

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

Children Looked After and Safeguarding

The role of health services in Ealing

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Provider services included:	London North West University Healthcare NHS Trust (LNWUH) Change, Grow, Live (CGL) Recovery Interventions Service Ealing (RISE). West London Mental Health Trust (WLMHT) Greenbrook Healthcare (Ealing Urgent Care Centre – Located at Ealing Hospital site)
CCGs included:	NHS Ealing CCG
NHS England area:	London
CQC region:	London
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Summary of the review

This report records the findings of the review of health services in safeguarding and looked after children services in Ealing. 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 Ealing, 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 49 children and young people.

Context of the review

The Ealing Joint Strategic Needs Analysis of 2017 notes that the population of Ealing has risen from 292,800 in 1996 to 343,000 in 2015. Ealing has a higher proportion of males and females aged 0-9 years and 25-44 years compared to England.

Ealing is the third largest London borough in terms of population, after Barnet (379,700) and Croydon (379,000). At 61 persons per hectare, Ealing is also the third most densely populated borough in Outer London (after Brent and Waltham Forest).

Between 2001 and 2015, Ealing's population of 0-15 year olds increased by 23.1% (from 59,700 to 73,500). In the same time period, the number of 0-15 year olds increased by 21.8% across London and by 5.1% across England. In 2016 there were 88,000 children and young people aged 0 to nine years in Ealing.

The rate of children in care has been consistently lower than the England average for the last four years. In 2016 there were 370 children from Ealing in care.

There were 426,086 people registered with 79 GP practices in Ealing in April 2016. This is larger than the number of residents in Ealing (343,000 according to 2015 mid-year estimates). The main reason for this difference is registration of people from abroad (e.g. visiting relatives, au pairs), who then leave and are not deregistered. In addition, some people will attend GP surgeries who are not picked up by the national census. Out of the 426,086 registered patients, 49% (206,900) were aged 15-44.

The population of government maintained schools in Ealing is ethnically diverse, with 83% of pupils classified as being of minority ethnic origin (this proportion has remained unchanged for the last four years). 84% of primary school pupils (compared to 30% nationally) and 82% of high school pupils (compared to 27% nationally) are from an ethnic minority. 30% of pupils are white, 29% Asian or Asian British, 16% black or black British, 8% from mixed backgrounds and 16% of other ethnic heritage. The ethnic composition of schools in Ealing varies. The proportion of children of minority ethnic origin ranges from 50% to 100% between schools.

The most common ethnic groups in Ealing's school population are white British (15%), Indian (14%), Eastern European (10%), Somali (8%), Pakistani (7%), Asian Other (7%), Afghan (4%), Arab Other (4%) and black Caribbean (4%). Whilst the white British population remains the largest group it continues to fall in numbers. There was a 2.7% increase in the overall school population in the year to January 2016; over the same period the number of white British pupils in Ealing state 14 funded schools reduced by 129. The Eastern European population continues to grow steadily. There are now 5,344 Eastern European pupils, an increase of 325 (6.5%) in the last year. The Indian population has also increased by almost 500 (7%) since last year to 7,540.

In the year ending 31 March 2016 in Ealing, there were 296 children aged 0-17 who were subject of a child protection plan. This represents a rate of 36.4 per 10,000 children, which is lower than both the London (37.9) and national (43.1) rates.

Traveller groups have frequented Ealing for many years. Department of Environment 'caravan counts' consistently record Ealing as having one of the largest traveller populations in the Greater London area. These figures do not include the large and unrecognised 'hidden' traveller communities who, due to a deficit in caravan site provision and rapid evictions from roadside encampments, live in other forms of accommodation. The total traveller population in Ealing is estimated to be in excess of 2,000 individuals at certain times of the year. Currently, traveller groups resorting to, or residing in, the borough are largely from the following traditional communities: Travellers of Irish heritage, East European Roma and English, European and international circus and fairground travellers.

Since the break-up of political systems in Eastern Europe, some Roma families have travelled to Ealing. They now constitute the second largest gypsy traveller group in the borough. Roma families have a very strong allegiance to their traditions, which can be traced back to northern India and ancient Persia (modern Iran and Iraq). Their first language is Roma, and their second language is generally that of their point of departure e.g. Polish, Czech, Slovak, Albanian, Romanian or any of the languages of the former Yugoslavia.

Ealing performs worse than London and England in both measures of homeless published in the Public Health Outcomes Framework. In Ealing, the rate of homeless households living in temporary accommodation is significantly higher than in London and more than five times the England average.

Most (90.2%) of Ealing residents are registered with a GP practice that is a member of NHS Ealing CCG Clinical Commissioning Group (CCG). There are some Ealing residents that are registered with GP's that are a part of further CCG's but these are much lower in number.

NHS Ealing CCG had a headline rating of good in the CCG Assurance Annual Assessment 2016/17.

Ofsted published a report on 26th August 2016 following their Inspection of services for children in need of help and protection; children looked after and care leavers and review of the effectiveness of the Local Safeguarding Children Board (LSCB). The reports overall findings were:

1. Children who need help and protection: *Good*
2. Children Looked After and achieving permanence: *Good*
 - 2.1 Adoption Performance: *Good*
 - 2.2 Experiences and progress of care leavers: *Outstanding*
3. Leadership, management and governance: *Good*

Commissioning and planning of most health services for children are carried out by Ealing CCG and Ealing Local Authority

Acute hospital services are provided by a range of hospitals, including London North West University Hospital NHS Trust (LNWUH)

Urgent Care services at Ealing Hospital are provided by Greenbrook Healthcare

Specialist Ophthalmology services are provided by Moorefield's Eye Hospital on the Ealing Hospital site

Community based services are provided by London North West University Hospital NHS Trust (LNWUH)

Child and Adolescent Mental Health Services (CAMHS) are provided by West London Mental Health Trust

Specialist facilities are:

Adult and Young People's Substance Misuse Services provided by Change, Grow, Live

The last inspection of health services for Ealing's children took place in May 2011 as a joint inspection, with Ofsted, of safeguarding and looked after children's services. Recommendations from that inspection are covered in this review.

The report

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

What people told us

We spoke with young people looked after in Ealing. When asked about the service they receive one young person told us;

"Health services are very good – I always get what I need. If something is wrong with my health I get referred and get seen really quickly. I last saw my GP a few months ago and that was fine – no problems."

They went on to say;

"I have never had to wait for any health appointment. The most I have had to wait is two months to be seen (for an eye complaint) when I needed to go to hospital but that was because the earlier appointment they gave was when I was on my holidays so they put it back for me. I am very happy with my health appointments, never had to complain and everyone is very nice."

We asked them about the health assessment process. They said;

"My last health assessment with the nurse was half an hour. I felt listened to and I think I was able to make a good contribution. They asked me about all kinds of things, like school, not just about my health. They listened to me then read it all back with me and explained everything and if I didn't agree with anything I could change it."

They went on to say;

"Been to one appointment with CAMHS and they were really nice, they really listened to me and let me talk and explain how I was feeling. They were very patient with me."

We then went on to speak with the young person's allocated social worker. They told us;

"I will just reiterate what you have been told, when they have their review (health assessment) all their appointments are made and they are always seen really quickly. For CAMHS, they know when they need to speak to someone and they are really responsive to their needs."

They went on to say;

"We all work really closely together, the foster carers, the young person and the health services. There is really good multi-disciplinary working and good robust processes for children and young people's health here in Ealing. Young people are listened to in their health assessments and so I would say that they are an important part of the planning process."

We spoke with another Looked After young person. They told us;

"I have been a looked after young person since I was six years old. I have always felt that my social workers have been kind, and that the looked after children's team have been kind too. If I have worries or concerns there are people that I can talk to, I know they will support me and listen. The Looked After Children team have made sure I can speak to other young people in my situation. That is important as they really understand what I have gone through."

We then spoke with the young person's foster carer. They told us;

"Health services in Ealing are good. I feel really listened to. As a long term foster carer as well, I feel well supported and like services really want what is best for the child. I have challenged the looked after team at times, when I haven't agreed with a course of action, but feel that they listen to my point of view and are committed to reaching solutions and conclusions that are in the best interests of the children in my care."

We spoke with one Ealing Foster Carer about the support they get to undertake their role. They told us;

"When I have fostered babies the midwife and health visitor are always there to give me advice, I just have to call them. We are supported very well and the training I have had has been very good."

They went on to tell us;

"I had a baby with lots of problems; they became very unwell and I needed to do CPR. The ambulance service were so good and the hospital too. I was very pleased I had my first aid training from foster training."

When asked about the health assessment process they told us,

"The doctors fully assess the children and they listen to what I have to say as they know I care for the baby and know how they are. You only have to ask and they explain everything to you."

We spoke with other foster carers. They told us;

"Health staff are open and friendly and work well together to be flexible. I don't have any problems getting any health support for Looked After Children (LAC). The LAC nurse is good and includes me in things; I attend some of the sessions for the health assessments if needed. I have good communication with the LAC nurse and get a say in when and where appointments are."

They went on to say;

"Sometimes if a child (LAC) doesn't want to engage, they [services] discharge them. It would be better if they were more flexible and patient too."

Another foster carer told us;

"My health visitor, GP and LAC nurse are all really good. I can contact them by telephone, text and email and they always get back to me quickly. I have meetings with the LAC nurse every six months. I haven't had any problems with any health services and there isn't anything I would change. Maybe the time for speech therapy is too long for some people but I don't need it for my [foster] baby who is doing really well."

We spoke with a young person attending the Ealing UCC with their mother. They told us;

"It's nice here, there is lots of space. The nurse spoke to me and not my mum which was good."

When asked if they felt safe they told us;

"Yes, it's all OK. We are sitting here I think to see a doctor next. (They had been directed to wait for a short time in the adult area). It's busy round there (the paediatric waiting area) but we should be seen soon. It's OK here."

