

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

Children Looked After and Safeguarding

The role of health services in Croydon

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CCGs included:	Croydon Clinical Commissioning Group (CCG)
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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 Croydon. 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 Group (CCGs) and Local Area Teams (LAT).

Where the findings relate to children and families in local authority areas other than Croydon, cross-boundary arrangements have been considered and commented on. Arrangements for the health-related needs and risks for looked after 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 2018.
- 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 nine 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 75 children and young people.

Context of the review

Croydon is a unitary authority in South London. It comprises three parliamentary constituencies and 28 local authority wards.

Croydon has a population of 384,837 (*Croydon observatory, 2017*), 19% of which [74,319] are school aged [5-19 years] (*Joint Strategic Needs Assessment, JSNA 2017*). 71% of those 5-19-year-olds came from a non-white-British heritage in 2017 (*Public Health England, PHE Child Health Profile, 2018*).

The percentage of children and young people in Croydon living in low income families is 19% [14,600] (*PHE Local Authority Health Profile, 2018*). The percentage of children in Croydon living in poverty is similar to the London average but higher than the England average. 20% of primary aged children and 17% of secondary aged children are eligible for free school meals (*JSNA, 2018*).

The number of children, including those eligible for free school meals, achieving a good level of development at school entry is better than the England average, and similar to the London average (*JSNA, 2018*).

The child mortality rate in Croydon is lower than London and England. The neonatal mortality rate is equal to the London rate but lower than the England rate while the infant mortality rate remains higher than the London rate and lower than England.

There were 33 deaths reviewed in 2017-18 and none were subject to a serious case review. Children from non-white-British ethnic groups were slightly over represented in the 33 deaths that were reviewed at almost 79% compared with 71% of the population (*Child Death Overview Panel, CDOP Annual Report 2017-18*).

The number of children who are looked after by Croydon local authority is significantly higher than the London and England average, with 83 per 10,000 looked after compared with 50 and 62 per 10,000 respectively. The number of unaccompanied asylum-seeking children (UASC) is higher still than the London and England average at 41 per 10,000 compared with 7 and 3 per 10,000 respectively (*JSNA, 2018*).

Injury related hospital admissions for children aged 0-14-years are significantly higher than the England average, yet admissions for young people aged 15-24-years are similar to the England average (*The National Child and Maternal Health Network, ChiMat, 2017/18*).

Alcohol related hospital admissions for under 18-year-olds and drugs related hospital admissions for 15-24-year-olds in Croydon are both similar to the London average and lower than the England average (*JSNA, 2018*).

In Croydon, 2.4% of school aged children have social, emotional and/or mental health needs, which similar to the England average (*PHE, 2018*). Mental health related hospital admissions for under 18-year-olds in Croydon is similar to the England average (*JSNA, 2018*). Admissions for deliberate self-harm in young people aged 10-24-years is significantly lower than the England average (*ChiMat, 2016/17*).

The number of young people aged 10-17 years entering the criminal justice system for the first time in Croydon was significantly worse than the London and England average in 2017 (*JSNA, 2018*).

Commissioning and planning of most health services for children and young people are carried out by Croydon Clinical Commissioning Group (CCG).

Acute hospital services including maternity, children's services and the emergency department are provided by Croydon Health Services NHS Trust (CHS).

Community based services including health visiting, Family Nurse Partnership and school nursing are commissioned by Public Health in Croydon Local Authority and provided by Croydon Health Services NHS Trust (CHS).

Sexual health services for children, young people and adults are commissioned by Public Health in Croydon Local Authority and provided by Croydon Health Services NHS Trust (CHS).

Child and Adolescent Mental Health Services (CAMHS) and adult mental health services are provided by South London and Maudsley NHS Foundation Trust (SLaM).

Specialist facilities for eating disorders and inpatient mental health services for children and young people are provided by South London and Maudsley NHS Foundation Trust (SLaM).

Substance misuse services for adults and young people are commissioned by Public Health in Croydon Local Authority and provided by Turning Point.

The last safeguarding inspection of health services for Croydon's children and young people took place in 2016 as a joint targeted area inspection with the theme of child sexual exploitation, with Ofsted; HMI Constabulary, Fire and Rescue; and HMI Probation. Recommendations from that inspection were considered as part of this review.

The report

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

What people told us

- We heard from a new parent using the midwifery service.

They told us:

“We are very pleased with the maternity service, the midwives are really friendly and all was ok with the healthcare we received. This is our first child and we would have liked a bit more information, but we were given leaflets and information about vaccines, which gave us the things we need to reassure us.”

- We heard from the parent of two young children in the health visiting service.

They told us:

“They [midwives, health visitors and the GP] have been really effective and supportive in getting the care right for me and my children. The health visitor is really flexible, and we work round each other.”

They also told us about a delay in accessing health services when they first moved into Croydon, but once accessed, they were happy with all services received.

- We heard from a carer with parental responsibility for two looked after children using the CAMHS service.

They told us that they had been disappointed at one of the children's last medication reviews [in CAMHS] as it was less focused on the child's care and more focused on the medicine. They also told us that communication between CAMHS and the social work looked after children team was very good. They told us that they had not been involved in planning the current care plan for one of the children, but that the service was good at obtaining the child's views.

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 Referrals by health professionals in Croydon Health Services NHS Trust (CHS) to the Single Point of Contact (SPOC) for Early Help are generally of poor quality. Voice of the child and assessment of risk was evident in just a fifth of referrals examined during our visit to the MASH, and none contained a thorough analysis to consider the impact of familial circumstances on the child or young person. *This will also be brought to the attention of the public health commissioners.*
Recommendation 2.1

1.2 Pregnant women in Croydon do not routinely benefit from their GPs' contribution to the assessment of risk. Although midwives share safeguarding and obstetric concerns with the GP, we did not see any evidence of GPs sharing important information which would contribute to the assessment of risk. We were told that some midwives can access the GP electronic patient record although we did not see any evidence of this in practice. This restricts the opportunity for all practitioners involved in the provision of care for pregnant women to plan individualised care and intervention based on holistic information. In one case record reviewed, the GP held important information that was not shared and would have alerted the midwife to significant concerns. **Recommendations 5.1 and 7.1**

1.3 Pregnant women who are at risk of, or who are suffering with mental ill-health, are able to access targeted and effective support. Women who need the dedicated services of the peri-natal mental health team are seen at a local clinic where assessment, advice and support is provided by a specialist midwife alongside an obstetrician specialising in mental health. For example, in one of the cases reviewed we saw a good proactive approach to co-ordinated care which means that the pregnant woman and her baby were safeguarded well.

