offer both agencies targets to measure themselves against and provide assurance to corporate parenting boards that measures to improve timeliness were having a positive impact. (**Recommendation 5.6**)
- 4.3 Increased funding in 2016 has resulted in Bromley CLA team proactively supporting their children and young people placed out of area. Approximately half of CLA in Bromley are placed outside of the borough, with the majority placed in neighbouring boroughs. We also saw evidence of the practitioners travelling further afield, including Kent to undertake RHA. This approach by CLA specialist practitioners offers a level of continuity of care, promoting trust and stability to children often exposed to multiple numbers of professionals. It is recognised though, that care must be taken to ensure that children placed out of area have good links with their local health providers and communities.
- 4.4 The designated doctor for CLA recognised that more work needs to be done to develop the CLA team's expertise to fully understand the health needs of unaccompanied asylum seeking children. (**Recommendation 5.7**)
- 4.5 Children looked after do not routinely benefit from a single complete CLA health record. In some records examined we saw that actions arising from initial health assessments (IHAs) were not included on the associated electronic records. Although we have since been assured that these actions were completed, it means that these records were not formally complete which could impact on the care planning of the child and is not best practice. (**Recommendation 5.8**)
- 4.6 Review health assessments (RHAs) were seen to be particularly strong in identifying and recording both the voice of the child and where younger children are concerned, their 'lived experience'. The responsibilities of carers was explicitly recorded which means the reader of the RHA can draw clear conclusions as to the needs of the child and how best to provide support to the carers. This is important for the child as it can help reduce the risk of placement breakdown and ensure that their health needs are met.

- 4.7 Pathways to ensure GPs effectively contribute to CLA health assessments are under-developed. We are aware of recent discussions between the named nurse for CLA and the named GP to review the way in which information is requested from GPs and this work is ongoing. We were unable to find any evidence of GPs, as primary record holders, providing evidence to inform the IHA and RHA process. Therefore the assessments may not be informed by the most up to date health information held in primary care.
- 4.8 It is important that GPs are provided with copies of completed IHAs and RHAs for their patients which should then be used to inform their interactions with these vulnerable children. We did not see how this sharing of information has impacted on the care these children receive within primary care in any of the records examined by inspectors.
(Recommendation 1.3)
- 4.9 Children looked after health practitioners use well developed assistive tools when working with children and young people across Bromley. Until recently, both strength and difficulties questionnaires (SDQs) and ASQs were used to aid the health assessment process. However, the SDQ process has recently been suspended by social care and we are advised that this is currently under review. It was clear the health tools used for assessing emotional wellbeing were informing care plans within the RHA's, including supporting referrals to appropriate services to meet the emotional needs of children and young people.
- 4.10 Young people leaving care are provided with a paper copy of their essential health information. This provides the young person with information so that they can start to take responsibility for managing their own health needs. The decision to provide health information in a paper copy form was taken following consultation with Bromley care leavers and they rejected the offer of a more formal passport of information. The designated nurse CLA was clear this would need ongoing evaluation to consider whether the information should be offered in different formats to support service user choice.
- 4.11 Children and young people who are looked after by Bromley and who need additional support for their emotional health and wellbeing are supported well. All CAMH referrals are made through a single point of access, which is managed 'Bromley Y' who then triage the referrals, prioritising CLA for assessment recognising their additional vulnerabilities.
- 4.12 The consultation model used by CAMHS CLA involves the child's social worker and foster and adoptive carers and is well-developed. The joint approach is regularly reviewed and promotes supporting the young person's mental health and managing any risk taking behaviour.

We saw targeted and skilled work by CAMHS LAC professionals in supporting Child X who has been severely traumatised by their experience of childhood abuse.

Therapy was offered to enable Child X to both understand what is safe and age appropriate behaviour and to help tackle the trauma from their childhood experience.

Other specialists were appropriately involved to build a clearer picture of the risks Child X posed to other children and how best to support Child X to be safe and to feel safe.

- 4.13 Both adult and young people's substance misuse services demonstrated good knowledge of the additional vulnerabilities of CLA and this was evidenced in cases examined.

