

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

Children Looked After and Safeguarding

The role of health services in Barnet

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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 Barnet. 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 Barnet, 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

Barnet is the largest borough in London by population and is amongst the 50th most deprived local authorities (157/326) in England. The north London borough is bordered by Hertfordshire, and London Boroughs of Enfield, Haringey, Brent, Harrow and Camden.

Data shows 92% of the residents to be registered with a Barnet CCG GP and 25% of the population are under 19years. Data from 2017 Child Health and Maternal Health Observatory information profile suggests that on the whole the health and wellbeing of children in Barnet is generally better than the England average.

Barnet has a diverse population, in 2017 there was a school age black minority ethnic population of 69%, the largest minority ethnic group of children and young people are Indian and Black African. Barnet also has the largest Jewish population in England and Wales.

As of June 2017, 347 children were LAC (37.9% per 10,000) were in the care of Barnet local authority, this is significantly lower than England data of 60,000 per 10,000), of these children 16% were unaccompanied asylum seeking children. Over half of Barnet looked after children are cared for out of area.

In July 2017 the London Borough of Barnet received an inadequate rating from Ofsted for their children and looked after children services. The improvement plan that is now in place is supported by all the statutory partners. Barnet Clinical Commissioning Group (BCCG) have a Children's Health Improvement Action Plan in place to support the work.

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

Looked after children services are provided operationally by Central London Community Healthcare NHS Trust in the London Borough of Barnet.

Acute hospital services are provided by The Royal Free London NHS Foundation Trust.

Community based services for children and young people 0-18 years are commissioned by London Borough of Barnet and provided by Central London Community Healthcare NHS Trust.

Child and adolescent mental health services (CAMHS) are provided by Barnet, Enfield and Haringey Mental Health NHS Trust.

Adult mental health services are provided by Barnet, Enfield and Haringey Mental Health NHS Trust.

Child substance misuse services are commissioned by London Borough of Barnet and provided by Westminster Drug Project.

Adult substance misuse services are commissioned by London Borough of Barnet and provided by Westminster Drug Project in partnership with Central and North West London NHS Foundation Trust. The partnership is known as Barnet Recovery Centre

Barnet sexual health service are commissioned by London Borough of Barnet and provided by Central and North West London NHS Foundation Trust

Specialist facilities are provided Barnet, Enfield and Haringey Mental Health Trust

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:

- *Mother having an induction of labour – “It feels very relaxed, there is good information and communication, they (midwives) keep me informed and up to date with what’s happening.”*
- *A mother postnatally with increased vulnerabilities “Level of communication is really strong, they all know what they are doing; my midwife, the midwives and doctors here, the handovers are really good, I don’t have to repeat my story over and over again, they all know what’s happened and where I am up to.”*
- *A young person told us they’ve [ED and ward staff] all been brilliant, I can’t fault any of them, everyone’s lovely. Everything in the NHS takes a long time, but it’s not their [staff’s] fault. They spoke to me on my own and spoke to my mum and I felt listened to. I didn’t want to stay in but they explained everything and I get it, I understand why.*
- *“The nurse goes beyond just doing the programme, she supports with other things too. I’ve suffered with anxiety for a while and have panic attacks when it’s bad. She really helped me with this and got me the right medication and I haven’t had an attack recently now as I’m feeling much better.”*
- *“It’s like she’s always on call for me, I can get in touch with her whenever I need and she will do extra visits if I need her to help with stuff, she’s never not been there when I needed her.”*

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 who attend Barnet Hospital (BH) for emergency care have vulnerabilities quickly identified and acted upon. The hospital has a separate paediatric emergency department (ED) that employs paediatric competent staff in accordance with Royal College of Nursing and Royal College of Paediatrics and Child Health guidelines.
- 1.2 Children attending ED are always cared for by nurses with appropriate skills, knowledge and experience to assess and meet their needs. All core nursing staff on the children's ED are children's trained, including paediatric life support, with at least one nurse on every shift competent in advanced paediatric life support. Nursing staff from the adult ED who support children's ED when required, have additional paediatric competencies assessments completed.
- 1.3 Children and young people receive a holistic assessment of needs that considers the whole person rather than just their presenting complaint when attending BH ED. Children and young people have their needs triaged, assessed, and treated using a specific children's assessment pro-forma known as 'Children's Emergency Pathway'. The proforma is comprehensive and considers physical, mental and social needs as well as recording who accompanies them to ED. Questions around social needs and family are mandatory fields on the electronic system to ensure completion.
- 1.4 All children aged 0-18 years are assessed in ED using this pro-forma, including 16 and 17 year olds who may choose to be seen in the adult ED if they wish. We saw evidence of the process in BH where a young man who was 16 made a decision to use the adult ED but staff used paediatric paperwork. This helps staff who are used to working with adults to retain a focus that their patient is a young person and therefore consider the additional vulnerability. However this consistent approach was not always seen for children attending the Urgent Care Centre, which is on the same site as BGH ED. **Recommendation 1.1 and 4.1**