1.4 Pregnant women who disclose domestic violence and abuse are supported by the CHS Independent Domestic Violence Advocates (IDVAs). We have seen evidence of good and effective liaison with the multi-agency risk assessment conference (MARAC) and sensitive planning to reduce risk. Midwives use the nationally recognised domestic abuse, stalking and honour-based violence (DASH) risk assessment to inform decision making around next steps following a disclosure, and there is close working between the IDVAs and the MARAC.

1.5 Pregnant women with identified vulnerabilities benefit from targeted home visits by midwives in CHS. Midwives will often undertake home visits with other professionals such as children's social workers, substance misuse practitioners and the peri-natal mental health team, to provide a joined-up approach to care. Women who have not already had additional vulnerabilities identified however, are not offered a home visit due to limited capacity. This restricts the opportunity for the early identification of previously unidentified risk through assessment of the home circumstances.

1.6 An effective multi-disciplinary psycho-social meeting takes place monthly at CHS' Croydon University Hospital, which involves a discussion about all pregnant women where safeguarding concerns have been identified. The attendees work together to produce good plans. Ongoing monitoring of cases takes place at the meetings, including the review of progress made, and are held alongside the community midwifery safeguarding meetings. This ensures a collaborative approach to planning the women's individualised maternity care, with a focus on safeguarding the unborn child.

In one area of Croydon, the health visiting team have identified some 'hard to reach' families. As a result, they have recently started a 'pop-up session' delivered in a local community centre to promote local services available for children and families within the local area. The sessions are promoted by giving out leaflets at the local market. This demonstrates innovative practice to better engage families and encourage them to access sources of support to help them to prioritise, and meet, the needs of their children.

1.7 Antenatal contacts are not routinely being offered to pregnant women, as part of the universal health visiting service. This limits the opportunity for a thorough assessment of holistic family health needs prior to birth and restricts the possibility for early intervention. Vulnerable women known to the health visiting service or identified through the monthly meeting between midwifery and health visiting leads however, are offered an antenatal contact in order to commence a detailed assessment of needs and risks. To improve the compliance of the antenatal mandated contact, we were told that improvement work has been carried out to strengthen the midwifery notification process, but we have not been able to assess its impact. *This will also be brought to the attention of the public health commissioners.* **Recommendations 2.2 and 2.11**

1.8 Furthermore, families who move into Croydon from another area and are categorised as requiring a universal health visiting service are not offered a face-to-face transfer-in contact. This restricts the opportunity for an updated assessment of need and risk, based on the changed circumstances that have led to the move, including the impact the new circumstances may have on the child and family. The lack of contact therefore, hinders the early identification and intervention for children and families in need of additional support. Leaders in CHS are aware of this and it has been added to the Trust's 'risk register' and RAG rated at red. *This will also be brought to the attention of the public health commissioners.* **Recommendations 2.3 and 2.11**

1.9 Children within the universal health visiting service who miss development reviews, are not routinely followed up. Furthermore, families deemed to require a universal service at the new birth visit are not allocated a named health visitor. There is a lack of oversight of the universal caseloads and children could miss several universal contacts without being followed up. This lack of oversight and robust follow up results in missed opportunities to identify hidden harm. Whilst the 'was not brought' policy is under review at present, the current arrangements do not sufficiently safeguard children in families where there may be changing risk. *This will also be brought to the attention of the public health commissioners.* **Recommendations 2.3 and 2.11**

1.10 Conversely, GPs in the practices we visited and substance misuse practitioners in Turning Point, do recognise the risks that children and young people missing appointments may signify. Where children and young people are subject to a child protection plan, are not brought to GP appointments and the parents are not contactable after two attempts, a referral to the multi-agency safeguarding hub (MASH) is initiated. There is a robust 'did not attend' policy in place in the young person's substance misuse service. This good practice ensures that the professionals are considering the hidden harm that missed appointments may indicate and are taking appropriate action to safeguard children.

1.11 Children and young people do not have access to a comprehensive school nursing service. The school nursing teams comprise predominantly of community staff nurses, with three specialist community public health nurses (SCPHN) holding caseload responsibility. Both staff nurses and SCPHN will be referred to as school nurses throughout this report. Staffing shortages have impacted on the opportunities for children and young people to engage with school nurses. The current offer does not include any drop-in clinics at primary or secondary school. Currently there is a universal offer of screening through school entry questionnaires, however, because of capacity the effectiveness of this is significantly reduced. This means that children and young people are not able to access early intervention and support in a timely manner. *This will also be brought to the attention of the public health commissioners.* **Recommendation 2.11**

1.12 Children and young people in Croydon with mental ill-health are able to work with the practitioners who are best placed to meet their needs. The Child and Adolescent Mental Health Service (CAMHS) provided by South London and Maudsley NHS Foundation Trust (SLaM) is configured in a way that enables children and young people to access the most appropriate level of support. This is achieved through the establishment of four teams offering different levels of contact or intervention depending on the nature of the identified need. These are the 'getting advice', 'getting help', 'getting more help' and 'getting support with risk' (GSRW) teams. The GSRW team is staffed by a multi-disciplinary team of practitioners who are skilled and experienced in working in partnership with other agencies to support vulnerable children and young people. This includes looked after children, those subject to child in need or child protection plans, and those for whom there are wider safeguarding concerns.

1.13 Effective systems in CAMHS further ensure children and young people who are referred into the service can gain access to the most appropriate support. Referrals are subject to an initial review by a duty clinician on the day of receipt, then passed to a multi-disciplinary meeting to determine whether the referral is appropriate for CAMHS. Referrals for children with moderate or severe mental ill-health are accepted and children and young people are placed on a waiting list, which has reduced from one year to the current wait of 12 weeks for non-urgent referrals. Children whose referrals are not accepted are re-directed to Early Help or to one of the two third sector organisations who support children with managing anxieties and emotional resilience known as 'Off the Record' and the 'Croydon Drop-in'. This means that children are signposted to other, more appropriate services to provide support to meet their emotional well-being needs.