We also spoke with an expectant mother at the Northwick Park maternity unit. They told us;

"I am very satisfied with my midwife; I have no worries or complaints. My only problem has been depression, it was worst in my first trimester. I was referred to a specialist midwife and I felt free to call anytime I needed. She is an amazing person, every time I saw her I felt better straight away. She also referred me (to the perinatal mental health team) to see what the next steps would be. She arranged talking therapy for me. It is a very nice service for depressed people and I really appreciate the help I get. She is like my angel."

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 Health input (provided by London North West University Healthcare NHS Trust (LNWUH)) at the Ealing Multi-Agency Safeguarding Hub (MASH)¹ is respected well by multi-agency partners we spoke with who also work at the MASH. Daily meetings take place within the MASH to discuss new cases referred for consideration by the team, and once a case has been presented at the MASH meeting, feedback is given within a maximum of 24 hours and a plan of action agreed of how best to progress the case. If a case is considered as urgent (red) then it will be referred directly to the Multi-Agency Safeguarding Team (MAST) for more urgent attention, generally within four hours.

During our review we were party to a more expanded weekly multi-agency meeting and saw how, once a case has been presented by one of the partner agencies, then those other partners will immediately share their own information regarding the case discussed which can disclose, for example; siblings, significant adults or other important information which can aid the decision making process. One case discussion we observed led to an initial 'amber' rating being raised to 'red' which meant the case was immediately referred to the MAST team for their interventions to take place. This ensured that children and young people identified as potentially at risk were protected at the earliest opportunity.

1.2 Children and young people missing from home are also discussed at the MASH. Where a young person remains missing after 72 hours the case will automatically be referred to the MAST if the case has not already been rated 'red'. This means that all available resources are directed to ensure the safety of those particular vulnerable young people.

¹ The Ealing MASH is a model for managing and responding to referrals received by Ealing Children's Integrated Response Service (ECIRS (the single point of entry for all referrals where there is a need for support, or where there are specific concerns about the welfare of a child or young person)). The MASH is a multi-agency team of professionals who work together to share information within a secure environment to support better decision-making on cases. By bringing representatives of different agencies together, more information is available in relation to each case, meaning a more sound assessment of risk can be made. This will ultimately result in better decisions being made, leading to better outcomes for children and young people.

1.3 There is a well-designed paediatric Emergency Department (ED) at Northwick Park Hospital (as provided by LNWUH) which allows children and young people attending the unit to wait and be seen away from adult attenders. This means that those young people do not routinely have contact with adult attenders who might cause them distress. The paediatric waiting area is also well equipped for children to be easily observed by clinical practitioners at all times during their attendance. This enables those practitioners to respond swiftly should a child's condition deteriorate, but it also allows them to observe the interactions between those young people and their accompanying adult(s) and act on any concerns accordingly.

1.4 A standardised electronic triage form is used Northwick Park paediatric ED for all children and young people attending the unit. The form also contains an inbuilt safeguarding screening tool. The discharge process from the ED cannot be completed until the screening tool is completed. In all the records examined we saw that this tool had been completed well. There is also a clear flagging system to alert clinicians and staff when a child has safeguarding concerns already identified.

1.5 When a child presents at the Northwick Park ED and is known to social care, is looked after, or when onward referrals to other services are known to have been made, a health visitor liaison form is completed which alerts the health visiting and school nursing services of the child's attendance. This then allows community services to provide ongoing and additional support when needs have been identified to children, young people and their families.

A health visitor liaison form is also completed when a child has presented at the ED on three or more occasions within a six month period. This ensures that community services are aware of multiple attendances and are attuned to emerging risks and needs.

1.6 The paediatric liaison team at Northwick Park Hospital comprises of three health visitors and one full time administrator. The paediatric liaison team screen all under 18 attendances at the hospital and since the recent closure of the designated ED department at Ealing hospital, all of their daily UCC attendances to ensure that any child that presents at the Ealing UCC have had their needs adequately met.

1.7 Where children and young people receive care and support from the Ealing Urgent Care Centre (UCC), then paediatric liaison are informed remotely so that appropriate information sharing can take place. Paediatric liaison then feed back to the UCC on a weekly basis requesting, for example, missing information. Paediatric liaison will also suggest a referral to children's social care if one has not already been made and this can then be actioned by UCC practitioners.

1.8 The use of alerts on patient casualty cards at the Northwick Park ED is effective. Clinicians and staff are easily able to identify when a child is vulnerable and has safeguarding concerns already noted. This is also the case in the adult ED, and we saw examples of how these alerts had prompted practitioners to enquire if the patient had parental responsibility and also to assess the impact that substance misuse, poor mental health and domestic abuse may have on children and other family members associated with the patient.

In one case examined we saw how an adult male had presented at the Northwick Park adult ED under the influence of alcohol stating that he had also taken an overdose. The clinician completing his triage assessment exercised professional curiosity and ascertained that the he was the father of two young children.

As a result, a health visitor referral form was completed, ensuring that the school nurses attached to the children's school were made aware of their father's attendance and presentation at the ED. This enabled community services to monitor the risks that might have potentially been posed to his children.

A social care referral was also made, and the case was discussed at the weekly 'safety net' meeting held on the ED, where it was identified that a referral to adult drug and alcohol services was also appropriate to further support the patient.

1.9 Currently, both paper and electronic patient records are in use in the ED at Northwick Park Hospital. Whilst there is a dedicated team of administrative staff that upload paper files and documents onto the electronic records, we heard that during busy periods there may be a delay in doing so, resulting in some patient records not being completed in a timely way. For example, we heard that when a CAMH assessment has been completed on the ED, a paper copy of the assessment is provided which should be uploaded onto the patient's electronic record. However, this is not always undertaken in a timely way, resulting in potential delays in meeting the needs of children and young people.

We could also not be assured that those paper records might not be mislaid before being uploaded to the electronic record which would result in those records remaining incomplete. (**Recommendation 2.1**)

1.10 At the Ealing UCC provided by Greenbrook Healthcare, we saw that there is a dedicated paediatric waiting and treatment area away from that used by adults. Those attending the unit are directed to a separate reception area where demographic details are taken before being asked to wait in the paediatric waiting area. The young person will then be seen by a nurse who will assess the nature of the attendance and continue adding information on the SystmOne electronic patient record system, including the associated safeguarding template. Information obtained includes full patient details, details of any accompanying adults, GP details and, if known, allocated social worker details.

Once a decision has been taken as to whether care and support can be provided by GPs at the UCC, then the child or young person will undergo further medical assessment. Before being discharged from the unit the electronic safeguarding element of the assessment must be completed before the discharge can be completed. Should the young person require additional support and care, then they will be directed to an appropriate ED where that additional support over and above what can be offered by a GP will be provided. If any safeguarding concerns have been identified, including issues of self-harm, unaccompanied young people or if there are suspicions regarding the accompanying adult, then transfer will take place automatically by ambulance to further ensure their safety.

1.11 Although the UCC generally does not provide care to children and young people over and above that which can be provided by a GP at an individual GP practice, there is a paediatric trained nurse on duty 24 hours per day, seven days per week as well as duty GPs. This ensures the medical needs of children and young people are met and vulnerabilities can be identified at the earliest opportunity.

1.12 The patient champion role at the Ealing Hospital UCC is a patient support role (including children and young people) to direct attenders to care and support that might be more appropriate to their needs as opposed to attendance at an ED or at the UCC. Young people for example, can be signposted to receive support from the Kidscape ZAP anti-bullying workshops or the Stem4 teenage mental health workshops. The patient champion practitioner is also pro-active in liaising with such groups allowing them to promote their service offer by undertaking regular presentations at the UCC.

1.13 LNWH midwives at Northwick Hospital provide supportive and personalised maternity care to women living in and around Ealing. There is a team of specialist safeguarding midwives – The Jade Team, for perinatal mental health, teenage pregnancy, Female Genital Mutilation (FGM) and also for vulnerable women. This means that those identified vulnerable expectant mothers will receive targeted support to ensure not only their own safety but also that of their unborn child.

1.14 Expectant women and post-natal mothers in Ealing who experience mental health problems are being better supported through the perinatal mental health service. We saw good links with the newly established perinatal mental health service. The named midwife attends the weekly multi-disciplinary meeting to discuss new referrals and there are joint clinics held by the consultant obstetrician, consultant psychiatrist, perinatal mental health nurse and specialist midwife for vulnerable women.

This leads to a coordinated assessment and package of care tailored to individual women with mental health needs during their pregnancy and for up to 12 months after birth.

1.15 The Early Start Ealing² (ESE) service (Health Visiting) comprises of the Family Nurse Partnership³ (FNP) covering the whole of the Ealing Borough, and three health visiting teams working geographically across the locality. The health visiting service has clear and effective systems to identify and support children and families who would benefit from early help.

² Early Start Ealing is a service for families - pregnant mums, expectant dads, parents, babies and children up to the age of five; bringing together workers from children's centres, early years, health and other specialist services.

³ The Family Nurse Partnership is a preventative programme for first time young parents. The programmes primary focus is improving the health and wellbeing of the child and mother in pregnancy, supporting parents understanding of their child's development and encouraging parents to fulfil their aspirations for their baby and themselves.

The teams are co-located with the local authority's ESE teams along with Ealing social workers. The locality leads and Early Start practitioners have access to Framework-I (the social care electronic records system) which means that multi-agency information can, where appropriate, be shared more easily between multi-agency partners.

1.16 We also saw a good use of the varied skill mix amongst the ESE teams comprising of; specialist health visitors (for families with complex needs), health visitors, community staff nurses, community nursery nurses, early start workers and health visiting assistants. This means children and their families can benefit from easy access to early help from a diverse skill mix.