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 CCG have been proactive in reviewing safeguarding arrangements across the Bromley health economy following the local authority Ofsted inadequate rating in June 2016.
- 5.1.2 The recommendations of an independent review of the safeguarding and children looked after services across Bromley in October 2016 has assisted the CCG and health providers to draw up an action plan to improve outcomes for children and families within the health economy. The plan takes account of areas of work that will only progress through effective joint work across agencies and services. An example is the mobilisation of the Child Protection Information Sharing programme (CP-IS). This programme is a national system led by NHS England that connects social care child IT systems with those used by the NHS in unscheduled care settings. A formal implementation group led by the designated nurse is progressing work which in time will support practitioners in identifying and protecting children known to be at risk of harm.

- 5.1.3 We saw good commitment by the CCG to working with the local authority to improve outcomes for children in Bromley. The CCG accountable officer is a member of the improvement board which was established following the Ofsted inspection. The designated professionals for safeguarding children and CLA are members of the work streams for the priority areas. In September the designated nurse attended the board to present a report on the progress update for health. It was reported there is increased confidence by the safeguarding leads that their expertise is valued and used in the development of joint strategies, guidance and in safeguarding practice.
- 5.1.4 The CCG, after a period of interim arrangements, have a full complement of experienced staff undertaking statutory roles. The capacity has been mapped against best practice guidance per head of child population. Although a relatively 'new team', individuals offer strong leadership within the organisation. Their profile is high with senior partner agencies through participation in LSCB subgroups and collective strategic work, such as the multi-agency strategy discussion protocol. The protocol highlights the importance of joint working practices and the shared responsibilities of children's social care (CSC), the police, health and other partner agencies to work together to safeguard children.
- 5.1.5 The designated doctor has played a significant role in enhancing working relationships between CSC and community paediatricians. There are now three monthly multi agency meetings with the children and assessment referral team with clinical presence, including the designated doctor. Bespoke pieces of work, led by the designated doctor, have supported the implementation of protocols such as a child protection medical pathway and increased social workers understanding of the paediatrician role.
- 5.1.6 The named GP has been proactive in developing service standards for primary care to support safeguarding arrangements in general practice. Bromley CCG has successfully implemented a local enhanced service (LES) for safeguarding children which has been taken up by all GP practices in 2016/17. Practices taking up the LES are required to complete a self-assessment regarding the safeguarding children arrangements that are in place. Compliance with all standards are still being developed and variability in GP practices safeguarding arrangements were noted during site visits such as in the correct and up to date coding of children's and families vulnerability. (**Recommendation 1.4**)

- 5.1.7 A Children and young people's safeguarding survey is being undertaken across the health economy led by the designated nurse and doctor in conjunction with Healthwatch. The independent review (October 2016) recommended the CCG and provider organisations "*ensure engagement with children, parents and young people in planning and raising awareness of health and care services in Bromley*". The CCG has responded by undertaking a children and young people's safeguarding survey across the health economy, led by the designated nurse, doctor and the CCG's Engagement Team. Over 150 older children responded to the survey and the results are in the process of being analysed. Healthwatch were commissioned to support the project and did some face to face work with just over 100 children aged 6 to 11 in school settings. Outcomes will be fed into the Bromley Children's Safeguarding Board to identify any changes required to support children and young people, young carers and other safeguarding practices. Outcomes will also be shared with local services, where specific issues are raised. The work, although not yet completed, highlights the CCGs responsive approach to areas where the need for improvement is identified.
- 5.1.8 The CCG and BHC managers recognise that the provision of health expertise in the MASH supports effective multi-agency working to safeguard children. However, to further embed a joint collective responsibility to information sharing and decision making, there will need to be increased presence of health practitioners in the current arrangements. **(Recommendation 3.1)**
- 5.1.9 The named nurse and specialist midwives at the PRUH lead on developing and promoting good safeguarding practice. They have well developed working relationships with multi-agency professionals and there is evidence of good information sharing and joint working to improve outcomes for vulnerable women.
- 5.1.10 The transition of the health visitor service from BHC to Oxleas as the provider has been well led by both organisations and the local authority public health commissioner, and this reflects positively on the agencies involved. Managers and frontline practitioners described the process as competently managed.
- 5.1.11 All IHA of children and young people taken into the care of Bromley local authority are undertaken by the designated CLA doctor. This is in line with intercollegiate guidance and the current arrangement assists the Designated CLA doctor to have strategic oversight of the issues and health trends as children come into care.
- 5.1.12 The CLA practitioners engage well with the corporate parenting group and also participate in the multi-agency partnership meetings and the ATLAS team which supports a collective approach to protecting those children identified at risk.