1.14 The most vulnerable children and young people with mental ill-health benefit from good joint working arrangements between the services supporting them. The CAMHS GSWR team has strong relationships with other agencies. Practitioners engage in regular meetings with other agencies, such as the looked after children's social work team, looked after children's placement managers, foster carers, and the youth offending service. These meetings, known as 'network meetings' are held regularly according to the child's current level of intervention, when risks and concerns escalate, or when other issues are identified that need to be addressed through a collaborative approach. This enables multi-agency practitioners to amend care plans and deliver the most appropriate support, by the right person and at the right time; and was evident in the children's records we reviewed.

1.15 The Croydon sexual health service strives to engage young people at the earliest opportunity. Young people attending the drop-in clinic open to all ages, are prioritised ahead of adults to ensure they are assessed as quickly as possible. This means that the most vulnerable who may otherwise not wait to be seen, have their needs assessed at the time they attend.

2. Children in need

2.1 Pregnant women who book their pregnancy with the maternity service in CHS, benefit from a comprehensive assessment of risk and vulnerability. In all records reviewed, we saw evidence of information being collected around the father's details, female genital mutilation (FGM) was always explored, the routine question around domestic violence and abuse was asked in most bookings, and there was good exploration of substance misuse. This helps to identify risk and make plans to protect the unborn child.

2.2 The youngest children have their experience of daily life appropriately considered in family health needs assessments. Health visitors and family nurses in the Family Nurse Partnership (FNP) routinely document their detailed observations, assessments and plans in children's health records. Records we reviewed clearly demonstrated analysis of risk and articulated strong voice of the child. This supports the planning of care and intervention that keeps the child as the focus.

2.3 The arrangements to transfer children from health visiting to school nursing are not robust. In records we examined we did not see any evidence of a detailed transfer between the services even when the child was subject to a child protection plan. *This will also be brought to the attention of the public health commissioners.*
Recommendations 2.4 and 2.11

2.4 The national child measurement programme (NCMP) is provided by the school nursing service and is available to all children in reception and again in year six. Where children are identified with underweight or overweight that may impact upon their health, referrals are made to the local weight management programme, 'Palace for Life' which is run by a local football team. This intervention demonstrates a positive impact of the NCMP screening programme on children's lives.

2.5 The school nursing service are commissioned to support schools with the development of health care plans, alongside a traded service to provide training to education staff on complex health needs. A Band 6 nurse has very recently been recruited to identify and work with children and young people who demonstrate risk taking behaviours, although it is too soon to evaluate the impact of this post.

2.6 Children and young people who require a health needs assessment by the school nursing service receive a holistic and thorough review which reflects well the voice of the child. We have seen evidence of how children and young people feel confident in disclosing their worries to school nurses and how these are effectively escalated to children's social care.

2.7 Children and young people accessing unscheduled healthcare in the GP Hub do not consistently receive a holistic assessment of needs and risks. Assessment templates to identify vulnerabilities such as domestic abuse, child sexual and criminal exploitation, substance misuse, and mental ill-health, are available for staff to use in the GP Hub, but these are not routinely completed. There is a commitment from leads to embed these tools into practice but currently, this lack of a complete assessment, analysis of need, and professional curiosity may leave children and young people at risk of harm. **Recommendation 2.6**

2.8 The local area are proud of the work they have done to increase the priority of the 'Think Family' agenda across services. Such raised awareness in the Emergency Department (ED) at Croydon University Hospital is evident by an increase in the number of referrals to the MASH however, the quality of referrals is poor. Such poor quality in referrals is despite good attendance by acute staff at safeguarding training that incorporates thresholds, referrals and the importance of analysis in order to safeguard children. The safeguarding advisors report the barrier being in the application of training into practice due to a lack of capacity. **Recommendations 2.1 and 8.1**

2.9 Furthermore, the ED attendance paperwork has been improved and developed to incorporate sections to prompt the practitioner to consider hidden harm to children and improve professional curiosity, but in records reviewed we found these sections were often not completed and there is no management oversight or audit processes to monitor completeness. **Recommendation 8.1**

2.10 The lack of a consistently robust 'Think Family' approach was also evident in some cases reviewed in substance misuse services and the adult mental health service, despite a thorough 'Think Family' strategy. Although an example of good practice was seen in adult substance misuse where lockable storage boxes and information on safe storage of medicines are issued to service users, further improvements are required to fully embed the 'Think Family' concept into frontline practice. *This will also be brought to the attention of the public health commissioners.* **Recommendation 8.1**

2.11 Children and young people attending the ED do not always benefit from practitioners who effectively consider their holistic needs and risks. The lack of professional curiosity in the ED, in conjunction with outdated safeguarding screening tools, do not support staff to gather and analyse information about vulnerabilities. This means that practitioners are not always aware of potential safeguarding risks. This does not facilitate a holistic approach to care and management of the child and their family. **Recommendation 2.6**

2.12 The new and updated design of the ED has been planned with safety at the centre. There are separate booking in procedures for children and young people as well as secure, age appropriate waiting areas. The environment allows staff to monitor children and young people easily. There are also a number of suitable rooms that are used for children and young people who attend ED in mental health crisis. ED staff told us they have good liaison with CAMHS practitioners and feel adequately supported.

2.13 Children and young people who attend the ED with self-harming behaviour or who are at risk of suicide, benefit from effective arrangements in place to enable CAMHS practitioners to see, assess and follow-up in a timely and appropriate manner. The initial response is provided by the CAMHS crisis team or duty psychiatrist, and children are seen in either the ED, the paediatric ward, or the acute medical unit if they are aged 16 or 17-years-old. This means that young people, including those who are seen initially in the adult ED, are assessed by staff from the crisis team who have the required skills and experience to support young people as is required by *'Self-harm in over 8s: short-term management and prevention of recurrence' NICE, 2004, chapters 1.4 and 1.9*. Arrangements for children seen by the CAMHS crisis team who are fit enough for discharge, include a review the following day if necessary, otherwise within seven days, as well as an onward referral into the community CAMHS team. This ensures timely and appropriate support for children and young people to meet their mental health needs.