1.17 Health visitors across Ealing ensure the full implementation of the healthy child programme⁴. Assessments are undertaken by health visitors at various stages following on from the birth of the child up to age five when handover to the school nurse service takes place. The healthy child programme aims to ensure that every child in Ealing gets the good start they need to lay the foundations of a healthy life. It is also an opportunity for health professionals to undertake checks to ensure the child and family are safeguarded.

1.18 School nursing in Ealing provides part of the integrated 0-19 service and is commissioned by Ealing Local Authority and services are provided by LNWUH. The current school nursing team is comprised of community nursery nurses, qualified school nurses and staff nurses.

1.19 There is an allocated school nurse in each primary and secondary mainstream school in Ealing, and they have effective and well embedded relationships with schools which can facilitate the early identification of need. However, due to a reduction in school nurse numbers, the school 'drop-in' service is no longer offered across Ealing. This means that the opportunity for children and young people to flag concerns and seek support in an environment where they feel comfortable has been diminished. *This matter will be brought to the attention of Public Health commissioners.*

1.20 Children who attend the Northwick Park Hospital ED are notified to the Ealing school nurse team by paediatric liaison and this is an effective process. However, we heard that ED notifications from other hospitals that serve the Ealing population, such as the Hillingdon Hospital, are not swiftly screened. This is due to other ED's not triaging referrals in the same way as at Northwick Park Hospital. At present, the school nurse team have a three month backlog of 'out-of-Borough' ED referrals which need to be screened. We were advised that this is due to the sheer volume of ED notifications and a reduction in staffing capacity within the school nurse team. *This matter will be brought to the attention of Public Health commissioners.*

⁴ The Healthy Child Programme for the early life stages focuses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting.

1.21 The CAMHS service provided by West London Mental Health Trust (WLMHT) is a strong contributor into Ealing's multi-agency early help offer to vulnerable children and young people. CAMHS practitioners are deployed to local authority area teams that provide early help services and enhance the support provided to children and young people and their families. These teams include the MAST, the Supportive Action for Families in Ealing⁵ (SAFE) teams, 'Brighter Futures'⁶, the Looked After Children team and the Ealing Service for Children with Additional Needs (ESCAN). CAMHs also support the behavioural support teams who provide an in-reach service to schools for children who are at risk of failing education.

The extensive reach of the WLMHT CAMHS service into the early help arrangements across Ealing ensures that emotional wellbeing and mental health needs are central to plans and interventions for children and young people who require additional or targeted support.

1.22 The single point of access into the WLMHT CAMHS service utilises a weekly multi-disciplinary team allocation meeting involving a senior CAMHS consultant and a clinician from the SAFE team. All new referrals into the service are directed to either one of the community CAMHS services or to the SAFE team. In this way, young people are offered support by the most appropriate service without delay.

1.23 There is a strong think child approach in the adult mental health team provided by WLMHT. Practitioners consider children who are associated with adult clients at the time they access the service through the trust's single point of contact by the use of a templated risk assessment in the electronic patient record system. This alerts all practitioners to the client's family make up. Risk assessments are updated frequently and whenever there are changes in a client's situation, such as when they disclose they have entered into a new relationship. This provides an at-a-glance picture of the current or changing risk at any given time and enables better oversight by team managers.

⁵ SAFE gives information, advice and help to children and families to access the appropriate services and support to help before a manageable problem becomes bigger and more difficult to resolve. The team is made up of psychologists, therapists, counsellors, pupil/ school workers, family workers and other experts. SAFE also have links with other support groups and services in Ealing to ensure those children and families are supported in the area in which they live.

⁶ Ealing's Brighter Futures Intensive Engagement Model is a complex, whole system intervention that was launched in June 2015. Its implementation was intended to support and enable the children's social care workforce to build effective, consistent relationships with adolescents, families, communities and carers, and to use those successful relationships to bring about positive change, particularly those young people living at the edge of care.

1.24 Ealing RISE (Recovery Interventions Service Ealing, provided by a consortium of Change Grow Live, Central & North West London NHS Mental Health Trust and Build on Belief and commissioned by Ealing Borough Council) is a drug and alcohol intervention service offering a community based support treatment and rehabilitation service for adult substance users. The service has an open referral system whereby people can 'self-refer' into the service or be referred by professionals. They operate from two hubs in Southall and West Ealing, share care with nine GP practices and also have a 24 hour crisis telephone service. 60% of referrals made into the service are 'self-referrals'.

1.25 Ealing RISE practitioners make good use of the electronic client record system to comprehensively capture risk and maintain a chronology of safeguarding events. In records examined we saw that there was good consistency in the way that those records were maintained which means they are kept up-to-date with information held by the team in relation to clients using services and, on the whole, children and young people in their care.

1.26 Although Ealing RISE substance misuse services electronic client records are good; those same records did evidence a lack of professional curiosity and responsive multi-disciplinary and multi-agency information sharing. This is true of both the adult substance misuse service and the young person's service. This is a missed opportunity to improve and build a comprehensive knowledge base regarding children and young people in the care of adult service users who can lead sometimes chaotic lifestyles which put those vulnerable young people at risk. A multi-agency approach to information sharing is integral to managing risk and the safety of vulnerable children and young people. *This matter will be brought to the attention of Public Health commissioners.*

In one record examined within adult substance misuse services we saw how a young person who was looked after and in the care of a children's home disclosed to her case worker that she may be pregnant. Although this conversation was recorded in the electronic record there was no evidence of any discussion regarding the appropriateness of the relationship and also no subsequent conversation with the young person's allocated social worker or carers to check on the young person's safety.

In another case examined we saw how a service user who also had a young child in their care had disclosed their concerns of being at risk from their ex-partner following a court non molestation order being granted. Although there was clear advice given on action to take to enhance their own and their child's safety by the Ealing RISE practitioner, there was no recorded contact with the social worker to share those disclosed concerns.

1.27 The LNWUH Genito Urinary Medicine (GUM) services and Contraception and Sexual Health (CASH) services provide flexible 'drop in' services without appointment to meet the needs of young people up to age 20 in Ealing who wish to seek advice regarding contraception and other sexual health advice. The CASH service provide dedicated young people's services twice per week at times to suit young people not having to miss education.

1.28 Both the CASH and GUM clinics are provided by practitioners who, on the whole, have provided care and support to the young people of Ealing for many years thus being well placed to recognise their individual needs well.

1.29 Although the GUM and CASH service do not 'hold cases' in relation to their clients due to the nature of the service offer, we saw that the assessment process prompts practitioners to identify any safeguarding issues that might be relevant. We examined assessment documentation that prompts practitioners to ask sometimes difficult questions and we were further assured that those practitioners expand on the document by way of professional curiosity whilst still building and maintaining good working relationships with their clients.

2. Children in need

2.1 The paediatric liaison team also maintains oversight of paediatric attendances at nearby hospitals such as Hillingdon (provided by The Hillingdon Hospital NHS Foundation Trust) and the Chelsea and Westminster urgent care centre. This enables them to identify if a child from Ealing is making multiple attendances at various sites, and can also help identify cases of Child Sexual Exploitation (CSE), and instances where a child may be involved in county line enterprises⁷.

2.2 The Paediatric liaison has good links with community services in Ealing and ensures that all vulnerable children are provided with support in the community. Paediatric liaison have well embedded links with the young person's substance misuse team, and regularly make onward referrals to them for ongoing support in cases where it has been identified that a child or young person has been attended to ED due to drug and alcohol misuse.

2.3 Children who present at Northwick Park ED who are under 16 years of age will be seen on in paediatric ED. However, once a child reaches 16 they are triaged and treated within the adult ED and adult wards. Children who are looked-after of this age group are also not eligible to be treated on a paediatric ward, unless they have a recognised learning disability. Children aged 16 to 18 are not given the option to articulate where they would feel most comfortable to be seen, and therefore have little input into this element of their care and treatment once they reach their 16th birthday. Adult wards can be anxiety provoking for some young people especially those who are vulnerable. (**Recommendation 2.2**)

2.4 The 'Jack's Place' paediatric ward at Northwick Park Hospital is well equipped to provide care and support to children and young people of varying ages. There are two nurse stations which allow staff good observation to the entire ward at all times. There is also a separate section for babies, infants and younger children and a purposely designed adolescent room, which affords those older children and young people who are required to stay on the ward privacy and space.

2.5 When a child is transferred from the paediatric ED to the paediatric ward and safeguarding concerns have been identified, a full individual risk assessment and comprehensive handover is undertaken. In addition to this, upon admission to the ward, all children are subject to an 'activities of daily living assessment' (a medical and social care assessment) which provides the child or young person with a further opportunity to discuss issues that may be of concern to them that they might not have been comfortable discussing on the ED, for example if an adult was present at the time.

⁷ County lines, or 'going country' means groups or gangs using young people or vulnerable adults to carry and sell drugs across county boundaries, including London boroughs and beyond. It is a tactic used by groups or gangs to facilitate the selling of drugs in an area outside of the area they live, reducing their risk of detection.

2.6 Ealing travelling communities are served well by a named health visitor to provide them with specific care and support that best suits their chosen lifestyles. This means that children within those communities can be provided with services that ensures the safe delivery of care to them so that they are less likely to miss out on services provided.

2.7 School nurses are delivering the National Child Measurement Programme (NCMP) and are issuing a school entry health needs assessment for all children who start school. However, we heard that when health needs assessments are not returned, no standard response or proactive follow up of families is in place. Due to commissioning arrangements, no additional health and needs questionnaire is offered at other key stages. This hinders the early identification of emerging and unmet health needs in school aged children. *This matter will be brought to the attention of Public Health commissioners.*

2.8 LNWUH school nursing links with the LNWUH health visiting team are strong, and the co-location of school nursing and health visiting teams facilitates the effective and timely sharing of information and concerns. Health visitors and school nurses are both using the same electronic record system, which ensures that the child's health and social history is easily accessible to the school nurse and can be used effectively to support a child who is transitioning from an early years setting into school.