- 1.5 Children and infants who attend the ED following injury are not always being assessed in line with national best practice. Whilst paediatric registrars and other senior clinicians have additional safeguarding knowledge and experience, decision making is reliant on professional curiosity and judgment of the reviewing clinician. We did not see evidence of policies to prompt practitioners to consider additional safeguarding concerns where disguised compliance may be a factor. Practitioners we spoke to were unaware of any local policy in place for dealing with bruising in non-mobile infants or head injuries in infants under a year old. This means that potential non-accidental injury in infants may not always be identified.
Recommendation 3.1
- 1.6 Children in Barnet whose parents chose not to wait for them to receive clinical assessment or treatment in BH ED do not benefit from a robust process to evaluate and ensure their safety. There is no 'Did Not Wait' policy in place, with a reliance on the professional judgment of senior staff to make decisions about whether a case needs to be managed as a single service or referred on to MASH. **Recommendation 4.2**
- 1.7 We saw good evidence of multi-professional engagement to support the identification and response to safeguarding concerns identified in ED. Weekly multi-disciplinary meetings are held between senior ED staff, safeguarding team, and senior practitioners from mental health services including CAMHS, substance misuse services, and domestic abuse liaison. This provides a forum for case discussion and is supporting identification and response to safeguarding concerns through reflective review.
- 1.8 The weekly Multi-agency panel meeting is well-attended by a range of professionals and considers what support families that have not met threshold for statutory service may benefit from. The community 0 – 19 years' service along with CAMHS, WDP Barnet Young Peoples Drug and Alcohol service, adult substance misuse service and adult mental health, attend to support a joint approach to the discussions and ensure families are supported holistically.
- 1.9 Families who are receiving support through local early help services are well supported by Children Adolescent Mental Health Services (CAMHS) and adult mental health services. In records we looked at we saw that CAMHS practitioners are fully involved in team around the child meetings. This ensures that plans to support children and young people receiving early help are fully informed by the ongoing clinical progress of their mental health needs.
- 1.10 In our review of cases we saw that adult mental health practitioners attend team around the child meetings and share information with multi-agency colleagues to enable services to be appropriately targeted to meet the needs of the family as a whole.

- 1.11 Midwives from the Royal Free London NHS Foundation Trust (RFLFT) provide supportive and personalised maternity care to women living in and around Barnet. Maternity care is offered from several hospitals and community hubs. Midwives are based in local children's centres, with a link Specialist Midwife for Vulnerable Women. This is supporting pregnant women to access care close to home and increase awareness of local services offering early help.
- 1.12 Expectant women benefit from a comprehensive risk assessment at booking which is revisited at regular intervals throughout the pregnancy as recommended by NICE guidance. The assessment includes consideration of the risk of domestic abuse which supports the joint work undertaken by midwives with the hospital based independent domestic violence advisor. This risk assessment helps to allocate the women to the most appropriate care pathway and there was evidence of good oversight of the care of the most vulnerable women.
- 1.13 We were told that there is good information sharing between GPs and the maternity service, with the majority of midwifery bookings coming from the GP. The booking referral template from GPs, where these are used, include the patient practice summary sheets highlighting risk factors. A letter requesting the same information is supposed to be sent to all GPs for any women who self-refer for maternity booking. This approach, when used, enables early identification of women who may have vulnerabilities and may need increased assessment and support. However, we are not assured that this good practice is used in all cases as some GPs told us that there was an inconsistent approach to information gathering and sharing with midwives. **Recommendation 3.2**
- 1.14 Some children in Barnet do not benefit from the full Healthy Child Programme. We were told the 0-19 service caseloads are categorised to the London Continuum of Need to prioritise support and contact with vulnerable and high risk families, however the Healthy Child Programme is instrumental in ensuring that every child gets the good start they need to lay the foundations of a healthy life. Vulnerable ante natal, new birth, 1 year and 2 – 2 ½ year contacts are being offered. Some GPs in Barnet offer the antenatal and six to eight weeks checks, however the lack of contact by health visitors means there are missed opportunities to identify families that are in need of additional support and children who are at risk of poor outcomes. The decreasing regular liaison with GP's by HV and SN also reduces the opportunity for a multi-disciplinary approach to identifying vulnerable families at the earliest opportunity. *This has been brought to the attention of Barnet Local Authority Public Health.*

- 1.15 Health visitors are not always made aware of children attending ED in a timely manner. Although urgent referrals to community practitioners are managed by community liaison health visitor in a timely way and this also includes notification to the safeguarding team, non-urgent are cascaded via the children health information system service (CHIS) and there are considerable delays. We saw evidence of cases where notifications of attendances had experienced a delay of between 4 and 6 weeks before they were brought to the attention of the health visiting service despite being rated with known risk factors. This means that the family health visitor was not fully aware of the most current risk and this impacted on their ability to provide support at the earliest opportunity. **Recommendation 5.1**
- 1.16 Children entering statutory education at reception, and again at Year 6 benefit from taking part in the National Child Measurement Programme. Children identified as having an unhealthy weight are able to access the healthy weight nursing service, who works with children, young people and their families to offer nutritional advice to achieve a healthy weight. This means that the whole family benefit from education around changing eating habits and lifestyle to improve overall health and weight. We saw evidence of the positive impact on the children and families engaged in the scheme in reducing weight and changing lifestyle.

We heard of an initiative that is utilising the skills of school nurses. Barnet Public Health as part of the Child Health Weight Management service has commissioned Central London Community Healthcare to deliver a focused programme of healthy eating and lifestyle to Barnet families through the Healthy Weight Nurses (HWN).

Children are identified through the NCMP and for those with a BMI above the 98 percentile at reception or year 6 are referred to the HWN team. Referrals are taken on children between 4-12years

The aims are to promote attainment of a healthy weight over a 12 month period by improving nutritional knowledge and healthier eating behaviours and to decrease sedentary behaviours. The programme has been running for 2yrs and a detailed evaluation is showing positive impact on the wellbeing of the children and families who have engaged.

Feedback quotes from the evaluation include

“The HWN made me feel comfortable”

“My daughter has started to opt for fruit as a snack instead of grabbing a bag of crisps”