CAMHS staff attend all partnership meetings for the children and young people they are supporting, including children in need meetings. This enables partners to take account of a child or young person's emotional well-being and mental health needs when making plans.

In one of the cases we were tracking across services, the CAMHS systemic psychotherapist worked closely with the young person's parent, the social worker, the placement manager and the youth offending service to ensure their needs were met in a co-ordinated and targeted way and using a variety of interventions.

CAMHS interventions included family therapy and dialectical behavioural therapy – a talking therapy used to change unwanted behaviours such as self-harm. Frequent telephone and email dialogue between the young person's professionals' network and regular network meetings, including child in need meetings, meant that practitioners were always up-to-date with their progress and expectations.

The young person's current goals relate to transition to adulthood and semi-independent living. The co-ordinated longitudinal support provided to the young person enabled them to achieve positive outcomes, particularly in relation to education where they had achieved 80% school attendance after previously having not attended at all.

2.14 Children and young people admitted to the children's ward at Croydon University Hospital do not have their immediate safety effectively considered and protected. We did not see any evidence of environmental risk assessments in place. Risks such as ligature points are not identified or isolated which means children and young people continue to be at risk of significant harm whilst on the ward.

Recommendation 2.7

2.15 Sexual health practitioners demonstrate strong professional curiosity, including 'Think Family' which is evident in their record keeping. Assessments, referrals and letters to multi-disciplinary and multi-agency colleagues capture the voice of the child well. Furthermore, records articulate a clear analysis of risk and impact for the young person. In one example reviewed, the young person was also the parent of an infant and consideration was given to the risks to the infant as well as the young person, and appropriate multi-agency liaison was evident. This enhanced the opportunity for the safeguarding needs of the infant to be properly assessed and improved.

2.16 Young people accessing sexual health and substance misuse services benefit from detailed and thorough risk assessments. Young people have a comprehensive risk assessment completed at the initial contact and updated at each contact thereafter in the event of a change in circumstances. This means that the risks young people may face from sexual and criminal exploitation, alcohol and substance misuse, mental ill-health, child abuse, domestic abuse, or FGM, are fully assessed, analysed and appropriate action taken to reduce the risks.

A vulnerable young person subject to a child in need plan was referred to the young person's substance misuse service by a third sector organisation working with vulnerable young people.

Whilst there was evidence of good multi-agency liaison between the substance misuse service, CAMHS and children's social care, the minutes and plans arising from multi-agency meetings were not attached to the young person's records resulting in an incomplete record.

There were two occasions where the young person was identified to be missing, and again, there was evidence of effective information sharing between services but no apparent multi-agency response to keep this young person safe.

Following the first missing episode, significant concerns relating the risks of child sexual exploitation were clearly shared by other professionals with the substance misuse service and documented, yet the risks were not explored further with the young person by the substance misuse key worker at the subsequent contact. However, county lines risks were discussed, and the young person made concerning disclosures relating to four separate incidents without any evidence of appropriate escalation.

There was evidence in this case of a lack of risk assessment, professional curiosity and escalation of concern which meant that the young person remained at risk from sexual and criminal exploitation.

2.17 Risk assessments in the adult mental health service are also updated regularly whenever a person's situation changes, or new risks are identified. Care plans arising from them are generally of a good standard although in two of the cases we reviewed the relapse plan was limited. It was not clear how a relapse would be identified and how any risks to, or impact upon the clients' children would be mitigated.

3. Child protection

3.1 The contribution to child protection processes by health practitioners in Croydon, including information sharing to support multi-agency decision making and attendance at conferences, is inconsistent and in some services, weak.

3.2 Referrals to the MASH submitted by midwives, CAMHS practitioners from the GSWR team, sexual health practitioners, young person's and adult substance misuse practitioners, and adult mental health practitioners, demonstrated clear analysis of risk and contained good information to support effective decision making.

3.3 Referrals to the MASH submitted by health visitors, school nurses and ED practitioners however, were of poor quality, contained limited descriptive information and did not articulate risk well and did not effectively capture the voice of the child. This was also the case with referrals to the SPOC for Early Help. *This will also be brought to the attention of the public health commissioners.* **Recommendation 2.1**

3.4 A multi-agency pre-birth protocol supports midwives to submit referrals into the MASH from 12-weeks' gestation. There is an expectation that pre-birth child protection conferences take place by the 30th week of pregnancy. We were told that most pre-birth planning and initial case conferences do start within or around this time.

3.5 Health visitors, family nurses and school nurses are not always invited to contribute to strategy discussions or MARACs, and evidence of safeguarding advisors' contribution on behalf of CHS is often absent from children's electronic health records. GPs are rarely informed of discussions at MARAC relating to their patients. This increases the risk of relevant information not being shared that could contribute to the decision-making process in the best interest of the child. *This will also be brought to the attention of the public health commissioners.* **Recommendations 5.2, 7.1 and 7.2**

3.6 Involvement of practitioners across the health economy in initial and review child protection conferences is also variable and, in some services, underdeveloped. Health visitors, family nurses, school nurses, and adult mental health practitioners are not routinely invited to attend, and when they are invited, the ongoing capacity issues means they are not always able to. School nurse health assessments and plans are often only completed if identified as a requirement for a child protection plan and are not always timely or reflected in the minutes. Such limited contribution to child protection processes means that children and young people do not always have their health needs sufficiently considered in multi-agency decision making and planning. *This will also be brought to the attention of the public health commissioners.* **Recommendations 2.11, 5.2, 7.1 and 7.2**

3.7 Midwives, sexual health and CAMHS practitioners however, are invited and always attend or submit a detailed report with good analysis. In one CAMHS case and one sexual health case reviewed, the quality of the report was exceptional. This supports the conference attendees to make good, accountable decisions. There is sometimes a delay in the midwifery service being able to identify and locate a pregnant woman on the recording system, based on the information included on the children's social care request which uses a unique index number exclusive to the local authority. This can cause a delay in responding to requests for information.