2.9 Health visitors and school nurses routinely hold face to face handover meetings when a child with health needs or safeguarding concerns is transitioning to the school nursing service. This ensures that the school nurse is well informed of the child's risks and vulnerabilities and can continue to provide good continuity of care and support once transition is complete.

2.10 School nurses are not provided with any training or support from CAHMs to assist them in their engagement with children and young people who have emotional wellbeing needs. School nurse practitioners report that when referrals are made to CAMHs, children are waiting for significant lengths of time until they can access support and therefore there are delays in their needs being met. Waiting times are exacerbated by school nurses not referring into CAMHs directly, but by referring the child to the GP who then requests to see the child at their practice in order to complete a CAHMs referral. *This matter will be brought to the attention of Public Health commissioners.*

2.11 Young people who elect to attend colleges to pursue their education are no longer able to access support from the school nursing service. Therefore, the school nursing offer is not equitable to all young people aged 16-19 as the school nurse service is not extended to them. *This matter will be brought to the attention of Public Health commissioners.*

2.12 Children schooled at home or who have disengaged from education also does not currently receive any school nursing support. As school nurses are not commissioned to support children not currently in mainstream education, the opportunity to assess if the child's parent is misusing their right to home educate to conceal risk and vulnerability, is missed. *This matter will be brought to the attention of Public Health commissioners.*

2.13 Throughout our review of the records of children and young people receiving a service from WLMHT CAMH, we noted that the voice of the child was clearly evidenced and recorded. Records examined were child focused and prominently described the wishes and feelings of the child or young person in a way that demonstrated that they were actively involved in their own support planning.

2.14 Practitioners from the WLMHT CAMH service play an active role in supporting children in need in Ealing. In cases examined, we saw that CAMHs practitioners attend child in need meetings and actively contribute information and carry out activity agreed as part of the child in need plan. As with early help, this ensures that children's emotional wellbeing and mental health are viewed as part of the bigger picture of need and lead to better, more meaningful child in need plans.

However, in those records examined, it was not always clearly recorded what had been discussed at those child in need meetings or what the agreed actions were. Records were inconsistent and child in need plans were not always uploaded to the electronic patient record system. This means that other users of the record may not have a clear picture of their role in supporting a child due to the variability in the detail of the information. (**Recommendation 4.1**)

2.15 Children and young people who have self-harmed and attend emergency departments that serve Ealing, benefit from a clear case management pathway where WLMHT CAMHs provide care and support. Children and young people up to and including the age of 15 who attend the acute hospitals where there is a paediatric ED and children's ward with CAMH services provided by WLMHT CAMHs, are seen by a CAMHS clinician during the day. Children who attend those served EDs out-of-hours or at weekends will be seen by a CAMHS duty psychiatric registrar who has access to a consultant by telephone. The registrar is supported by an out-of-hours mental health nurse. Both these resources are rostered to work and so they are not on-call and this means that children and young people are seen in a timely way.

Assessments were seen to be comprehensive and child focused and, where appropriate, support discharge to community services.

2.16 Young people aged 16 to 18 who taken to the Ealing hospital UCC and are in mental health distress are seen and assessed by the WLMHT hospital psychiatric liaison team, supported by CAMHS staff or the out-of-hours CAMHS practitioners at West Middlesex Hospital. This is primarily an adult team. However, our review of records showed that assessments are detailed and child/young person focused and that they also support effective discharge to the community CAMHS service.

2.17 Children and young people who present at the paediatric ED at Northwick Park Hospital may be transferred to the paediatric assessment unit (PAU) for up to 24 hours whilst they wait for a CAMHs assessment from the out of hours CAMHs team provided by Central and North West London Foundation Trust (CNWLFT). However, we heard from practitioners on the ward that out of hours CAMHs assessments are often delayed.

Staff on the paediatric ward told us that there have been recent cases where a child has been admitted to the ward over the weekend as they had to wait until Monday for a CAMHs assessment to be completed. This impacts on the capacity on the paediatric ward, and in some cases (for example where self-harm is a presenting factor) the child will require one to one constant observation to minimise the risk of further incidents of harm which might impact on workload. (**Recommendation 6.1**)

2.18 A newly developed transitions protocol has been implemented for children and young people who will require support from the WLMHT adult mental health service on transition from CAMHs. The protocol is aimed at enabling some flexibility when the young person reaches 18 in relation to a gradual hand-over of their care plan.

In the WLMHT adult mental health service, we examined two cases and noted that the system is effective in ensuring the young person's precise needs are well understood and clear plans made for a graduated hand-over of care from CAMHs to adult mental health.

2.19 Children who are referred for assessments for Autistic Spectrum Disorder/Condition (ASD/C) or Attention Deficit Hyperactivity Disorder (ADHD) are currently subjected to long waiting times for assessment. However, once admitted to the waiting list, children and young people are offered a range of services that will meet behavioural needs or support them with managing anxieties whilst awaiting further assessment and therapeutic interventions. This includes; the SAFE team, family support workers from the early help teams, the behavioural support team and sensory support from the integrated therapies service. Young people who develop an acute psychiatric need are prioritised for early neurodevelopmental assessment.

2.20 Women who experience mental ill-health during or following pregnancy are supported by a dedicated, well-resourced perinatal mental health team provided by WLMHT. Whilst there are challenges in relation to the six different birth units supported by the team, a robust pathway ensures that the service is consistent for all sites.

2.21 Where a woman is identified during pregnancy as requiring additional support, a multi-disciplinary team meets at 32 weeks pregnancy, comprising a perinatal mental health nurse and midwife and often including the health visitor and a member of the mental health recovery team. The team agrees a joint perinatal mental health plan that covers the antenatal and perinatal period and the plan is kept under review. This ensures a holistic view of the woman's care is taken and any impact on the baby is well understood and planned for.

In one of the cases we examined, we saw that a woman who had given birth during a weekend was identified as experiencing acute mental ill-health whilst still on the birth unit.

After an initial assessment by the WLMHT Crisis and Assessment Team over the weekend, the perinatal mental health nurse completed a comprehensive assessment on the following Monday and identified a number of social factors, including domestic abuse that added to the risk of the mother's mental health and her ability to care for her new born baby. We noted an exceptionally detailed and well-reasoned formulation of risk resulting in the mother ultimately being admitted, with her baby, to a mother and baby unit under a section of the Mental Health Act where her needs could be better assessed and met.

At the point of her discharge sometime later, the perinatal mental health nurse compiled a comprehensive plan that outlined clear relapse indicators and a plan for mother, her supporters and associated health professionals to ensure risks were identified early and mother and baby were kept safe.

In another case examined we saw that adult mental health practitioners have a clear understanding of safeguarding thresholds and make appropriate referrals to children's social care whenever there is a risk of harm to a child associated with an adult client. We saw that a woman who had a young son had been assaulted by her male partner (the client of the service) and that there were additional risks in relation to alcohol misuse that placed the child at greater risk.

The practitioner recognised the risk and ensured a referral was made straight away to children's social care. The practitioner also went on to support the woman's wish to make a complaint to the police. The practitioner's advocacy of the woman in this case in this case ensured that both she and her child were protected.

2.22 Both GP practices visited in Ealing were seen to have effective arrangements in place to manage and follow-up children who are identified as vulnerable or at risk. This activity is coordinated by regular multi-disciplinary team meetings involving the GPs, practice nurse's, midwives, health visitors and district nurses. School nurses tend not to attend due to capacity issues but both practices liaise with school nurse teams on a case by case basis if appropriate. We saw a number of examples where those multi-disciplinary meetings had helped the practice to coordinate activity to ensure children were kept safe.

3. Child protection

3.1 We heard that whilst the alert systems on casualty cards and the triage system used within the ED at Northwick Park Hospital are effective in highlighting risk, if a child has just recently become subject to a child protection plan or looked after, the alert may not show immediately on the child's record. LNWHU Trust is aware that timely and effective sharing of information across health and social care is vital in aiding the identification of vulnerable children and young people and required to protect them from further harm.

There is a plan to implement the Child Protection Information system (CP-IS). CP-IS will connect local authority social care systems with systems used in unscheduled care settings such as ED departments at Northwick Park and Ealing Hospital and also the UCC, notifying practitioners with immediacy when a child has become subject to a child protection plan or has been given looked after status. However, the CP-IS system cannot be implemented until the current electronic patient record system (Symphony) is upgraded. (***Recommendation 2.3***)

3.2 There is a clear did not wait policy in place within Northwick Park ED. When a child was brought into ED but did not wait to be triaged, or to be seen by a clinician post triage assessment, a letter is generated and sent to the child's GP to inform them. A health visitor referral form is also completed, alerting their health visitor or school nurse of their attendance so further assessment and contact can be made with the child in the community and thus better ensure their safety and wellbeing.

3.3 In cases where the child is thought to have a serious medical condition or injury and may be at significant risk of harm as a result of not seeing a medical practitioner, Northwick Park ED practitioners will call the police and social care will be notified. Checks will be carried out as a priority to ensure that the child is safe, well and able to receive the medical treatment that they may need.

A similar, effective system is also in place at the Greenbrook UCC at Ealing Hospital to ensure the safety of vulnerable children who attend the unit but did not wait to be seen.

3.4 In some cases, older young people who present with mental health concerns are placed on adult wards at Northwick Park Hospital. We were advised that individual risk assessments would be undertaken to mitigate any risk to those young people, but at the time of the review we could not be assured that the reasons and rationale for such decisions were being appropriately documented within patient records. (***Recommendation 2.4***)

We heard an example of a 15 year old boy who presented in paediatric ED as being aggressive due to his poor mental health. Due to his presentation, it was assessed that he could not be placed on the paediatric assessment unit due to the risk posed to other children and young people, so he was admitted to an adult ward to receive care and support. Managers we spoke with expressed their concern and frustration about the delay in accessing the CAMHs out of hour's service and the impact that this delay has on the wellbeing of children and young people.