- 1.17 Children and young people of school age and their parents in Barnet are able to access to online information, support and resources without the need for formal referral to the school nursing service. This gives families an alternative route to accessing advice about a range of physical, social, emotional health and well-being issues. In addition, families and children can use the 'Health Matters' website which includes a function to contact a school nurse and receive an online response within two working days. The school nursing service offer targeted health support where this is identified by the school nursing service, school or other agency, a package of support and intervention is then offered.
- 1.18 Opportunities to identify vulnerability in school aged children across Barnet are limited and there has been a decrease in the number of referrals to children's social care by the school nursing service. The school nursing service has a limited offer outside of term time, as the majority of nurses are employed "term time" only. In addition, the school nurse service does not offer vulnerable young people attending Post-16 education or those who are home educated a school nursing service unless there is a specific health need or where there is an identified safeguarding concern. The opportunity to identify and offer additional support is therefore limited, this reflects some of the findings of the Lightning Review (2016). We were told school nurse support is formally introduced when child protection procedures are initiated. *This has been brought to the attention of Barnet Local Authority Public Health.*
- 1.19 It was reassuring to note that some schools across the Borough are now introducing drop in clinics for school age children. It also is positive that the school nursing service is running a pilot to offer a targeted drop in clinic at the Youth Offending Service. Both the Royal College of Nursing (2017) and British Youth Council (2012) highlight the role of school nursing in being accessible to young people and continuing to play a role in receiving disclosures and offering support to vulnerable children. *This has been brought to the attention of Barnet Local Authority Public Health.*
- 1.20 Children and young people have access to a wide range of support for their emotional health and wellbeing, supported by the CAMHS. Recent training has been offered to GPs and to schools on managing self-harm, this relates in part to a local serious case review. At the time of the inspection school nurses had not had access to the training. We were told school nurses did not feel confident in supporting children who self-harmed. *This has been brought to the attention of Barnet Local Authority Public Health.*
- Recommendation 5.2**
- 1.21 Young people receive a good integrated contraceptive and Sexual Health service in Barnet. The recent integration of Contraception and Sexual Health (CASH) and Genito Urinary Medicine (GUM) means that their care is coordinated and any issues they have around sexual health can be addressed within the same appointment.

- 1.22 Those young people who find it difficult to access sexual health services because of their vulnerability are supported well through the work of the CASH outreach worker. We saw an example of this flexible approach in how the worker had developed and uses a pictorial power point presentation to overcome language barriers for unaccompanied asylum seeking children.
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2. Children in need

- 2.1 Expectant women and post-natal mothers who experience mental health problems are being better supported through the newly introduced peri natal mental health service. The Named Midwife attends the weekly multi-disciplinary meeting to discuss new referrals. There are joint clinics held by the Consultant Obstetrician, Consultant Psychiatrist, Perinatal Mental Health Nurse and Specialist Midwife for Vulnerable Women. This means for those women who need additional support, there is a co-ordinated approach to their care through a multi professional team.
- 2.2 Expectant women and victims identified within the ED who disclose domestic violence are supported well through close links with the independent domestic and sexual violence advisors (IDSVAs) at both Barnet and Royal Free hospitals.

We heard about a young female of 16 years who presented in hospital emergency department (ED) with anxiety, low mood and suicidal thoughts. She was given the choice of being assessed in adult or children's ED and waiting in adult's or children's waiting area as legally still a child the hospital wanted to ensure she waited in a safe appropriate environment. The young person choose to wait in adult's ED, she was assessed using the children's assessment pro-forma to ensure a focus continued was given to children's safeguarding. After a prompt assessment she was admitted to the paediatric ward within 4.5 hours of arriving at the emergency department. She was admitted overnight before a detailed mental health assessment the next day. This decision was made in consultation with the young person, parent and clinician. The care given to the young person was coordinated and maintained a clear focus on her needs.

- 2.3 Well established systems are in place to ensure women with a learning disability and are pregnant receive a co-ordinated package of care. The specialist midwives for vulnerable families and the acute liaison nurses for people with learning disabilities based at the Barnet and Royal Free hospital work collaboratively to support women with learning disabilities. Evidence in records sampled showed positive outcomes for these women and their babies.
- 2.4 Children and young people at home are not routinely considered when adults attend BH ED. The 'Think Family' approach is not well embedded when adults with concerning behaviours attend for urgent care. Whilst there is a guideline/flow chart in place promoting 'Think Family' this does not directly relate to the adult assessment template or cas-card in the form of triggers or prompts to help practitioners consider risk factors. We are aware that the trust is redesigning the proforma and this would be a good opportunity to ensure inclusion of prompts and space to record pertinent family details.
- 2.5 Children and young people attending ED in Barnet having self-harmed, are supported by a responsive CAMHS service during office hours. However, outside office hours and at weekends, this response does not meet their needs. Involvement of CAMHS is limited to telephone consultation between paediatric staff at the hospital and an on-call consultant psychiatrist. This means that young people, who do not otherwise require medical treatment over the weekend, may remain on the ward longer than necessary whilst awaiting a CAMHS assessment. We are advised that the CAMHS service have been working with commissioners to develop a more comprehensive service specification for an Assertive Outreach Service to improve the crisis response. However, at the time of the inspection this new service has yet to be commissioned. *This has been brought to the attention of Barnet Local Authority Public Health. **Recommendation 9.1***
- 2.6 Some children and young people referred into Tier 3 CAMHS are waiting too long to be seen by clinicians. Referrals are made into a single point of access where they are triaged by a duty clinician to ensure they are allocated to the most appropriate service. Current waiting times from referral to treatment can be up to 13 weeks for their first appointment and a further 6 weeks before they commence therapy. We also heard that children waiting for neurodevelopmental assessment can wait up to a year before being assessed. Whilst we acknowledge that the provider is working towards improving these waiting times, the delays are currently unacceptably long. GPs told us that they support families during these long waits by offering appointments and escalating with CAMHS where the young person's mental health deteriorates. **Recommendation 2.1**