3.8 There is a process in place to complete an incident reporting form if practitioners are not invited to the initial case conferences, which is then escalated to leaders within health and social care services, but the effectiveness and impact of this could not be demonstrated at the time of our review.

3.9 Child protection conference minutes and plans are not consistently shared with staff across the health economy. Children's electronic health records kept by GPs, health visitors, family nurses, school nurses and substance misuse practitioners do not routinely contain minutes or plans. When midwives and sexual health practitioners attend child protection conferences, minutes and plans are shared and were attached to the records we reviewed; yet they are not always shared when a report is submitted in lieu of attendance. Records are often therefore, incomplete and lack a clear narrative and safeguarding action plan to protect the child. *This will also be brought to the attention of the public health commissioners.* **Recommendations 2.15 and 7.2**

3.10 Children and young people who are home educated are unable to access a full school nursing service. The school nursing service have not been commissioned by the public health commissioners to provide a service for this group. These children and young people are however, able to access immunisation sessions that take place in a clinic setting. This means that children and young people do not always receive an equitable service to assess and meet their needs and support them to be safe. *This will also be brought to the attention of the public health commissioners.* **Recommendations 2.8 and 2.11**

3.11 The approach to sharing information of concern in CHS, that does not meet thresholds for a MASH referral, is inconsistent. Practitioners we spoke to in the ED and the school nursing service were unclear about the correct proforma to use, we were unable to find evidence of completed forms on electronic records and one proforma was a basic tick box information sheet which does not support analysis. This means that practitioners do not always hold all relevant information to support decision making. Furthermore, there is a lack of quality assurance and audit processes, which means the safeguarding team do not have an accurate oversight of the number of referrals and cannot be assured that all referrals have been made as appropriate. *This will also be brought to the attention of the public health commissioners.* **Recommendation 2.9**

3.12 The use of the Child Protection Information System (CPIS) in the ED and the GP Hub, ensures that health professionals have an updated safeguarding history of those children and young people who are considered vulnerable and at risk. This enables them to provide better care and earlier protective interventions.

3.13 Staffing shortages in the ED cause delays in the timeliness of children and young people being assessed and treated. There are currently 10 nursing vacancies which mean the children and young people are not streamed as they enter the ED and are waiting for triage before they are assessed. This means children and young people's vulnerabilities are not being identified as quickly as possible.
Recommendation 2.11

3.14 Risk assessments for children who are accessing the CAMHS service are completed using a templated form on the electronic patient recording system. These templates require practitioners to consider, first and foremost, any safeguarding concerns including whether there is any risk presented by those close to the child or young person as well as any risks they pose to themselves. The risk assessments in the seven cases we reviewed were thorough and were updated regularly whenever there was a change in the child's behaviour or situation. Evolving risks were discussed at network meetings which enabled agencies to take account of these when agreeing changes in support arrangements.

3.15 Risk assessments completed by practitioners in adult mental health, adult and young person's substance misuse, and sexual health services are generally also thorough, detailed and analyse risk well. In some of the cases we tracked across services however, there was a lack of professional curiosity which resulted in delays in required safeguarding action being taken.

3.16 Safeguarding referrals are made by all CAMHS staff who identify potential abuse of the young people they are supporting. Where children are already known to children's social care, referrals are passed immediately to allocated social workers as part of the professionals' network arrangements. These were well documented in records we reviewed of children who were being supported by the GSWR team. We were not able to review any referrals made by practitioners from other CAMHS teams although all referrals are tracked and monitored by the Croydon CAMHS safeguarding lead practitioner. Similarly, information relating to child protection conferences is also monitored and tracked and this ensures the safeguarding lead practitioner has good oversight of all such activity.

3.17 The sexual health service is not routinely represented in the multi-agency child exploitation (MACE) meetings. Practitioners do contribute to the MACE meetings on a case by case basis, but do not form part of the panel on a regular basis. This limits the opportunity for the specialist knowledge and skills of these professionals to inform decision making for young people at risk. *This will also be brought to the attention of the public health commissioners.* **Recommendation 2.12**

3.18 The most vulnerable young people in Croydon are alerted to the sexual health service regardless of whether they are already known. The service creates new records for vulnerable young people brought to their attention by multi-agency colleagues, for example those who are missing. This means that in the event of the missing young person accessing the sexual health service, a swift multi-agency response to safeguard the young person is possible.

3.19 When service users access the adult mental health service for the first time, they are subject to a robust screening discussion by the assessment and liaison team. The discussion involves practitioners from different disciplines to consider risks that are identified, including those that relate to the service users' families. In two records we examined, we saw that good decisions had been made to initiate contact with children's social care to share information about those risks.

3.20 Information sharing between the adult mental health service and other health providers, such as GPs and health visitors, and with children's social care, is variable. In two of the seven cases we reviewed, there had been delays in the service receiving important information. In one case, this had led to an injury to child being missed by the service, as well as the ensuing strategy meeting and initial child protection conference. We acknowledge that, in this case the staff member to whom the information was sent had been on leave, but there was no system to enable their inbox to be checked, or for information to be sent to the service's generic inbox. This meant that the adult mental health service missed the opportunity to participate in key safeguarding processes. [Recommendation 7.1](#)

3.21 Information sharing and joint working between CAMHS, young person's substance misuse and sexual health services however, is stronger and improves practice for the most vulnerable children and young people.

3.22 The adult mental health service is represented at the MARAC by the team manager from the mood, anxiety and personality disorder treatment team. Information about clients who are discussed at the MARAC are researched and shared. This ensures that information is risk assessed and shared by an appropriately senior staff member who can agree to any ensuing monitoring activity required by the service.

4. Looked after children

4.1 The quality of initial and review health assessments, and health action plans for looked after children in Croydon is variable. Local leaders are aware of the areas that need to be improved, through their own audit of assessments completed by North Croydon Medical Centre. Required improvements however, were not yet evident in the assessments we reviewed.

4.2 Initial health assessments of children new to care are carried out by two separately commissioned providers and initial health assessments carried out by the primary care provider were not as detailed across a range of parameters as those for children under 5-years that were carried out by CHS.