3.5 There is significant variation in the way referrals are being made into social care by practitioners at Northwick Park Hospital. We were advised that due to the Ealing social care e-mail address not being secure, acute staff have been advised to make referrals via fax, which is breach of the hospital's information governance policy. Referrals can be made securely via 'Egress Switch' secure email, but updates from social care can only be received if the sender has created a receiver account, and updates are not being sent to a central location or safeguarding team. This means that if the receiver is absent from their place of work pertinent safeguarding information may not feature in the patient record. This issue has been flagged on the Trust's risk register with an action plan in place. However, practitioners we spoke with were inconsistent in their understanding of referral processes. (**Recommendation 3.1**)

3.6 At Ealing Hospital's UCC, we saw how that paediatric liaison will, on receiving attendance information, suggest that a referral is made to children's social care if considered appropriate and one has not yet already been made. We examined one case where on initial examination the GP did not make a referral to social care but paediatric liaison suggested later that one be made. Although the reasons for a referral not having been made in the first instance was explained to us during our review, there was nothing written in the client notes on SystmOne that explained the GPs decision making rationale. It is important that, when making such decisions, then the reasons for them are clearly explained. In this instance the referral was rejected by social care. (**Recommendation 5.1**)

3.7 Expectant women in Ealing benefit from a comprehensive risk assessment when booking their pregnancy which is revisited at regular intervals throughout the pregnancy by midwives both at Northwick Park Hospital and in the community. In records examined we saw that questions pertaining to the increased risk of domestic abuse during pregnancy are also asked and the answers recorded accordingly.

3.8 Expectant women who disclose domestic abuse and/or violence are supported well through close links with the Independent Domestic Violence Advisors (IDVA) who offer support and guidance where domestic abuse is indicated. This also supports early identification of risk to children and young people who might witness and be affected by such domestic abuse.

3.9 We saw that there is good information sharing between GPs and the maternity service. We were further advised that the majority of midwifery bookings come from GPs in the first instance. The booking referrals template used by GPs is also used to highlight concern regarding medical or social vulnerability so that midwives will be aware of any concerns when interacting with vulnerable women.

3.10 Unborn children are generally safeguarded well by midwives. However, records examined contained variable chronologies of significant events and copies of child protection plans to protect the new born infant were also not visible in those records. This was also highlighted in one case we tracked where a mother and baby on a child protection plan for emotional abuse were discharged home without a discharge planning meeting or social worker being made aware of the birth.

This incident was raised within the Trust and has been investigated. However, from those records examined we could not be assured that systems put in place are robust enough to ensure that risk of similar incidents occurring is appropriately mitigated. (**Recommendation 2.5**)

3.11 Good arrangements are in place to ensure timely follow up of those expectant women who do not attend their antenatal appointments as arranged. Midwives are tenacious in ensuring women are seen regularly during the antenatal period, therefore protecting the health of the woman and the unborn child.

3.12 Health assessments, care planning and review arrangements are well targeted within the Ealing LNUH health visiting service. They were seen to be child centred, and recognise the diversity of children and their families' needs.

We were informed and also examined evidence of families' ethnicity and language clearly documented with the targeted allocation of appropriate members of the multi-lingual skill mix team to support those families.

3.13 In cases where a child is at risk of disengaging from their school, the LNUH school nurse will offer to conduct a home visit. Some home visits are carried out jointly with social care or a health visiting practitioner and this facilitates the school nurse to see the child in their home environment and offer the opportunity to identify additional concerns that may not have been apparent by seeing the child in a school setting. In some of the cases we examined, we saw that the offer of home visits was evident in the child's health record.

3.14 If a child has been identified as a Child in Need or is on a Child Protection Plan but has no presenting health needs, the LNUH school nurse will not keep them on their active caseloads due to a revision of the Safeguarding Children School Nursing Pathway. This cohort of children are now placed onto an inactive caseload which is not regularly subject to audit or regular review, and therefore the school nurse may not be aware of safeguarding updates or changes in the child's circumstances.

The change in the safeguarding pathway means that school nurses do not have oversight of all children who are at significant risk of harm due to the inactive caseload not being effectively audited or reviewed regular intervals. *This matter will be bought to the attention of Public Health Commissioners.*

In one of the tracked cases we examined we saw how the school nurse knew the child in the case but had removed them from her active case load due to the child having no presenting physical health concerns, despite the child being subject to a child protection plan. The child's mother had raised concerns with regard to her child being sexually active with a significantly older person and that the young person might be at risk of exploitation.

The School nurse had no prior knowledge of the child's involvement with CAMHs and had not been made aware of the new risks the child was exposed to due to the child no longer being proactively monitored on the school nurse active caseload.

3.15 In cases where a child moves out of borough, LNWUH school nurses have a clear protocol in place to ensure that the child's needs, risks and vulnerabilities are clearly articulated to the school nursing service in the area where the child is relocating to. A standardised transfer form, containing clear summaries and chronologies, is consistently completed and shared. This increases the likelihood of the child continuing to be robustly safeguarded in their new area.

3.16 LNWUH school nurses are not using a standardised CSE identification tool when exploitation has been identified as a possibility. Whilst they are attending CSE strategy meetings to discuss cases where CSE may be a concern, the use of a standardised screening tool where risk is being considered may assist school nurses in the early identification of need, and enable them to provide a more proactive as opposed to reactive response and also support any referral to children's social care. *This matter will be bought to the attention of Public Health Commissioners.*

3.17 WLMHT CAMHS practitioners are generally clear about child protection thresholds and make detailed referrals to the children's social care single front door, the Ealing Children's Integrated Response Service (ECIRS). Most records we examined showed a good level of detail in referrals although there was no routine use of an assessment model or framework which would enhance the analysis of risk factors. The understanding of thresholds was not always consistent.

(Recommendation 4.2)

In one case we examined, we saw how a young person of primary school age was previously being supported on a child in need plan.

The young person's anxiety and behaviour rapidly deteriorated following a child in need meeting and their suicidal thoughts and verbalisation of those thoughts also escalated. Within a number of weeks it became clear that the young person was at significant risk of self-harm with their parents not being able to control their outbursts.

In this case the young person's clinical needs had been managed and a placement was found to keep them safe while their mental health needs were assessed. However, during this period of escalation, the young person's social worker was not informed of their deteriorating condition and there was no child protection referral made. This was despite the practitioner having clinical supervision during this period.

3.18 There is no routine use of risk assessment tools for CSE within WLMHT CAMHS. In two cases examined we saw that potentially exploitative situations were correctly identified and referrals made, largely due to the diligence and professional curiosity of the staff members. However, the use of an established assessment tool would support practitioners to fully explain the risks arising from a young person's situation and enable wider risks to be understood and informed decisions made. For example, in one case examined we saw that a key piece of information that was known about the perpetrator was not provided on the referral document. This was a missed opportunity to ensure children's social care and the CSE team were aware of key intelligence. (**Recommendation 3.2**)

3.19 WLMHT CAMHS practitioners routinely attend child protection conferences and provide information to enable the conference decision making process. CAMHS practitioners also attend core group meetings and ensure the child or young person's mental health needs are foremost when measuring progress against plans. However, as with child in need plans, records of conferences are not routinely uploaded to the electronic patient record system and the level of detail in the record's progress notes is inconsistent. This means that other users of the record may not be clear about the current child protection plan, a particular risk if the care co-ordinator is on leave or if the case gets handed over to another practitioner. (**Recommendation 4.1 as at 2.14 above**)

3.20 Child protection referrals made by WLMHT CAMHS practitioners are not always uploaded on to the electronic patient record system. This was the case for two of the three cases we tracked in CAMHS. Although the nature of the referral was outlined in each case within the progress notes, the absence of a clear record of referrals made means that the record is incomplete and there is no surety about the extent of the information passed at the point of referral. (**Recommendation 4.1 as at 2.14 and 3.19 above**)

3.21 WLMHT adult mental health practitioners routinely attend all child in need, child protection and core group meetings relating to children of their clients. Reports are submitted to the child protection conference chair in advance of the meeting and are also shared with parents. In cases examined we saw that reports are not always submitted in the same format, but are nonetheless detailed and analytical, enabling the conference to make good decisions about children subject of child protection plans.

3.22 A lack of a single standardised template and guidance on how to complete this is hindering practitioners within Ealing RISE substance misuse services to effectively analyse risk to inform case conference reports, although the service can access the multiagency case conference report template that does facilitate risk assessment. Although information is being shared, and in the majority of cases examined showed practitioner involvement in statutory meetings, there is room for improvement in the quality and consistency of reports submitted to inform the decision making process. *This matter will be brought to the attention of Public Health commissioners.*

In one tracked case we examined we saw how the client electronic record contained appropriate ‘flags’ to highlight to the practitioner that there were safeguarding concerns and the safeguarding template had been completed. There was evidence of discussions held with social services but not with associated health partners, in this particular case midwifery services.

Although the Ealing RISE practitioner did attend case discussions, we saw that reports submitted were not analytical and detailed in relation to recognised concerns. They were more of a chronology of contacts between practitioner and service user. This means that had that practitioner not been able to attend the conference meetings in person then the conference might not have had full access to important information.

3.23 Adult substance misusers who have responsibility for the care of children and young people must agree to a home visit from Ealing RISE practitioners, however in some cases due to risk concerns an unannounced visit may take place. This is so that practitioners can assure themselves of the home environment and subsequent safety of those children service user care. It is also a requirement that those service users prescribed a substance substitute such as methadone, must agree to the fitting of a ‘safe box’ so that medication can be stored safely out of the reach of vulnerable young people. Safe storage boxes are also offered no non prescribed clients. This is checked at subsequent home visits to ensure compliance.

3.24 Both GP practices we visited were confident in how to refer a child or family to children’s social care via email to the ECIRS. In records reviewed, we examined detailed safeguarding referrals which clearly articulated risk. This means that the decision making process at the ECIRS and the MASH will be well informed.