- 2.7 Practitioners in both the CYPSSMS and CAMHS services are well engaged with child in need procedures. We saw in Children and Young People substance misuse service (CYPSSMS) and CAMHS practitioners consistently attend child in need (CiN) meetings and provide relevant information. In records we looked at, we saw that CiN plans reflected the child/young person's needs. The two services offer joint visits to young people this facilitates effective information sharing and means children receive a coordinated approach to this part of their care within their plan.
- 2.8 Young people who are engaged with CAMHS and meet the threshold for adult mental health services benefit from a clear transition pathway. However, the majority of young people do not meet the threshold for adult care and we are not assured that there are sufficient services to support these young people as they turn 18 and are facing often significant challenges as they move into adulthood.
- 2.9 Children in households where adults have mental health problems are safeguarded well. Clients of the adult mental health service receive a safeguarding screen as part of the service access assessment. The assessment in use in the personality disorder team, for example, directs practitioners to ask questions about children that clients are associated with or have care responsibility for. The safeguarding screen prompts clinicians to consider the impact of the client's mental ill-health on the child or young person to support planning that takes account of the child's needs.
- 2.10 We found that the "Think family" approach is not well embedded in adult substance misuse service. Although practitioners are capturing basic details of children who may be associated with clients they do not accurately record whether they have parental responsibility or routinely ask and document who else a client may be living with. Furthermore there is no mechanism to link partners who may be in treatment as this information is not held in a central repository which is easily identifiable therefore relying on individual knowledge of the case. This means that risks to children may not be fully explored and may remain hidden. **Recommendation 7.1**
- 2.11 Young people accessing the Young People Drug and Alcohol Service (YPDAS) in Barnet, are seen quickly and benefit from thorough assessment of needs. Details of family and household members including genograms are included within the assessment. This client focused approach also forms part of transition planning. Joint work between the adult and young people service is undertaken to support transfer of care in order to avoid a crisis and continue with intervention and treatment to improve health.

3. Child protection

- 3.1 We found MASH specialist health practitioners to be diligent and committed in their approach to information gathering to protect children from harm across the partnership and their expertise is valued by partner agencies. All referrals to Barnet children's social care are sent to and considered by the local Multi Agency Safeguarding Hub (MASH). Partnership working is further supported by the Hidden Harm worker from the adult substance misuse service offering specialist advice through twice weekly attendance at MASH.

We saw a case of good multi agency and interdisciplinary working in Barnet.

Following attendance at the emergency department a baby was referred to the MASH with unexplained head injury. The specialist health practitioners in MASH were able to gather information from the electronic record and alert the HV and request any further information.

The decision was made to escalate to a strategy meeting, the meeting was held promptly, the appropriate professionals attended to consider the risk collectively and the actions that need to be taken by professionals to safeguard the baby.

- 3.2 A number of specialist health practitioners MASH cases were reviewed, all showed timely responses to information and high level of professional curiosity when seeking out information. There was a consistent approach to contact back to the community practitioner via a task on the electronic record or call to ensure the named practitioner is able to support the family.
- 3.3 Inspectors looked at a number of referrals in to the MASH made by CAMHS, maternity, young people's substance misuse service and sexual health services and these were of a good standard and in most cases risk were clearly articulated. There is a culture in CAMHS and adult mental health of using the datix system to record referrals into children's social care to support monitoring and trend analysis which can work towards improving organisational learning to safeguard children.
- 3.4 We have seen and heard how professional disagreement, between professionals on outcomes of referrals to children's social care are being resolved more successfully since the launch of the new policy. We saw strong practice in adult mental health where they also escalated concerns about a referral made to a different local authority which resulted in a more thorough investigation being carried out by the receiving police force and local authority area.

- 3.5 It is positive that a recent evidenced change to the local authority's processes and audit confirmed 100% of all referrals into the MASH reviewed had been responded to. This in turn increases the opportunity to support a family in a cohesive, planned approach. Health practitioners reported in the past they were not always updated on the outcome of referrals to children's social care where a decision was made not to proceed with a Section 47 child protection investigation and this a view still largely held on speaking to practitioners.
- 3.6 We saw good practice of health practitioners, with the exception of adult substance misuse, being engaged in child protection processes including attendance at pre-birth conferences, initial/review child protection conferences, core groups and child in need meetings when actively involved with families. Attendance at strategy meetings by health practitioners is much improved and is effectively supported by MASH practitioners where the named worker is not available. This means that decision making benefits from a true multi agency approach and supports effective planning to protect children at risk.
- 3.7 Quality assurance processes on the content of referrals and reports for child protection conferences are variable across Barnet. The quality assurance processes of sexual health service provided by CNWL, adult and children's substance misuse services do not include quality assurance by safeguarding leads, this can support organisational learning and identify trends *This has been brought to the attention of Barnet Local Authority Public Health.*
Recommendation 6.1, 7.2 and 8.1
- 3.8 The unborn child is safeguarded well by midwives. The use of alerts on the electronic patient record easily identifies vulnerability. Records seen contained chronologies of significant events and copies of child protection plans to protect the new born infant. This means that when a newborn baby is delivered, well established plans are in place to ensure the newly delivered woman is supported whilst effectively protecting the baby.

We heard of a young couple who were supported to consider their options when an unplanned pregnancy was confirmed at 34 weeks gestation when the women's labour had already commenced.

A midwife from the Vulnerable Women's Team was allocated and built a good rapport with the woman and offered to stay with her and provide intrapartum care and continuity of carer. During the labour the woman reported that she did not feel in a position to raise the baby and having had the options explained to her; the woman and her partner reported that they would like the baby to be adopted. The woman and her partner were advised that appropriate support could be put into place to facilitate this however they were reassured that they had the option of changing their minds if they choose to do so.

Through multi-disciplinary and multi-agency working the family received excellent, individualised care. The family were listened to, they were given information so that they could make informed decisions and were then supported with these. The mother and father decided to parent the baby and for the family to remain united.

The Midwife and Health Visitor shared information and coordinated their care while visiting and at handover the GP was also updated prior to discharge from midwifery care.