- 5.1.13 Public health commissioners have described a number of challenges following a decision to decommission the school nursing service in 2016. This strategic decision led to uncertainty within the workforce which had a direct impact on staffing levels and ongoing capacity within the newly configured service. We acknowledge that Bromley PH are delivering the components of the HCP through a number of different teams and initiatives, though we have not seen any evaluation on the impact of this approach. We also did not see data on how the care of the more vulnerable children is being evaluated outside of practitioner engagement in the child protection conference setting. In the absence of any evaluation of this model it is not clear how commissioners are measuring impact and their achievement of optimal health outcomes for the school aged population. *We have brought this to the attention of Bromley Public Health Commissioning Team.*
- 5.1.14 The legacy of historical commissioning of local children and young people's mental health services does not effectively promote whole system working and oversight of organisational demand and capacity. Different routes to accessing CAMHS services are still in existence and we found stress points at junctures of these services which impacts on children in relation to waiting times and transfers between services. The capacity of both Bromley Wellbeing who provide early support to children and young people with emotional needs (tier two) and the CAMHS (tier three) service is under increasing pressure, although the contractual timescales from referral to assessment to treatment are generally being met. Work continues to improve the service through a number of projects, including the service transformation partnership.
- 5.1.15 Access to Tier 4 CAMHS for children and young people who need in-patient or crises care is not meeting local demand and is an area for development. We heard strategic plans are progressing through senior management to strengthen the approach to CAMHS tier 4 bed management and out of hours' crisis response through a South East London borough approach. It is, however, too early to assess the impact of this collaborative work. **(Recommendation 2.1)**
- 5.1.16 The safeguarding lead practitioners within both the adult and young people's substance misuse services provide robust oversight of each service and they routinely liaise with each other. This ensures that children and young people, both as service users or in the care of adult service users, are identified and protected well.

5.2 Governance

- 5.2.1 Bromley CCG has a robust governance structure in place which extends across the health economy. The reporting systems for the provider organisations and within the CCG committees support the board being assured on safeguarding arrangements within commissioning and provider organisations.
- 5.2.2 Bromley CCG safeguarding leads have developed a detailed dataset of provider safeguarding activity to support monitoring and quality assurance processes. This work has been driven by the designated nurse and has assisted in building mature relationships with provider organisations which allows for challenge and improving safeguarding arrangements. We heard examples of when it had identified risk and of the CCG requesting further analysis from the provider to understand the data and consider appropriate action.
- 5.2.3 Partnership working between Oxleas and BHC has supported the exchange of information to support effective safeguarding decision making and practice within MASH. The BHC safeguarding team, including the CLA health team, have received training on use of the electronic clinical record system, enabling the BHC safeguarding advisors and colleagues to both read and input contact and progress notes. This partnership working; reflects well on both organisations in reaching a sensible and pragmatic agreement with appropriate governance arrangements in place.
- 5.2.4 The BHC named nurse has recently introduced the requirement for practitioners making referrals to also make a datix entry as well as copying the referral to the BHC safeguarding. Although too early for the inspection to consider the impact, continued analysis and feedback of referrals can offer a level of assurance that practitioners are appropriately skilled in identifying risk to the child.
- 5.2.5 The quality of record keeping in maternity is good. The electronic record system for maternity services is robust and supports effective record keeping, audit and oversight. Staff routinely collect and record details of a range of risks as standard. The electronic patient records system includes prompts for practitioners to ask details. We saw examples of this used effectively to identify and manage risk to the unborn child. The system also supports staff within a number of clinical settings to access to up to date information and ensure care is focused on any increased need of the pregnant women.