3.25 Where CSE risk is considered, GPs are not using appropriate tools to further identify risk and therefore strengthen referrals made to children's social care. This means we cannot be assured of practitioners identifying some important safeguarding concerns as the approach to undertaking risk assessment is too variable. There is an over-reliance on professional curiosity with decisions not underpinned by the use of available screening tools. (***Recommendation 1.1***)

3.26 Both GP practices visited had appropriate processes in place to ensure that reports written in response to requests for information sharing for child protection conferences and core group meetings were responded to appropriately and those seen in patient's records were detailed in nature so as to inform the decision making process. Where the GP practice had received child protection conference minutes, these were uploaded onto the patient's record and appropriate flags updated on electronic patient records.

3.27 In both GP practices visited we saw that the details regarding adults accompanying a child to a GP appointment is not consistently recorded and needs strengthening to include full names and relationships. For example, recording simply 'mum' or 'dad' as opposed to recording their full details is insufficient, particularly if the person accompanying the child is not a patient at the same practice and their own records are not linked to the child's.

This is important not only to ascertain who has parental or carer responsibility for a child or young person and therefore able to consent to treatment, but in a fractured family with complex dynamics, the recording of names is as relevant as the reported relationship. (***Recommendation 1.2***)

4. Looked after children

4.1 The Looked After Children's health service in Ealing is provided by LNWUH. We saw that there are effective processes in place to meet the health needs of Looked After Children in Ealing through services provided. All initial health assessments of children and young people taken into the care of the London Borough of Ealing are undertaken by a team of appropriately qualified paediatricians and associated specialist doctors in line with intercollegiate guidance and best practice.

4.2 Initial health assessments reviewed were seen to contain appropriate and adequate information to inform the reader of the child or young person's needs when first becoming looked after and, where appropriate, demonstrated the 'voice of the child' to show that they had been involved in the assessment process.

4.3 Ealing looked after children placed 'in borough' receive timely access to Review Health Assessments. The LNWUH Looked After Children's nurses have changed their availability to 8am-6pm to offer additional flexibility to children and young people in their care, especially those not wishing to interrupt their school day. This was in response to service user feedback about the service.

4.4 Overall, review health assessments we examined undertaken by the Looked After Children's nurse specialist were seen to contain detail that ensured care plans were SMART and support the child's health needs being met.

4.5 Review health assessments examined also demonstrated that consent was routinely sought and in some cases those consenting young people had signed their assessment to demonstrate this. We also saw a consistent approach to raise and discuss internet safety within all review health assessments seen.

4.6 Some records seen within the Looked After Children service demonstrated that, where issues were identified, they were not always explored further to measure any impact or if additional support might be required. In one record examined we saw how the young person was noted as being underweight and that this was a worry to their carer. However, there could have been greater exploration of their physical activity and possible impact on their physical activity against food intake in preparation for the referral offered to be assessed by a dietitian. (**Recommendation 2.6**)

4.7 LMWUH Looked After Children nurses are not using a local or national CSE tool to support exploration of CSE where it is indicated as a possible risk. The use of such screening tools, especially where a referral is made to children's social care, might strengthen that referral and thus support the decision making process. Practitioners we spoke with articulated well how they would escalate concerns in relation to CSE but did not use tools to support this. (**Recommendation 3.2 as at 3.18 above**)

In one case examined we saw how a young person placed in care had been the subject of neglect. It was correctly identified by the Looked After Children nurse that the young person's behaviours were likely to place them at risk of being sexually exploited.

The nurse raised this with the young person's social worker and challenged them when they felt that their views regarding the case were not being given due consideration and, following being provided with advice and guidance in supervision on how to progress the case, the young person was subsequently placed in a setting that would provide them with a sense of increased safety.

However, the approach in this particular case would have been enhanced by the use of available CSE screening tools to better articulate those risks already identified.

4.8 The LNUWUH Looked After Children team have established processes to support a consistent standard of care for Ealing children placed out of the borough. Service level agreements are established with the area undertaking the review and an information pack is issued by the Ealing Looked After Children team outlining guidance and expectation of the area undertaking the review health assessment. The last review health assessment is also shared with the receiving area. This is further supported by rigorous quality assurance by the Looked After Children lead community paediatrician of all out of borough review health assessments. We heard how this has led, in consultation with the allocated social worker, to children being brought back to Ealing for their review health assessment if it is felt their needs are not being adequately assessed or met elsewhere.

4.9 All unaccompanied asylum seeking children receive a comprehensive initial health assessment by LNUWUH clinicians who have received additional training in relation to assessing the holistic health needs of this vulnerable cohort of LAC young people.

4.10 One unaccompanied asylum seeking child's initial health assessment we examined captured well the voice of the child and the impact of experiences they had been exposed to. The emotional health and wellbeing of the child was assessed through the use of the evidence based 'Impact of Events Scale'⁸. We noted in another case reviewed that, although the young person reported feeling 'normal,' the tool assisted the practitioner in objectively identifying the risk of Post-Traumatic Stress Disorder. This work is ensuring unaccompanied asylum seeking children receive timely help to address emotional trauma they may have experienced.

⁸ The Impact of Events Scale is a widely used screening tool measuring children at risk for post-traumatic stress symptoms, and is designed to be used in children aged eight years and over. It has been applied in a variety of cultures as post-traumatic stress symptoms in children are more similar than they are different from one culture to the other.

An unaccompanied asylum seeking young person had undertaken a long solo journey to the UK from their own country. As part of the initial health assessment the paediatrician sensitively explored if any sexual harm had come to the young person during the journey, and it was disclosed that this was the case.

Following on from the disclosure, we saw how a high level of liaison between clinicians was undertaken to identify the right services to manage the young person's physical health needs and further to support them to access them.

The disclosure also led to the paediatrician advocating for the young person who then shared the distress caused to them by living in supported lodging in close proximity to members of the opposite sex not known to them. Joint discussions with the local authority led to more appropriate accommodation being found where the young person then felt safe.

4.11 The LNUWUH Looked After Children team engage well with care leavers and seek to ensure their health needs are met as they move into adulthood. When leaving care, young people receive a comprehensive summary of their health history which was developed in association and in consultation with the care leaver's councils. Another outcome of liaison with care leavers is for Looked After Children health clinics being run in the Local Authority Horizons Centre⁹. Young people are also directed to the comprehensive information contained on the NHS GO app¹⁰.

4.12 The LNUWUH CASH service has developed good relationships with the Looked After Children service, recognising well the additional vulnerabilities of this particular cohort of young people. Although the CASH service provides confidential care and support to young people in Ealing, if a young person requests, then a member of the Looked After Children's team will accompany them to a CASH clinic to provide support. This means that those vulnerable young people are supported well to obtain appropriate care which they might not otherwise choose to do.

Where a young person is known to be Looked After attends a drop-in clinic they are 'fast tracked' to a consultation with a practitioner to better assure engagement with them.

⁹ Ealing Horizons Centre is part of Ealing social services leaving care programme in partnership with Ealing Youth and Connexions Service. The centre offers young people in care and those who have recently left care a 'safe space' where they can share experiences, seek information, help and advice in order to plan and prepare for independent living. The centre also promotes inclusion through programmes of social education, personal development, and recreational activities in an informal and relaxed environment.

¹⁰ NHS Go is a free to download health app designed for young people by young Londoners. It gets its information directly from the data that fuels NHS Choices but is organised differently, with topics and articles that appeal to young people. It is an up-to-date resource relating to issues that might affect young people as they are taking greater responsibility for their own health.

4.13 The Ealing CCG Named GP for safeguarding children has developed a Looked After Children information pack. This has been distributed to GPs across Ealing informing them of the definition of a Looked After Child, the demographic of Looked After Children in Ealing, the additional risks posed to Looked After Children and their responsibilities in relation to informing the health assessment process. The pack, including the LNWUH 'Rainbow Guidance' is also sent to any out of Borough GPs undertaking an Ealing child's LAC Health Assessment. Use of this guidance was evident in both Initial and review health assessments seen during our review.

Management

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

5.1 Leadership and management

5.1.1 Health access to multiple health electronic systems and also social care electronic records at the MASH, with the facility to also update those records, is a positive step to ensure the safety of vulnerable children, young people and families. Having such access enables the health practitioner at the MASH to be able to maintain full and detailed records and also undertake accurate checks on children, young people and families of concern. Information sharing protocols ensure that as electronic systems develop as planned then such access will continue.

5.1.2 There is strong, visible leadership and management within the ED at Northwick Park Hospital. The head of safeguarding children has been in post for 12 months and has successfully integrated the safeguarding team in Ealing with the neighbouring boroughs of Harrow and Brent, to ensure that the teams work together in a co-ordinated way to safeguard children and young people who may be transient across Boroughs. The move from silo working has resulted in greater information sharing, along with a consistent approach to safeguarding which has been adopted across sites. This means that if a child from Ealing presents at ED's in neighbouring boroughs then they are more likely to receive equitable standards of care.

5.1.3 Joint strategic work is ongoing to improve the health of Looked After Children through the Ealing Looked After Children Wellbeing Project. Data has, for example, identified that more Looked After Children are obese than those not Looked After. The CCG Looked After Children leads are working with Public Health and the local authority to set up initiatives that give Looked After Children free access to local fitness facilities, foster carers access to dietetic advice and also a CAMHS psychologist up-skilling Looked After Children's nurses regarding the underlying issues that may be associated with overeating to support discussion in health assessments.

This collective approach recognises the complexity of weight management and is taking a multi-agency approach to tackling the problem for an already vulnerable group of children.

5.1.4 A joint project to produce a Foster Carers Handbook is currently in final draft. This has been created in conjunction with looked after young people and foster carers but has yet to be published. We had access to a draft copy of the handbook and saw that it contains relevant information that will be of use to foster carers in Ealing and that it contains material that evidences co-production with those service users and carers.