- 3.9 Vulnerable families benefit from informed and supportive general practice. We have seen evidence of a rigorous approach to GPs coding concerns, including children looked after, children with a child protection plan in place and more recently the newly introduced code for children "not brought" for appointments. GP practices we visited were proactive in identifying and recording concerns and making referrals to children's social care. GPs we spoke to were responsive to requests for information to support children's social care and submitted reports where they were unable to attend conference.
- 3.10 Children and young people accessing the integrated sexual health service are not always safeguarded well. The detail recorded in the standard or specialist risk assessment in the service for children under 16 were variable. Although senior management were able to direct us to the proformas available to support practitioners in their line of enquiry with young people we were not assured of their consistent use at an operational level. In addition, there is still work to do to ensure sexual health practitioners identify important safeguarding concerns, such as Female Genital Mutilation. *This has been brought to the attention of Barnet Local Authority Public Health.*
Recommendation 6.2 and 6.3

- 3.11 Well-developed joint work was evidenced in the work between CAMHS service and Barnet children's social care. Joint case consultation is undertaken through monthly meetings. The purpose of this consultation service is to discuss complex cases, examine the risk and make decisions about difficult to engage young people. This collaborative approach helps to support young people who may be waiting for assessments.
- 3.12 Adult mental health practitioners are clear about safeguarding thresholds and consistently make referrals when risks to children associated with their clients are identified. We noted a good standard of record keeping and analysis of risks in the records we reviewed. This supports an accurate understanding of those risks and good decision making at the front door when referrals are made.
- 3.13 Further work is needed to develop a comprehensive approach to safeguarding children within adult substance misuse services. This includes the integrated adult substance misuse service which comprises a partnership between WDP and CNWL. While we heard of positive initiatives within the service, such as the Hidden Harm worker offering specialist advice to practitioners, MASH and MARAC. We found evidence of inconsistent practice around the involvement of practitioners in formal child protection procedures, submission of case conference reports and the quality of referrals to CSC. There was also inconsistent use of electronic flagging within the records to ensure all practitioners were aware of vulnerable children. A recent safeguarding audit has been undertaken and managers have an understanding of how and where to improve services from a safeguarding children perspective and an action plan has recently been put in place. *This has been brought to the attention of Barnet Local Authority Public Health. **Recommendation 7.3 and 7.4***
- 3.14 Children attending ED, who may be at risk of exploitation, do not routinely have their vulnerabilities considered using a recognised screening toolkit. ED staff are not using nationally or locally developed tools such as 'Spotting the Signs' or Gangs Screening Tool to support decision making, relying on the training given to inform professional curiosity and judgment. This increases the likelihood of vulnerable young people at risk of exploitation being missed and discharged without appropriate intervention or onward referral to have the risks assessed. **Recommendation 4.3**
- 3.15 During our review we have not seen a strong and consistent approach to the identification of child sexual exploitation (CSE) across Barnet. Although practitioners in some key areas such as ED, GPs, school nurses and CASH reported that they have received CSE training and have access to a CSE toolkit, there is a lack of rigour in how this is used. There is an over reliance on practitioners using professional curiosity to carry out a formal assessment. We have not seen any audits carried out across the Borough to provide assurance that CSE is being identified at the earliest opportunity. This reduces the opportunity for a multiagency approach to protecting young people vulnerable to CSE. *This has been brought to the attention of Barnet Local Authority Public Health. **Recommendations 2.2, 4.3, 5.3, 6.5 and 8.2***

4. Looked after children

- 4.1 Children and young people, who enter into the care of Barnet local authority are not benefitting from a robust approach to ensure they receive timely, thorough initial health assessments (IHA). Although there is an improving picture of looked after children's health assessments being completed within the statutory timeframes it is still significantly below target. There is ongoing monitoring of the trajectories through appropriate health provider and local authority committees.
- 4.2 The overall quality of IHA's of children and young people entering care is variable and this is recognised by the designated doctor who quality assures the GP IHA's. At present children under two years old are automatically seen by a paediatrician and the remainder are predominantly assessed by GPs who have received additional training. There are plans to increase the age range of paediatrician appointments to children aged 9 years and under and this is more in line with national guidance. Records seen were limited in capturing health needs, with little exploration of issues particularly in relation to emotional health and wellbeing which may be impacting on a child. This means that children's needs may not be fully explored and articulated at the earliest opportunity which inhibits the ability to create meaningful, comprehensive health plans and refer into services which may be able to address any health need. **Recommendation 3.3**
- 4.3 The looked after children health team and the local authority are working together to improve the quality of initial health assessments by ensuring the neo-natal health summaries are available at the time of assessment. Increasingly, the social worker and/or birth parent(s) are present at the IHA, which is assisting information sharing. This approach supports important information from before a child becomes looked after being retained and available to the young person when they get older which will also help to improve the content of care leaver's summaries when issued. It also means that the impact of any health concerns from the neonatal period can be considered as part of the infant and child's ongoing health assessments.

We saw a completed Initial Health Assessment (IHA) that was comprehensive and fully explored the needs of the baby.

The booking of the IHA was sensitively managed between social care and health to ensure the birth mother could attend. The paediatrician had received the neonatal discharge which ensured the clinician had the most recent medical report to support her assessment. The IHA captured the holistic needs of the baby and there was evidence of how both foster carer and mother were involved in the discussions.

The final section of the report gave a good summary and indicated where the additional needs of the baby may arise in the future, this could then be used to support both carers and professionals in planning care.

4.4 GPs completing IHA's for unaccompanied asylum seeking children have not received additional training for this group of children's specific health needs. Assessments reviewed captured physical health needs but were less skilled in exploring emotional wellbeing issues. This is of particular significance as unaccompanied asylum seeking children in Barnet make up 16% of the looked after children population. Plans to offer a specialist, tailored service, including access to sexual health, mental health and infectious diseases support are being developed. This means that this cohort of children may not be having their needs fully assessed and potentially are further disadvantaged compared to their peers. **Recommendation 5.4**

4.5 Children and young people in the care of Barnet LA receive timely review health assessments (RHA). The specialist LAC nurses are undertaking the vast majority of review health assessments for looked-after children across all ages and will travel to most placement settings across the country to carry these out. This means that the service retains a close overview of the health and wellbeing of looked-after children and monitor any changes over time effectively.