- 5.2.6 Although the perinatal mental health midwife gathers feedback from training and some qualitative feedback from women she supports about their experience, the outcome data collection could be stronger, to demonstrate the impact of her role and assess any need for further investment due to the increasing demand on the service..
- 5.2.7 Oversight by the CLA team of IHAs and RHAs is new and has not yet been fully tested. A system for 'dip sampling' records has recently commenced and the outcomes of a recent audit of cases were not recorded. Current QA arrangements do not support a formal policy of sampling and recording to identify areas for development and good practice. This makes it difficult to support a culture of continuous improvement. (**Recommendation 5.9**)
- 5.2.8 The BDAS electronic client records were generally seen to be comprehensive and detailed. The electronic system's memory capacity CGL has developed an electronic document library to upload necessary Child Protection documents, including minutes from child protection meetings, which are now stored on the main internal electronic system. This is best practice, However it is recognised by the BDAS adult safeguarding lead, when reviewing and auditing cases that these documents are not always cross referenced on an additional contact tab, which would indicate that a document has been uploaded. The document library is a new recording process and staff need to ensure this is captured. (**Recommendation 9.3**)
- 5.2.9 We saw an example of good proactive work between Bromley Changes, adult substance misuse services and midwifery services. The manager of Bromley Changes and the manager of the adult services worked together to develop a robust transition pathway, policy and flow chart. This enables a flexible approach to transition based on assessed risk and tailored to meet the client individual needs resulting in young people remaining engaged in the service and experiencing a smooth transition.
- 5.2.10 We heard of a number of IT system incompatibility across Bromley. It is recognised through serious case reviews this can lead to barriers in timely sharing or access to information. Practitioners who need to work together do not have access to the each other's client record. Examples include urgent care/PRHU, BHC/Oxleas (MASH). KCFT/Oxleas (perinatal mental health). We also identified inaccuracies in the flagging systems in a number of services, which reduces practitioner's abilities to work in partnership with statutory agencies in the care of the child. The CCG and provider organisation recognise the challenges and some work has taken place to mitigate risk. (**Recommendation 1.5, 4.6, 5.10 and 6.6**)

5.3 Training and supervision

- 5.3.1 Most provider organisations, (with the exception of Kings College NHS Foundation Trust (KCH), are able to provide assurance that their workforce are appropriately trained in safeguarding. The CCG will be increasing targets for levels one to three intercollegiate guidance from 80 to 90% in 2018/19 to gain greater assurance the workforce has had exposure to appropriate safeguarding training. Access to safeguarding training supports staff to have the requisite knowledge and understanding to identify and respond appropriately to safeguard children and young people.
- 5.3.2 The KCH cannot be assured on compliance with safeguarding training across the organisation following the amalgamation of data. We were concerned at levels of training in ED and maternity departments. Inspectors were told that there are plans to hold more safeguarding training on the PRUH site. Where staff have not accessed training this may limit their ability to identify safeguarding children risks and respond effectively to protect those in their care. (**Recommendation 4.7**)
- 5.3.3 Midwives are specifically identified within the intercollegiate document 2014 as requiring multi-disciplinary, inter-agency level three training at specialist level (a minimum of 12-16 hours over a three year period). It is not clear that midwives and other clinical staff within maternity services at PRUH currently fulfil the learning hours required and therefore training may not be fully compliant with the intercollegiate document. (**Recommendation 4.7**)
- 5.3.4 Staff in the ED and in the paediatric ward at PRUH told us they received protected time for supervision which allows for reflection and learning in a supportive structured environment. Learning from both national and local serious case reviews form part of the supervision process to support improving practice and supports staff to understand complex issues and to be clear about their role in individual cases.
- 5.3.5 Maternity safeguarding supervision in the community service is well developed, midwives benefit from opportunities for this support, reflection and constructive challenge to practice. Although the CCG dataset records some variability, there is an upward trajectory to 90% compliance. Regular supervision is an integral part of a practitioner's development and supports effective safeguarding practice.
- 5.3.6 Safeguarding training, safeguarding supervision and line management supervision arrangements for the health visitor service are robust. A particular strength, inherited from the previous provider, is the use of a supervision template which sets out decisions arising from case discussion at supervision and uploads this onto the case record. This assists all practitioners considering the care of the client.