5.1.5 There is a strong collaborative approach to audit from the Looked After Children service provider and Designated Doctor in Ealing and these are working towards improving outcomes for children and young people. A well-developed action plan is in place for the Looked After Children service which this forms part of the annual report. Evidence of work seen demonstrated that it had progressed well over the year. An example of ongoing work is an audit to assess whether transition planning was robust for young people placed out of borough leaving care. This then led to focused care planning on the health needs of a number young people in readiness for them moving to adult health services.

5.1.6 There are some recognised capacity issues within the health visiting service. We were informed that one of the three teams in Ealing has reached a critical staffing level with a 40% practitioner vacancy rate. This is currently on the LNUWUH risk register and steps have taken to mitigate risk including, for example, part time health visitors currently undertaking additional 'bank' hours to manage the shortfall. LNUWUH is also planning to utilise the use of appropriately trained agency staff. We were given assurances all bank or agency staff are, and continue to be trained at level three safeguarding children training as recommended by intercollegiate guidance.

5.1.7 Management oversight and review supports the effective tracking of risks to children and improvements in child health outcomes within the LNUWUH health visiting service. The health visiting teams have a robust duty and triage system with good managerial oversight of all referrals made to children's social care and also of notifications and requests for information coming into the service.

This means risks to children are effectively tracked and appropriate plans and interventions can be put into place in a timely manner to improve outcomes for children.

5.1.8 One of the locality leads for the LNUWUH school nursing service is a non-clinician from a social care background. We heard how she has worked well to ensure that school nurses are not only completing clinical assessments, but are taking an holistic, 'think family' approach when engaging with the children and young people of Ealing. She is also able to access local authority records which further support school nurses in being able to quickly and efficiently obtain additional information concerning the child to support their own risk assessment and decision making processes.

5.1.9 Partnership working between WLMHT and children's social care is well developed at both strategic and operational levels. Vulnerable adolescent panels with leaders from the WLMHT CAMHS and children's social care meet regularly to discuss individual cases where there are complexities that have led to delays in the progress in those cases, whether due to processes or availability of resources. The purpose of these panels is to ensure that where progress is delayed then the reasons are dealt with at an operational management level and that work continues to provide good outcomes for young people.

5.1.10 Partnership boards have recently been set up between the CAMHS and the local authority at executive level. These panels are intended to improve multi-agency pathways and to agree programmes to implement changes that would lead to systemic improvements. For example, the most recent board discussion relates to improvements in the way that children and young people with Special Educational Needs and Disabilities (SEND) are facilitated to gain access to services; this latest discussion is very recent and so at the time of our inspection we are unable to say whether this has yet made an impact.

5.1.11 Within WLMHT there is good management oversight of safeguarding children activity in relation to children who are associated with clients of the adult mental health service. There are daily 'zoning' team meetings where all cases that have complex features or specific risk factors are discussed and any additional activity required by the care co-ordinators is triggered. Clients who have access to children and where there are safeguarding concerns are discussed at the Monday zoning meeting and this ensures any risks are discussed fully and action taken in a timely way to mitigate those risks. In the cases we sampled in the East recovery team, we noted that action that had been agreed at the zoning meetings had been taken including referrals to children's social care.

5.1.12 Managers in the WLMHT adult mental health service also have a clear picture of children and families of clients where there are safeguarding concerns, including children who are referred to children's social care and children who are the subject of child in need or child protection plans. A 'safeguarding referral map' database is updated with all new information about children. This is used to trigger discussion at the daily zoning meetings and also to provide the WLMHT safeguarding team with monthly data returns. This eliminates the risk of children and young people of clients being overlooked and is evidence of the strong think child approach reported in early help above.

5.1.13 In both the WLMHT CAMHs and adult mental health services, referrals to children's social care are not routinely copied to the trust safeguarding team at the point of referral. Instead, a monthly return is required by each service team which enables the safeguarding team to gather data about the nature and extent of referrals. In the absence of any formal means of sampling cases, this system is not sufficiently robust to enable proactive monitoring of the nature and quality of referrals by the safeguarding team. (**Recommendation 4.3**)

5.1.14 CGL substance misuse services have been responsive in their review of the GP shared care option for clients following a small number of patient deaths. A deep dive audit of those clients who receive shared care has led to recommendations to improve the offer. As part of the subsequent action plan, a review of safeguarding risk indicators for these clients is being revisited. This is an ongoing piece of work within the Ealing RISE service with the aim to improve the shared care package on offer.

5.2 Governance

5.2.1 The Central London, West London, Hammersmith and Fulham, Hounslow and Ealing Clinical Commissioning Groups collaborative (CWHHE) provided a Savile Report to provide assurance regarding arrangements and practices in place to protect vulnerable people following on from the Lampard 'lessons learnt' report of 2015 and subsequent NHS investigations. This especially relates to safeguarding, access to patients and listening to and acting on patient concerns. Current practice in Ealing was examined and strengthened where required to ensure that the safeguarding team across the CWHHE collaborative are assured that robust and evidence based procedures are in place to protect vulnerable children and young people and that governing bodies are kept up-to-date and informed. We saw that practice in relation to the report and its findings are regularly reviewed.

5.2.2 The theme of the November 2017 Ealing Safeguarding Children Board (ESCB) conference was to promote an understanding of domestic abuse and the effect it has on children, adolescents, families and the elderly in Ealing. The conference brought together professionals from across the Ealing partnership including; social care, the police, health and the private and voluntary sector with the objective to share experiences and responsibilities, learn from domestic homicide reviews and serious case reviews and work together across the partnership.

We saw that feedback following on from the conference was overall positive with partners describing feeling empowered and encouraged to share the experience with colleagues in their respective workplaces. This means that those delegates in attendance at the conference better understood and could share with colleagues the importance of identifying and reporting domestic abuse to protect not only those people subject to the abuse but also those witnessing it.

5.2.3 This first CWHHE joint safeguarding report dated January 2018 provides an updated position on the key safeguarding activity within the main provider trusts which CWHHE commissioned during quarter one 2017-18 into one document. This approach is envisaged to develop over time to reflect the views of those CCGs to ensure required strategic content and local reflection. In addition, the report highlights key issues in relation to multi-agency working and compliance with the Children Act, Care Act and other CCG requirements in respect to NHS England. Future reporting could include (depending on trending issues) safeguarding supervision, Ealing Violence Against Women and Girls (VAWG) and looked after children progress.

The report also provides assurances that Ealing CCG is compliant with the duties and responsibilities placed on it by existing legislation, guidance and frameworks to ensure children and young people are supported by practitioners who are suitable trained to recognise and report safeguarding concerns.

5.2.4 The Out Of Borough Looked After Children Transition Review dated July 2017 recognises the CCGs statutory responsibility to support Ealing Local Authority to ensure that Ealing's Looked After Children's health needs are met irrespective of where the child or young person is placed, including those placed out of Ealing. The review aimed to identify all Looked After Children who were in their last years of being in care and placed 'out of borough' to establish if their health needs were being met. It also seeks to identify those children and young people Looked After who had been assessed as requiring SEND provision to assess if their health needs were being met and that appropriate transition planning had or was taking place.

The report identified that there was strong evidence to show that, for example, just under a quarter of 17 year olds placed out of borough required SEND provision and further that just under half of all 17 year olds placed out of borough lived with a mental health, behavioural or developmental disorder.

As a result of the findings contained within the report, the Designated Doctor for Looked After Children identified a need to work with the Looked After Children's team to ensure appropriate transition referrals were made where they had not been, that young people placed out of the Ealing area do not wait longer for a CAMH assessment than those placed in the Ealing area and that those young people requiring SEND provision would be reviewed with greater scrutiny to ensure appropriate transition planning was in place.

5.2.5 WLMHT has well-established and responsive governance arrangements for safeguarding that provides good accountability and generally good oversight of safeguarding activity. There are safeguarding children leads for each of the localities that serve each of the three West London Boroughs and for the specialist forensic and high security hospital services. This includes a dedicated safeguarding lead for CAMHs and adult mental health services provided by the trust in Ealing. The safeguarding leads work closely with the operational managers and the teams to support their safeguarding activity, develop safeguarding practice and promote a safeguarding culture. The visibility and influence of the safeguarding leads and the strong safeguarding culture was evident in our interviews with managers and practitioners and in the strength of the 'child's voice' in the records we reviewed.

5.2.6 The WLMHT safeguarding team is led by a medical director of safeguarding children and vulnerable adults. The safeguarding team is resourced with a named nurse, named doctor, safeguarding children advisor, practice development lead and business support staff. However, given the size of the trust's geographical footprint and the population it serves, it is unclear if the team has sufficient capacity to carry out a quality monitoring role on live cases. For example, there is currently no dynamic system of monitoring the quality of referrals to children's social care with a reliance on monthly returns to provide management information. (**Recommendation 4.3 as at 5.1.13 above**)

5.2.7 There is a strong culture of learning and the sharing of learning at all levels within Greenbrook Care and this is shared across all of their Urgent Care sites including that at Ealing. This ensures that practitioners delivering care and support to vulnerable children and young people are aware of their associated roles and responsibilities.

5.2.8 Commissioners across Ealing effectively consider learning from both local and national serious case reviews. Ealing safeguarding children board action plans seen were detailed and clearly focussed on the findings from those serious case reviews and what actions are to be implemented to negate further risk. However, where, for example, risk assessment tools were reviewed and amended in line with report findings, there is more to do to ensure that those tools are used effectively by practitioners in their interactions with children and young people where risk is identified. The use of screening tools, such as when CSE is indicated, is too variable. Robust oversight and quality assurance measures would better ensure those tools readily available are used effectively. (***Recommendation 3.2 as at 3.18 and 4.7 above***)

5.2.9 In one GP practice we visited we saw that the use of alerts on the SystmOne electronic patient record was effective in identifying children and young people with safeguarding concerns. This also included the recognition of the risks posed by, and vulnerabilities of, adults within the household with appropriate linking of information between parent and children's records.