The RHA undertaken by LAC nurses overall were of a satisfactory standard. Documentation of the voice of the child was not consistently recorded although there were clear indications in a number of records that the children engaged in meaningful contact with the LAC nurses. Some assessments were not always reflective of the individual child, this can limit the reader having a clear picture of the child's interests or unique characteristics. **Recommendation 5.5**

- 4.6 Health plans generated as a result of health assessments were not always SMART. Although a useful tool, the use of a standard template aimed at prompting practitioners to consider different domains was sometimes leading to generic care planning that did not reflect the individual child's needs. We also saw evidence of needs identified in the assessment not being fully represented in the health care plan. This means that children and young people who are looked after, may not always benefit from referrals into services to help improve health outcomes. For example, in one record seen a child was identified as "over eating" by the carer, however, the health plan did not reflect this finding or make any recommendations as to how this might be addressed. **Recommendation 5.6**
- 4.7 Looked after children in Barnet with mental health needs benefit from a well-resourced LAC CAMHS service. The team liaise closely with the LAC health service ensuring that children's mental health needs are included in the statutory health assessments.
- 4.8 Children who are looked after with special educational needs and/or disabilities do not benefit from a specialist pathway or ability to expedite referrals into the Child Development Centre for assessment and treatment. The current wait is reported to be in the region of 40 weeks and this means that children who are looked after are not having their needs met in a timely way and experience delays which may compound difficulties they are already experiencing. **Recommendation 5.7**

Management

This section records our findings about how well led the health services are in relation to safeguarding and looked after children.

5.1 Leadership and management

- 5.1.1 The designated professionals work effectively to meet their statutory requirements and fulfil their safeguarding board responsibilities. We saw good commitment by the Clinical Commissioning Group (CCG) to working with the local authority to improve outcomes for children in Barnet. A robust CCG Children's Health Improvement Action Plan is in place that has been RAG rated and is regularly reviewed and aligns with the overriding local area Improvement Plan.
- 5.1.2 We found good leadership, support and guidance provided to services and frontline staff by all provider safeguarding teams, designated doctors and the designated nurses for safeguarding. Practitioners in a number of services, spoke positively of the accessibility of safeguarding specialists to advise them on safeguarding concerns.
- 5.1.3 The named GP is well established in post and has been influential in championing the development of child protection and safeguarding across Barnet. We have seen evidence of effective training programmes across primary care and the development of committed safeguarding GP practice leads. An area for development remains in supporting GPs with the assessment and identification of CSE and contributing to LAC RHA.
- 5.1.4 The co-operative working between health and children's social care (CSC) has strengthened over recent months. We heard there is an open culture to challenge on case decisions within the MASH, this is facilitated by the daily threshold meeting attended by partner agencies. The number of challenges to CSC decisions is reducing and specialist health practitioners consider this is in part due to greater understanding by CSC of health's perspective and expertise they bring to the assessment. Evaluation of the data collected on health cases requiring challenge has not been undertaken.
- 5.1.5 GPs are well engaged with developing their understanding of MASH arrangements. A number of GPs have attended the MASH following targeted training to gain greater insight the MASH work, and the named GP shadowed the service for half a day prior to delivering joint training with CSC to GP. This is a positive initiative in joint working.

- 5.1.6 The health leadership arrangements for looked after children in Barnet are not compliant with intercollegiate guidance which indicates the need for designated and named roles to be held by separate post holders to avoid potential conflicts of interest. The designated nurse is also the named nurse for looked after children. This dual responsibility can lead to a conflict of interest, with the post holder having responsibility for strategic and operational delivery of the service. Resource within the LAC health team has been an ongoing issue meaning that the named/designated nurse has not been able to fully discharge her strategic duties due to the increased pressure to maintain operational delivery. Despite this being a long standing issue, we are advised that there are no current plans to alter the service structure to address this conflict. **Recommendation 1.2**
- 5.1.7 The named/designated nurse attends the quarterly Designated LAC Nurse London regional meetings which provide opportunity for learning, peer support and for best practice to be shared. We were told this has allowed consideration of service development given the newly increased capacity in the team. However although we note the recent appointment of a full time specialist LAC nurse will significantly increase capacity in the looked after children's team, we are not assured that this additional post will meet the requirements of the intercollegiate guidance in terms of capacity.
- 5.1.8 Plans to streamline assessments for children with special education needs and/or disabilities and LAC are being developed. The named/designated nurse has met with the Head of Special Educational Needs and the head teacher for virtual schools to look at how the IHA/RHA process can be aligned with the Educational Health Care assessment to promote more meaningful assessment for the child and avoid duplication.
- 5.1.9 The looked after children's health team are co-located with a number of services which supports effective communication and increased information sharing. Furthermore access to children's social care IT system enables join up and closer tracking of children in care, such as completed health assessments being uploaded directly onto social care records for the attention of the relevant social worker and Independent Reviewing Officer. The system is also used to generate monthly reports to support quality assurance of health assessments. This helps promote a shared approach to meeting its statutory responsibilities for looked after children.

5.2 Governance

- 5.2.1 Robust systems to identify children the most vulnerable children receiving support from statutory organisations are in place within the Royal Free London NHS Foundation Trust. RHFT has worked with the local authority to implement the Child Protection Information Sharing initiative in all unscheduled care settings where children are seen across the Trust. This is also now being implemented in maternity with plans to also implement Female Genital Mutilation Information Sharing (FGM-IS) at the same time.
- 5.2.2 Managers within health visiting do not have a reliable system of monitoring clinician caseloads and service demand. The electronic patient record system does not currently provide an accurate picture of health visitor's caseloads and information contained is not always reliable. We were told that health visitor caseloads are very high, exceeding the guidance from Lord Laming and other national bodies. We heard that high caseloads are balanced by the fact that health visitors are not providing the full healthy child programme and therefore have more capacity, however data on contacts to deliver the mandatory visits for the HCP are not at expected levels. We told of the HV and SN service transformation plan which has commenced includes work to deliver the HCP 5 mandated reviews to all families in Barnet by September 2018. Additional administrative support is being utilised to attempt to improve the quality of the data on the system however there was no clear timescales for when this will be completed. *This has been brought to the attention of Barnet Local Authority Public Health. **Recommendation 5.8***
- 5.2.3 Practitioners and managers in the 0-19years service cannot be assured that information which may impact on the safety of a child is being received and actioned by the appropriate practitioner. The electronic patient record system has a very high number of unopened tasks as a result of information 'tasked' to the attention of a practitioner or team within the organisation. Efforts continue to address priority tasks, however these have been RAG rated by a non-clinician and managers cannot be assured that all safeguarding information is being responded to appropriately. *This has been brought to the attention of Barnet Local Authority Public Health. **Recommendation 5.9***