4.3 Records we examined showed that there was often superficial exploration of important aspects of children and young people's health histories. Assessments of physical health were sometimes incomplete, this was also the case in those audited by leaders. In three of the seven records reviewed for children aged five to 18 years, the bespoke template for examining a young person's emotional health and well-being did not always contain sufficient information. In another assessment of a 15-year-old young person, they had not been asked to consent to the review, they were referred to as 'the patient' and they were not provided with a copy of their health plan. In addition, there are no arrangements in place to obtain from the local authority the outcome of strengths and difficulties questionnaires (SDQ) to support an assessment of young people's emotional health. This means that assessments do not accurately reflect the holistic health needs of children and young people. **Recommendations 4.1, 6.1 and 6.3**

4.4 The arrangements for gaining access to information held on the electronic patient recording systems used by both providers and GPs are fragmented. GPs told us they are rarely invited to contribute to looked after children's health assessments. In some records reviewed, information about, for example, hearing checks was not always available to assessors and so did not feature in the assessments. Information about immunisations was also variable and differed between the recording systems and so could not be relied upon to support accurate health planning. **Recommendation 4.2**

4.5 Looked after children's health action plans mostly reflect areas of risk identified in both initial and review health assessments. However, in four of the eleven records reviewed across all three age bands (0-4, 5-10 and 11-18-years) we noted that actions were not sufficiently specific or timebound. This does not support the looked after children's health service to measure any health improvement arising from the action plan and was identified as an area for development in an audit completed by leaders. **Recommendation 6.4**

4.6 The voice of the child was not consistently captured in looked after children's health assessments. For example, in a health assessment of a five-year-old child who was new to care, the assessor had relied upon the reports from the child's relatives and foster carers in relation to questions about how the child was feeling. In this case the child had no opportunity to tell the assessor how they felt at a time when they had been recently removed from their birth parent. In the case of another looked after child aged nine years, the health action plan was not child focused. An action relating to the child's personal hygiene and bathing habits was attributed to the child, and not to the carer or any other adult with responsibility. **Recommendation 6.2**

4.7 Consent to carry out looked after children's health assessments was not properly managed in half of the records we reviewed and was identified as a weakness in a local audit. In one record of a young person who was seeking asylum, there was no record of consent being properly sought. This was despite it being clear that they were mature enough to understand the process and be given the opportunity to consent or not. In two of the records we saw that written consent had been properly obtained from a social worker acting on behalf of the local authority whom had parental responsibility. In one other case, however, the looked after children's health service had relied on an incorrect assumption that the referral itself from the local authority acted as a valid consent. **Recommendation 6.3**

4.8 The system for ensuring the timely completion of looked after children's initial health assessments for those placed out of the area, by the receiving local health service is not effective. The current arrangements for organising the large number of health assessments for looked after children who live locally are cumbersome and time-consuming impacting upon capacity within business support. In addition, the need to reduce the number of children who are not brought to clinic appointments has resulted in telephone contact with foster carers in an effort to manage appointments more efficiently. These demands on business support have led to drift in those assessments requested of other areas, as there is no additional capacity to follow-up those requests. This means that children placed out of Croydon have to wait to have their needs properly assessed, and none have been completed and returned within statutory timescales. **Recommendation 2.13**

4.9 Children and young people who are new to care, do not all have their health needs assessed within statutory timescales. This has been despite closer working relationships developed with the local authority since October 2018, which has resulted in improved notification times from 22% to 41% notified within three days over three months to December 2018. Although not satisfactory this is, nonetheless an improving picture. However, there has been a corresponding decline in the number of health assessments being completed within statutory timescales from 21% to 8% over the same period. This means that over 90% of children coming into care in Croydon are not seen on time and have to wait to have their health needs assessed, planned for and met which is unacceptable.

4.10 The process for quality assuring review health assessments is still being developed. Currently, only out of area review health assessments are subject to formal quality assurance by the named nurse for looked after children in CHS. These assessments are reviewed on their return to Croydon and any shortfalls are resolved through feedback to the assessing provider. A dip sample audit of health assessments carried out by local clinicians had been carried out in July 2018. This identified the same shortfalls in the quality of health assessments that we found in our more up-to-date sample of cases in this inspection and which we have outlined in this report. Therefore, the audit's impact on driving improvements has been limited. We have been advised that plans were well advanced to introduce a programme of clinical peer review audit involving selected cases and one-to-one discussions with practitioners. This programme had yet to begin at the time of our inspection. [Recommendations 4.1 and 6.1](#)

4.11 The number of children who are not brought to assessments has significantly improved. The introduction of the use of telephone calls to foster carers to check availability for clinic appointments, as opposed to the former, letter based system, has reduced the number of missed appointments although we have not been provided with any data to support this. CHS acknowledge that there is still work to be done to bring this figure down to acceptable levels due to foster carers who allow looked after children and young people to attend appointments unaccompanied. Part of the multi-professional improvement plan will be the implementation of a programme of joint visits between social workers and looked after children nurses to reduce the number of children and young people not brought to appointments still further although we cannot assess the impact of this yet. [Recommendation 2.17](#)

4.12 Looked after children with emotional well-being needs and mental ill-health are able to access the CAMHS quickly. All referrals to the service for looked after children are expedited through the initial review and referrals meeting and are allocated for assessment at the top of the waiting list. In one case we reviewed, an unaccompanied asylum-seeking young person who had been in the UK for over a year was referred to the service for an assessment. The young person was seen within one week and was quickly diagnosed with post-traumatic stress disorder. This meant they were able to access support without delay and their condition was prevented from worsening.

4.13 Children and young people who are about to leave care are provided with a leaving-care health summary based on a review of their records by the looked after children's nurses approximately two months prior to the young person leaving care. This is in letter format and contains information about the young person's health needs whilst being care. The letter also contains health promotion information to enable the young person to plan their own health care as they move into independent adult life. However, in records we reviewed, the health summaries were very brief and there was no evidence that the young people to whom they referred had been involved in compiling them. In which case, it was not clear if young people would find them of value.

For one young person who became looked after, there was a lack of robust multi-agency working. Prior to the young person becoming looked after, the school nurse had not attended any of the child protection conferences or core group meetings and did not contribute effectively to the safeguarding of this young person.