However, this was not seen to be as strong in the second GP practice visited and it was recognised that the use of alerts could be strengthened. Better governance procedures would ensure a more standardised approach to the use of alerts across GPs in Ealing. (***Recommendation 1.3***)

5.2.10 There is more to do by leaders and managers to ensure continuity of both understanding and implementation of methods to refer cases of concern to children's social care. Too many practitioners across multi-disciplinary services in Ealing have a different understanding of the referral route; be it by email, fax or delivered by hand in person. This is particularly important as Ealing shares its borders with other London boroughs that might have different methods in which way a referral should be made. (***Recommendation 3.3***)

5.2.11 There is variance in the way that safeguarding teams across providers in Ealing are made aware of referrals made to children's social care and thus maintain oversight of both the quality of those referrals and their effectiveness in influencing the decision making process. Too often we heard and saw variations in the quality of referrals made to social care and we heard how practitioners making those referrals are not given feedback on either the quality of that referral or any eventual outcome. (***Recommendation 3.3 as at 5.2.10 above***)

5.3 Training and supervision

5.3.1 The LNUWUH target for level three safeguarding children and adults training is 90%, but currently 80% of staff who are required to be trained to level three in accordance with intercollegiate guidance have completed this training. Leaders at Northwick Park Hospital are aware that regular audits and data cleansing needs to be undertaken in order for them to form an accurate picture of exactly what percentage of staff require training commensurate to their roles, as there is a cohort of staff and clinicians highlighted as requiring training who are no longer with the Trust, are on sick or maternity leave. This means that current data cannot be accurately relied upon and as such the 80% figure might be inaccurate in the positive or negative. (**Recommendation 2.7**)

5.3.2 Within LNUWUH there are two full time Named Nurse posts (one acute and one community), linked to Ealing borough based services. One of these posts is currently vacant and this has impacted on the ability to provide regular 1:1 structured safeguarding supervision within acute settings, although 1:1 advice and guidance can be requested and is provided as required.

5.3.3 Group safeguarding supervision is provided on a three monthly basis at the Northwick Park ED, and this has been successful in developing practitioner's knowledge base and safeguarding competencies which ensure that they are able to effectively identify and respond to safeguarding concerns.

In addition to group supervision, weekly 'Safety Net' meetings are held in Northwick Park ED and are attended by the Named Nurse, Named Doctor, ED nursing staff and consultants. Outside agencies such as the young person's drug and alcohol service also attend on a regular basis. During these meetings, cases that have presented at the ED during the previous week are discussed. Good practice is highlighted and shared, and cases are screened to ascertain if any further action is required. These meetings also provide an opportunity for peer support and reflection.

5.3.4 Safeguarding supervision is regularly provided to all LNUWUH school nurses, Family Nurse Partnership practitioners and Health Visitors. One to one child protection supervision is provided on a quarterly basis and group supervision is provided every six weeks. Group supervision provides a forum to discuss more complex and challenging cases and receive peer support and guidance. This ensures that staff are well supported and that their safeguarding practice is subject to regular scrutiny and challenge.

5.3.5 WLMHT have made significant inroads in ensuring that CAMHS staff and relevant staff in the adult mental health service have all received relevant training to recognise and report children and young people's vulnerabilities and safeguarding concerns. At the time of the trust inspection in November 2016, the compliance rates of training at level three and level three specialist of the relevant guidance were around 60%. This has now improved and, at the time of our inspection, the numbers of staff who are up-to-date with level three or level three specialist training varies between 80% and 90% (against a trust target of 90%), although the figures are slightly skewed in some teams due to the lower numbers of staff in those teams.

5.3.6 WLMHT have a well-developed system for monitoring training compliance and so we are assured that they remain on trajectory to deliver relevant safeguarding training to their key staff groups. This means that children and young people using CAMHS or clients of the adult mental health service who have access to children are supported for by staff with the appropriate safeguarding competencies.

5.3.7 There is a multi-layered supervision model in use in the WLMHT CAMHs service. One-to-one clinical supervision is offered to all staff. All of a staff member's cases are routinely reviewed at each clinical supervision and this ensures those cases of concern are properly discussed. In addition, complex and high risk cases are discussed at weekly team meetings. Lastly, reflective practice sessions are also arranged by the trust's safeguarding team and these are open for all staff members to attend and to discuss cases of concern.

5.3.8 WLMHT practitioner attendance at reflective practice sessions is not mandatory and data supplied by the trust shows that attendance is variable from session to session. The absence of discrete safeguarding supervision can lead to an overly clinical focus to cases where there are complex safeguarding features and this was evident in one case we examined. (**Recommendation 4.4**)

5.3.9 Managers in the WLMHT adult mental health service run a weekly safeguarding clinic. Practitioners can book single or multiple 15 minute slots during the day to discuss safeguarding cases of concern that might require additional support and guidance or to help with their thinking around particular issues. Other team members and agency staff are invited to attend these clinic slots to enable a multi-disciplinary or multi-agency discussion of the issue. A strength of the system is that clients themselves are also invited so that they are involved in the discussions and can add their views on the issues or the solutions and this leads to better outcomes for children and young people.

5.3.10 As with CAMHs, adult mental health practitioners also receive regular scheduled clinical supervision during which all safeguarding cases are discussed and any further actions are agreed. As well as being noted on client's records, the outcome of supervision sessions are noted on the daily zoning meeting template which ensures that actions can be tracked.

5.3.11 There is a good training offer to practitioners within the LNWUH CASH and GUM services to ensure they are qualified to meet the needs of vulnerable young people in their care. Practitioners who are involved in any one-to-one work with young people are trained to level three safeguarding in line with intercollegiate guidance. Healthcare assistants are also trained to the same level recognising the important contribution they play in the safeguarding.

5.3.12 The supervision model within the CASH service would be strengthened by the addition of structured, mandatory safeguarding supervision. The current practice is fragmented and relies heavily of practitioners seeking advice and guidance from the safeguarding team as and when required. This means that those same practitioners might be providing care to a young person without recognising risk that might be better identified within more formal, recorded safeguarding supervision.
(Recommendation 2.8)

Recommendations

- 1. Ealing CCG should:**
 - 1.1 Ensure GPs use recognised screening tools to assist the safeguarding process where vulnerability is identified.
 - 1.2 Ensure that GPs are thoroughly recording the details of accompanying adults when children attend a consultation.
 - 1.3 Ensure that GP practices across the Borough manage the use of alerts on electronic patient records to provide consistency in the way that those records are managed.

- 2. London North West University Healthcare NHS Trust should:**
 - 2.1 Prioritise the amalgamation of paper records and electronic records so that potential risk can be identified on those electronic records at the earliest opportunity and that those electronic records are complete.
 - 2.2 Provide young people aged 16 to 18 the opportunity to be seen in either the paediatric ED or the adult ED according to their own needs and wishes.
 - 2.3 Expedite the upgrading of patient electronic records systems at Northwick Park ED to ensure the implementation of CP-IS can be undertaken at the earliest opportunity.
 - 2.4 Implement methods to ensure that when young people are admitted to adult wards when in mental health distress or for any other reasons then those reasons must be clearly documented to provide an accountable audit trail.
 - 2.5 Ensure that patient records are appropriately maintained and complete and contain up-to-date information to inform practitioner interactions with vulnerable pregnant women and unborn children.
 - 2.6 Ensure that practitioners explore need and evidence those explorations by recording those explorations in client records. More robust quality assurance of records will also assure leaders of the quality of such work.
 - 2.7 Ensure that there are systems in place at the earliest opportunity to assure themselves of the accuracy of training records in line with intercollegiate guidance and provider targets.

2.8 Ensure that structured, formal safeguarding supervision is offered and provided to CASH practitioners providing care and support to vulnerable young people and that a record of the session is made in the patient record and the staff file.

3. Ealing CCG, West London Mental health NHS Trust and London North West University Healthcare NHS Trust should:

- 3.1 Implement clear pathways to ensure referrals are made into social services in a way clearly understood and acted on by all health professionals making a referral to maintain continuity.
- 3.2 Work together to ensure that tools provided to assist practitioners in the identification of risk, including the risk of CSE, are used appropriately to assist in the management and appropriate referral of vulnerable children and young people.
- 3.3 Ensure a continuity of practice for practitioners in the way that they can refer into social care and further that those practitioners are made aware of how to make referrals using those same systems. This must be supported by quality assurance measures to ensure the quality and consistency of those referrals made.

4. West London Mental health NHS Trust should:

- 4.1 Ensure that electronic client records are up-to-date and complete and that agreed actions and plans culminating from external meetings, referrals to social care and meeting minutes are uploaded to those electronic records and considered as part of the wider care planning process.
- 4.2 Ensure that clear guidelines are in place for practitioners to use when making referrals to children's social care to ensure consistency in the quality of those referrals made.
- 4.3 Ensure more robust processes are in place to monitor referrals made to children's social care to ensure consistency in their quality and further that practitioners receive appropriate feedback.
- 4.4 Better assure themselves that practitioners are both seeking and being provided with appropriate safeguarding supervision at reflective practice sessions and that where non-attendance is noted then this should be investigated to ensure risk is mitigated accordingly.

- 5. Greenbrook Healthcare should:**
 - 5.1 Ensure that professionals making decisions in relation to whether to refer to children's social care or not, clearly document the rationale for those decisions made in patient records.

- 6. London North West University Healthcare NHS Trust and Central and North West London NHS Foundation Trust should:**
 - 6.1 Work together to ensure better mechanisms are in place to enable young people attending Northwick Park Hospital in mental health crises are able to access timely support and further that ward staff are trained to assist in the support process.

Next steps

An action plan addressing the recommendations above is required from Ealing 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.