- 5.3.7 All HSSS are appropriately trained for their roles and responsibilities. LSCB training is accessed, which increases specialist knowledge and also increases the opportunity for developing working relationships with partner agencies. Importantly, this supports compliance with the multiagency element of level three intercollegiate guidance.
- 5.3.8 The BHC is prioritising, and is committed to, the delivery of one to one safeguarding supervision as well as ad hoc advice to all its practitioners, including MASH advisors and HSSS. This is good practice, although it is adding to the significant capacity pressures of the BHC safeguarding team.
- 5.3.9 Safeguarding children training is accorded a high priority within Oxleas NHS Trust (90% plus against all intercollegiate levels) and CAMHS have access to a flexible range of learning and development approaches which continuously enhances the knowledge and skill base of its workforce. This equips them to manage children and families with complex safeguarding issues.
- 5.3.10 Whilst CAMHS clinical supervision pays good attention to children and young people on child protection plans; current supervision arrangements do not sufficiently focus on children and young people who do not yet meet/or no longer meet the child protection threshold where risks may be escalating.
- 5.3.11 The CLA practitioners receive group supervision within their monthly team meeting. However a more robust approach is needed to ensure the safeguarding supervision arrangements within the meeting are formalised and desired outcomes and timescales are recorded in the client electronic record to support the focus on keeping the child or young person safe.
(Recommendation 5.11)
- 5.3.12 The CCG data indicates Bromley GPs are appropriately trained in safeguarding children. Compliance with training is primarily through attendance at the annual academic safeguarding half day established by the named GP. We heard that topics such as domestic abuse and FGM had featured on the safeguarding session within the half-day training. It is a positive initiative that the named GP has undertaken a number of audits to assess knowledge base post training. This dual approach recognises a well-trained primary care workforce can support early identification of need for children and assessment of risk within families.
- 5.3.13 We saw a proactive approach by the lead GPs in two practices in reviewing and distributing safeguarding information and updates to the primary care team. For example, one lead GP had received a short CSE video from the Bromley Safeguarding Children Board (BSCB) and had put this item onto the agenda for the practice clinical meeting to raise awareness amongst colleagues and other staff members.

- 5.3.14 The BHC sexual health advisors are appropriately trained to level three and a database evidences specialist areas of training undertaken by staff which includes CSE, FGM and domestic abuse.
- 5.3.15 A robust supervision model is in place for the Sexual Health Bromley practitioners. The lead practitioner spoke highly of the support and advice offered by BHC safeguarding named nurse. As well as formal supervision, safeguarding is a standing agenda item on the weekly team meeting to allow peer discussion on cases. The opportunity for personal development and case discussion with safeguarding practitioner input can enhance practitioner confidence in identifying and escalating risk.
- 5.3.16 Workers in Bromley Changes have appropriate safeguarding training. . Safeguarding is a standing item on the agenda for the weekly team meeting where cases and new safeguarding topics are discussed. The team leader is available to offer supervision and ad hoc advice and oversight of cases. This approach supports staff to reflect on complex issues and appropriate actions to maintain the safety of the child.

Recommendations

- 1. Bromley Clinical Commissioning Group should ensure that:**
 - 1.1 GPs are supported to effectively share information held within the primary care setting about parent/carer's and children that impacts on the child's wellbeing. This will inform child protection reports and multi-agency decision-making.
 - 1.2 The CCG safeguarding leads should review and maintain oversight of the consistency and quality of CSE risk assessment tools in use in the health economy, benchmarking against the LSCB CSE tools.
 - 1.3 GPs review IHA and RHA plans to inform their interactions with you CLA and CCG processes assess the impact of the work.
 - 1.4 GPs use current and relevant coding as recommended within the CCG Local Enhanced Service for safeguarding children agreement and quality assurance processes to support compliance.
 - 1.5 Record keeping and IT systems across Bromley health economy support effective information sharing; appropriate flagging / alerts; access to safeguarding records and multi-agency plans so vulnerable children are highly visible and can be safeguarded.

- 2. Bromley CCG, Oxleas NHS Foundation Trust should ensure that:**
 - 2.1 Work with NHSE so that children and young people in Bromley have timely access to specialist mental health care close to their home.

- 3. Bromley CCG and Bromley Healthcare should ensure that:**
 - 3.1 Consistent and sufficient health presence in the MASH is available to enable full contribution to multi-agency decision making.