There was a delay in completing and initial health assessment of six-months, which was of poor quality. Consent to carry out the assessment was not sought from the young person. There was insufficient regard paid to parental history and other current presenting concerns, with conflicting information around immunisation history. It was also unclear whether the young person had received their own copy of the health plan and there was no evidence that CAMHS had contributed to the assessment.

This does not ensure that the health needs of vulnerable young people are met.

Management

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

5.1 Leadership and management

5.1.1 Senior leaders and operational managers across the Croydon health economy know themselves well. They are aware of the areas that require further development, as highlighted in the multi-professional action plan for looked after children for example and have carried out a lot of work to make improvements but have started from a low base. Further improvements are needed, and, in some cases, progress is too slow.

5.1.2 Arrangements for designated and named professionals in Croydon are improving. The newly appointed designated nurse for safeguarding children works closely with the designated doctor and the designated nurse for looked after children. The support, challenge, and supervision provided is highly valued by the named professionals. The CCG are aware that there is more work needed to strengthen arrangements including the appointment of designated doctor for looked after children, and further increasing capacity in the team of named professionals in CHS. There is a proposal in place to strengthen arrangements in the future, however greater scrutiny is required prior to its implementation, to ensure that designated professionals remain impartial and that governance structures are robust in enabling the CCG to monitor and hold providers to account.

5.1.3 Joint working is strong at a strategic leadership level. Senior leadership representation on the Croydon Safeguarding Children Board (CSCB) helps to ensure that the local area work together in identifying and implementing improvements for children, young people and their families. An example of the commitment to improve the culture of multi-agency working at the front line is the integration and co-location of health and social care staff who work specifically with looked after children. Such joint working promotes better consistency for the children and young people and a more collaborative workforce to better meet their holistic needs.

5.1.4 Health representation in the MASH has improved with four safeguarding advisors each rotating into the MASH on a weekly basis. Capacity remains under-developed however, with cover being provided on only four days per week. This means that referrals received on a Friday and rated amber, therefore requiring action within 24-hours, are not reviewed by a health practitioner until the following Monday. This increases the risk of escalation of need for children and young people, and further delays the response to hidden harm when valuable health information is not sought or accessed within agreed contractual timescales. [Recommendation 2.14](#)

5.1.5 There is a lack of a consistent approach in the MASH regarding requests for specific and valuable information from GPs, therefore the quality of information shared remains under-developed. There is no current pro-forma prompting professional curiosity or the analysis of health information or its impact for children and young people. Furthermore, there is no robust monitoring system in the MASH of requests for information made to GPs, or requests returned including timeliness. This limits the opportunity for effective decision making based on holistic information. **Recommendation 1.1**

5.1.6 The named GP within Croydon CCG is aware of the need to improve GPs' contribution to child protection processes. Workshops for GPs and staff from children's social care to raise knowledge and increase understanding of the importance of their own and each other's contribution to safeguarding, have been facilitated and attended by a number of staff. Part of the improvement work has included the introduction of 'bypass' telephone lines to allow MASH staff to access primary care quickly and request a timed telephone consultation appointment with a GP to request specific information to inform multi-agency decision making. However, not all practices have a 'bypass' line and further work is needed to remove barriers to effective information sharing. GPs we spoke to reported that information flows from children's social care remain under-developed. **Recommendations 1.1 and 1.2**

5.1.7 The introduction of GP safeguarding self-assessments has begun to increase the CCG's understanding of the contribution GPs make and where further improvements are needed to inform effective and appropriate multi-agency decision making in order to safeguard children. It is too early however, to demonstrate any impact.

5.1.8 The named midwife in CHS has good oversight of the safeguarding arrangements in midwifery services. The post is an integral part of the Trust's safeguarding arrangements. The named midwife also sits on the steering group for female genital mutilation (FGM) for the Trust and is instrumental in the development of the peri-natal mental health pathway across Croydon. This ensures that appropriately senior maternity staff are engaged in the development and improvement of safeguarding practices for women and their babies.

5.1.9 Health visiting, and school nursing caseloads remain too high, as identified in the joint targeted area inspection (JTAI) in 2016 and CHS' regulatory inspection in 2018. Increased caseloads have impacted on the delivery of the healthy child programme for families with children under 5-years-old. Not all schools have a named school nurse, but the majority have a named community staff nurse as there are only three specialist community public health nurses (SCPHN) responsible for the school caseloads. Commissioners are monitoring CHS' performance in meeting their contractual obligations and despite the challenges with capacity being on the CHS 'risk register', progress in driving improvements in this area is slow. *This will also be brought to the attention of the public health commissioners.* **Recommendation 2.11**

5.1.10 Recent appointments to senior leadership roles within the school nursing service however, has led to a renewed energy and enthusiasm to reconfigure the service and provide additional opportunities to identify and respond to health needs.

5.1.11 Health providers in Croydon participate in local safeguarding children board's learning initiatives. During the week of our review the CSCB held a large conference to share findings from a thematic review into the lives of 60 young people, including two serious case reviews, to increase understanding of risks faced by young people locally. Health practitioners from the providers in Croydon attended this event. The intention of the event was to enable those who attended to share learning from the published review with colleagues, although we cannot assess its impact for children and young people at this stage.

5.1.12 Team leaders from the CAMHS GSWR team attend all local operational panels where risk to individual clients is discussed. These include the Risk and Vulnerable Management Panel (attended by police, the youth offending service, children's social care and schools); the Gangs Management Panel and the MACE panel. This ensures that decisions can be made by these groups with insight about any child or young person's mental health.

5.1.13 SLAM have identified the need to develop and implement a 'Think Family' strategy across all of the Boroughs in its footprint, including Croydon. This strategy sets out the Trust's vision for an approach to recognise needs and secure positive outcomes, not just for a service user but for the whole family. The strategy was launched with a range of resources to support practitioners, service users and their families, to understand the impact of mental ill-health on family life. The strategy has been delivered through a series of workshops and has ensured staff, particularly those in the adult mental health services, can identify and respond to situations where children of service users may be at risk or have greater needs as a result of parental mental ill-health. The strategy has provided the basis for embedding family focused practice in adult services and this was evident in records we reviewed however, the Trust have yet to devise a programme to measure the impact of the strategy on practice.