- 5.2.4 Potential risks to children from males and other adults associated with mothers are not always fully assessed and documented by the health visiting service and school nursing services, this issue was raised at CQC regulatory inspection October 2017. In the tracked cases there was evidence of clear concerns regarding the presentation of males in households however opportunities to fully explore this with the mothers were not acted upon. This restricts the ability to assess not only risks which may be posed by these men but also the mother's ability to safeguard her child. MASH specialist health practitioners also face challenges in gathering information when the electronic record family and relationships template has not been completed, evidence of this was seen during inspection. The 0-19years community provider managers are aware of the issue and we were advised changes are being made to electronic recording systems and awareness training for staff is due to be completed by June 2018, however this continues to be a risk. *This has been brought to the attention of Barnet Local Authority Public Health.*
Recommendation 5.10
- 5.2.5 We have concerns that despite the use of a "red flag" to alert the practitioner of significant events, the lack of a dedicated space to record safeguarding information is leading to a lack of consistency in recording this key information. We are aware that the service has clear guidance on how the alerts on the system should work, however, in some cases reviewed this was not clear and practitioners we spoke to were not able to articulate how they would put an alert on a patient record. *This has been brought to the attention of Barnet Local Authority Public Health.* **Recommendation 6.4**
- 5.2.6 There is poor governance around referrals made to MASH, the IT systems are not supporting practitioners retaining a copy of the safeguarding referrals that are completed via an online portal. This means some health practitioners do not retain a copy of safeguarding referrals and have evidence within their records of the concerns they raised. This can inhibit quality assurance and performance management by the provider organisations *This has been brought to the attention of Barnet Local Authority Public Health.*
Recommendation 1.3, 2.3, 4.4, 5.11, 7.5 and 8.3
- 5.2.7 There is a strong audit culture in Barnet, Enfield and Haringey CAMHS which leads to improvements in practice. For example, an audit by the CAMHS provider demonstrated that effective records were made in most cases however not all records were shared with children's social care. Recommendations have been made from the audit to ensure the consultation service is effective.

5.3 Training and supervision

- 5.3.1 The majority of provider organisations are able to provide assurance that their workforce are appropriately trained in children's safeguarding in line with intercollegiate guidance (2014). For the provider organisations where levels have fallen below that agreed with the commissioner's trajectories have been set and processes are in place to monitor improvement. 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 We noted a discrepancy in data collection for staff trained to level 3 in BEHMHT. Although we are advised that this anomaly is created by the way that training data is collected, there remains an inaccurate picture of the level three training compliance across Barnet and so the trust cannot be assured of the competence of the workforce. **Recommendation 2.4**
- 5.3.3 We heard how services are building on practitioner safeguarding awareness and knowledge. The majority of services are offering specialist training on topics such as domestic abuse and CSE, to support practitioner's ability to identify and respond to risks. The mental health service, adult substance misuse team and the named GP produce safeguarding newsletters to raise awareness. The CAMHS team have a dedicated safeguarding champion in each team. Their role it is to support and advise staff dynamically about safeguarding issues. These initiatives can support practitioners to focus on current safeguarding issues for their area of practice.
- 5.3.4 Staff at BH ED, including healthcare assistants, are offered training to level 3 safeguarding on an annual basis which exceeds the minimum intercollegiate requirements. Staff spoke highly of the Level 3 training and subject specific sessions.
- 5.3.5 Supervision is underdeveloped in ED and the paediatric ward. Further work is needed to ensure ED and paediatric staff have the opportunity to reflect on learning and impact on practice through access to a formal safeguarding supervision, currently only ad hoc sessions are available.
Recommendation 4.5
- 5.3.6 Midwives and midwifery staff's compliance with Level 3 training across the service is high. However, we are not assured on the robustness of the current supervision arrangements for community midwives, which would facilitate exploring and embedding learning through case discussion. Currently the offer is for ad-hoc sessions without formal monitoring to check that midwives are accessing support. **Recommendation 4.6.**

- 5.3.7 The named GP and designated professionals have produced an exemplary suite of documents for primary care settings. They are available on the intranet to support safeguarding practice and build on their training, such as guidance on documenting safeguarding concerns, a 'frequently asked questions in safeguarding' document and case conference and registration templates. The CCG has recognised the challenges of evaluating the impact of training on participants. A 'survey monkey' has been undertaken post GP training and the data will be used to consider the impact and shape further sessions.
- 5.3.8 Practitioners in 0-19years service benefit from a strong safeguarding supervision offer from a well-resourced safeguarding team. The record of supervision template on the electronic record prompts the detailed, analytical documentation of supervision discussions. The supervision template has recently been updated to include the father and any other male's details, this will in time offer some assurance of male adults being recorded in the electronic record.
- 5.3.9 Staff in the adult and children mental health service are well supported through a good safeguarding supervision offer were they are enabled to discuss cases of concern. This includes notes of the supervision made in client records by both the practitioner and the supervisor so that actions arising from it can be tracked. Within children's records the recording of supervision was not as consistent as in the adult mental health record. This means that future users of the records may not fully understand the risks in individual cases, and that the records did not fully reflect outcomes from discussion and therefore were incomplete. **Recommendation 2.5**
- 5.3.10 We saw good compliance in safeguarding training of sexual health practitioners, with all staff, including administration and reception staff trained to Level 3. The safeguarding team provide telephone support and guidance when requested. However, since the transfer of services to the new provide practitioners have not had access to formal safeguarding children supervision. *This has been brought to the attention of Barnet Local Authority Public Health.* **Recommendation 6.6**
- 5.3.11 Adult substance misuse service has received additional training of Domestic Abuse and Child Sexual Exploitation as part of the mandatory training programme. This helps to support assessment of risk with families and children they work with. We also were told of recent training delivered on prevailing drug trends and maintaining professional boundaries due to the nature of drug and alcohol services. This ensures that staff are aware of their professional responsibilities and able to use relevant mechanisms should any conflicts of interest arise. The safeguarding supervision offer is good, however, the effectiveness of this is not strongly evidenced when considered alongside the quality of the safeguarding practices within the service.