- 4. King's College Hospital NHS Foundation Trust should ensure that:**
 - 4.1 UCC and PRUH IT systems in each clinical area can identify and flag vulnerable children on the electronic record.
 - 4.2 ED records are completed and that the Trust has assurance through robust governance arrangements.

- 4.3 Maternity staff routinely ask questions about domestic abuse of expectant mothers throughout their episode of care and answers are recorded and subject to managerial oversight as per the NICE guidance.
- 4.4 Maternity staff are competent in identifying, recording and safeguarding those experiencing or at risk of CSE and that CSE screening and risk assessment tools form part of the electronic record.
- 4.5 Safeguarding referrals to children's social care are quality assured to support organisational learning and a consistent standard in meeting thresholds.
- 4.6 Record keeping and IT systems across Bromley health economy support effective information sharing; appropriate flagging / alerts; access to safeguarding records and multi-agency plans so vulnerable children are highly visible and can be safeguarded.
- 4.7 The Trust must ensure that it is able to identify practitioner attendance at safeguarding training through robust training needs analysis and compliance data.

5. Bromley Healthcare should ensure that:

- 5.1 Children and young people who attend emergency and urgent care are enabled by information sharing to be followed up by the most appropriate professional.
- 5.2 They work with the local authority to ensure that the Health Support Service for Schools has access to data of the cohort of home educated children so their health needs can be assessed and met.
- 5.3 They work with the local authority to ensure that the HSSS are alerted to all children being assessed or with EHCP to allow consideration of their input into plans to improve children's outcomes.
- 5.4 There is consistent and sufficient health presence in the MASH to contribute to multi-agency decision making.
- 5.5 Safeguarding referrals to children's social care are quality assured to support organisational learning and a consistent standard in meeting thresholds.
- 5.6 The CLA team set trajectories with Local Authority to work towards improving IHA compliance and improve notification arrangements.
- 5.7 Ensure that the physical and emotional needs of asylum seeking young people are well understood by practitioners who conduct IHA and RHA who have undertaken appropriate training.

- 5.8 The CLA electronic record contains all information pertaining to the looked after child's care.
- 5.9 Quality assurance processes including tools to benchmark IHA and RHA are developed and outcomes from the process inform strategic and operational practice.
- 5.10 Record keeping and IT systems across Bromley health economy support effective information sharing; appropriate flagging / alerts; access to safeguarding records and multi-agency plans so vulnerable children are highly visible and can be safeguarded.
- 5.11 Formal supervision for CLA is implemented and includes practitioner's routinely recording supervision actions within the client's records.

6. Oxleas NHS Foundation Trust should ensure that:

- 6.1 Practitioners records clearly reflect how the home environment is impacting on the wellbeing of the child, quality assurance of this should form part of supervision practice.
- 6.2 The use of chronologies and genograms is routine within the health visiting service.
- 6.3 Children and young people have increased timely access to specialist CAMHS support and care to assess their mental health within the acute setting.
- 6.4 CAMHS staff are competent in identifying potential CSE and articulating risk within records and on referral to children's social care so children and young people can be effectively safeguarded.
- 6.5 Safeguarding referrals to children's social care are quality assured to support organisational learning and a consistent standard in meeting thresholds.
- 6.6 Record keeping and IT systems across Bromley health economy support effective information sharing; appropriate flagging / alerts; access to safeguarding records and multi-agency plans so vulnerable children are highly visible and can be safeguarded

7. Oxleas NHS Trust and King's College Hospital NHS Foundation Trust should ensure that:

- 7.1 Care records are shared appropriately so that practitioners from both organisations are able to offer a co-ordinated approach to care and management of risk.

8. Oxleas NHS Foundation Trust and Bromley Y should ensure that:

- 8.1 CAMHS and Bromley Y ensure the process and quality of information sharing at point of handover consistently meets the child's needs.

9. Change Grow Live Adult service should ensure that:

- 9.1 Work with the local authority MAP to enhance information sharing for young people who are at risk by developing and embedding a formal communication pathway
- 9.2 Safeguarding referrals to children's social care are quality assured to support organisational learning and a consistent standard in meeting thresholds.
- 9.3 The electronic record is a comprehensive composite of information including documents that relate to the persons care.

Next steps

An action plan addressing the recommendations above is required from NHS Bromley 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.