5.3.12 YPDAS practitioners benefit from a strong supervision offer with weekly clinical supervision incorporating safeguarding in addition to monthly one-to-one safeguarding supervision. We saw records are routinely stored on the electronic part of the young person's record, with reference to the WDP record's management policy printed on the supervision pro-forma.

Recommendations

- 1. Barnet Clinical Commissioning Group should ensure that:**
 - 1.1 The assessment for children and young people who attend the BH Urgent Care unit benefit from improved assessment of risk through the use of the ED children's assessment pro-forma.
 - 1.2 The commissioning of the role of Designated Nurse Looked After Children's Nurse reflect the Looked after children: Knowledge, skills and competences of health care staff Intercollegiate Role Framework Guidance (2015).
 - 1.3 GP's are supported to ensure a copy of referrals made to the MASH are available within children and young people's electronic record.

- 2. Barnet, Enfield and Haringey Mental Health NHS Trust should ensure that:**
 - 2.1 Children and young people attending the emergency department have access to and benefit from specialist CAMHS support and care.
 - 2.2 There is governance assurance that screening for CSE is embedded in practice.
 - 2.3 A copy of referrals made to the MASH are available within children and young people's electronic.
 - 2.4 Data for Level 3 safeguarding training is accurately recorded and reported on within governance assurance processes.
 - 2.5 The actions from safeguarding supervision are recorded on the children's and young people's electronic record.

- 3. Barnet CCG and The Royal Free London NHS Foundation Trust should ensure that:**
 - 3.1 They work together and with partner agencies to develop local protocols to identify and respond to bruising in non-mobile infants and/or head injuries in infants under a year old.
 - 3.2 Information sharing processes are in place between GPs and midwifery services particularly for women who self-book.

3.3 Initial health assessments are of a consistently high standard and provide a clear focus on child /young persons' voice, their emotional and mental wellbeing and identity.

4. The Royal Free London NHS Foundation Trust should ensure that:

4.1 The assessment for children and young people who attend the BGH Urgent Care unit benefit from improved assessment of risk through the consistent use of the ED children's assessment pro-forma.

4.2 A 'did not wait' protocol is in place to guide ED practitioners on what action to take when a child or young person leaves the ED before assessment or treatment is completed.

4.3 There is governance assurance within their organisation that screening for CSE is embedded in practice.

4.4 A copy of the referrals made to the MASH are available within children and young people's electronic record.

4.5 A model of safeguarding children supervision is introduced for ED and for paediatric practitioners.

4.6 Community midwives have access to formal, regular safeguarding children supervision.

5. Central London Community Healthcare NHS Trust should ensure that:

5.1 A process for sharing information via the CHIS system enables practitioners to be alerted in a timely way of attendance at ED and allows for a response by the practitioner at the time of need.

5.2 Practitioners within the school nursing service offering services to children of school age have access to training on supporting children and young people who may self-harm.

5.3 There is governance assurance that screening for CSE is embedded in practice.

5.4 All practitioners who conduct IHA and RHA have LAC specific training to improve their understanding of the asylum seeking young person's experience and the impact on their physical and emotional wellbeing.

5.5 Review health assessments are of a consistently high standard and provide a clear picture of the child or young persons' voice and identity.

5.6 The health plans for looked after children are SMART and reflect the individual needs of the child or young person.

- 5.7 Care pathways are developed to ensure that looked after children are not further disadvantaged by extensive delays into health services.
 - 5.8 Systems are in place that offers organisational assurance of the quality and timeliness of health visitor's contacts to support managing the demand on the service.
 - 5.9 Systems are in place to offer assurance that the work being undertaken on the priority tasks workstream has appropriate clinical oversight.
 - 5.10 Children and young people's electronic record reflects significant males associated with the family and governance arrangements evidence compliance with this requirement.
 - 5.11 A copy of referrals made to the MASH are available within children and young people's electronic record.
- 6. Central and North West London NHS Foundation Trust should ensure that: Sexual health services should ensure that:**
- 6.1 Safeguarding referrals to children's social care are quality assured to support organisational learning and a consistent standard in meeting thresholds.
 - 6.2 Management seek assurance that the quality of risk assessments within the records reflect the needs and vulnerabilities of the young person.
 - 6.3 Routine enquiry of FGM is integrated into sexual health records.
 - 6.4 Information on children and young people with safeguarding concerns are highly visible to practitioners within the young person's electronic record.
 - 6.5 There is governance assurance within their organisation that screening for CSE is embedded in practice.
 - 6.6 Staff have access to formal, regular safeguarding children's supervision.
- 7. Westminster Drug Project Adult service should ensure that:**
- 7.1 The electronic record state the service users parental responsibility and records children and young people details when the service user has a significant role in the care of children and young people they live or are in regular contact with.
 - 7.2 Safeguarding referrals to children's social care are quality assured to support organisational learning and a consistent standard in meeting thresholds.

- 7.3 Practitioners are fully engaged in child in need and child protection procedures and assurance is gained through governance arrangements.
 - 7.4 The electronic flagging systems within client records identify vulnerable children.
 - 7.5 A copy of referrals made to the MASH are available within patient electronic records.
- 8. Westminster Drug's Project Young Persons Service should ensure that:**
- 8.1 Safeguarding referrals to children's social care are quality assured to support organisational learning and a consistent standard in meeting thresholds.
 - 8.2 There is governance assurance within their organisation that screening for CSE is embedded in practice.
 - 8.3 A copy of referrals made to the MASH are available within children and young people's electronic record.
- 9. Barnet CCG, Enfield and Haringey Mental Health NHS Trust should ensure that:**
- 9.1 They continue to work together to develop timely increased access to specialist CAMHS support and care from the out of hour's service.

Next steps

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