5.2 Governance

5.2.1 The health representative in the MASH does not have oversight of all health referrals into the SPOC. Early Help and MASH referrals are all submitted to the SPOC, but only those categorised by children's social care as red or amber and therefore directed to the MASH, are routinely brought to the attention of the health representative. This means that decisions are often made regarding the outcome of a referral without complete health information. **Recommendation 2.14**

5.2.2 There are strong quality assurance and auditing processes within the adult and young person's substance misuse services. All referrals to the MASH are audited by team leaders and an incident reporting form is completed. This strengthens the opportunity to identify areas of good practice and areas for improvement at an operational level. Moreover, the team leaders within the young person's service review all comprehensive assessments which enables them to gain valuable insight into clinical practice, to ensure a consistent standard is being achieved, and to identify areas for development resulting in improved practice to safeguard children and young people.

5.2.3 The safeguarding team at Croydon University Hospital do not have the capacity or systems in place to routinely carry out functions in the ED such as conducting audits, quality assuring referrals or collating the referrals and sharing learning. Safeguarding information shared by the safeguarding team is not routinely received by ward staff, which indicates a lack of oversight in ensuring the process is effective. The liaison health visitor role in the ED is covered for four days with Friday-Sunday remaining uncovered. This means that referrals and information sharing of cases relating to children attending on these days is delayed until Monday morning. This impacts on the ability of all health practitioners to effectively plan care and intervention based on potentially important safeguarding information that is not always shared in a timely manner. **Recommendations 2.5 and 2.10**

5.2.4 There are robust flagging and alert system within children's electronic health records in community, primary and acute services across the Croydon health economy. This is important as it means that practitioners are aware of additional risks and vulnerabilities including whether a child or young person is looked after, when accessing personal records. However, such alerts are not always up to date with the most current information for individual children and young people. There is an initiative ongoing to cleanse health records and improve the accuracy of the alerts.

5.2.5 The electronic record keeping system used by the school nursing service has not been tailored for their use. It does not contain specific templates to promote professional curiosity and does not support the school nursing service to be efficient in their record keeping. *This will also be brought to the attention of the public health commissioners.* **Recommendation 2.16**

5.2.6 Furthermore, there are no effective or robust information sharing agreements in place to support effective joint working between GPs and multi-agency professionals working with children and young people. Health services sharing the same electronic recording system as many GPs have not been given access to valuable GP information. The 'GP Hub' walk-in-centre which offers unscheduled care, is able to access some GPs' records directly, but not all practices use the same system and there is no process in place for the remainder of practices. This impedes the opportunity for effective and appropriate decision making based upon complete health information to safeguard children and young people. **Recommendation 1.2**

5.2.7 Croydon has one of the largest populations of school age children and young people. We felt that the significantly reduced capacity within the school nursing service was not accurately reflected on the Trust's risk register. We were advised that capacity and administrative support within the school nursing team is rated as amber, whereas the impact of the high vacancy rates is having a significant and enduring impact on the availability of the team to identify and support children in need and at risk. *This will also be brought to the attention of the public health commissioners.* **Recommendation 2.11**

5.2.8 Governance arrangements are in place in the GP Hub. A safeguarding log is used to monitor and track referrals as well as outcomes for children and young people. Monthly audits are carried out on GPs' safeguarding practices and any areas highlighted for clinical improvement are used to inform learning. This robust practice supports staff to better safeguard the children and young people who use the service.

5.2.9 Referrals made to the MASH by practitioners in the adult mental health service are logged by the Croydon locality safeguarding team in SLaM. A database is maintained to enable progress to be tracked and actions arising from referrals to be monitored. Furthermore, daily team 'zoning' meetings enable practitioners to discuss cases of concern with their colleagues and supervisors and this supports good planning. Cases are RAG rated so that those of more serious concern are reviewed daily whilst those with significant concerns are reviewed weekly. Other cases are reviewed monthly but there is also a mechanism to escalate whenever concerns increase. This management process enables local managers to have good oversight of safeguarding activity of the team.

5.3 Training and supervision

5.3.1 The safeguarding team in CHS provide multi-disciplinary safeguarding children training at level two and level three that is accessed by both community and acute staff in accordance with ‘*Safeguarding children and young people: roles and competencies for health care staff. Intercollegiate Document. January 2019*’. The team have identified that there is further work to do to increase the application of the training into practice, to ensure that the children and young people of Croydon have their safeguarding needs identified and receive appropriate, timely support and intervention.

5.3.2 Compliance with safeguarding children training at the required level is good in the majority of services across the health economy. This includes acute and community services, and primary care with all clinicians including practice nurses, accessing level three. Managers in SLaM assure compliance through automated alerts from the training database whenever a staff member’s training is due to expire. The training of specialist midwives to level four demonstrates a strong commitment to safeguarding children. This means that children accessing the service are assessed by staff who understand and could make well-considered judgments about risk.

5.3.3 Training in the adult substance misuse service however, is under-developed. In this service, only managers are currently trained to level three, but plans were in place at the time of our review to imminently address this. *This will be brought to the attention of the public health commissioners.*

5.3.4 Training for staff in CHS following serious case reviews has covered practice improvement topics such as faltering growth, which has resulted in the development and implementation of a new pathway. A range of additional internal and external training is also available, including the graded care profile for identifying and responding to neglect, domestic violence and abuse, and adverse childhood experiences (ACEs) training. This increases the skills, knowledge and expertise of staff working with children and families, strengthening early identification and mitigating risk.

5.3.5 Multi-agency professionals from a wide variety of services including health, education and housing can access training on sexual health and child exploitation from the Young Person’s outreach team. The team also provide screening and information stalls at festivals and community events directly to young people, as well as sex and relationships education (SRE) ‘train the trainer’ sessions in schools and colleges. This raises awareness of sexual health and how sexual health links to the general health and well-being, and how to identify and work in partnership to safeguard young people at risk.

5.3.6 Supervision arrangements in community health services are robust. Midwives, health visitors, family nurses, and school nurses benefit from regular safeguarding supervision, which is clearly evident within case records. This means that children and families benefit from a workforce who are effectively challenged to improve practice. This could be further strengthened however, to improve referrals and engagement in multi-agency child protection processes.

5.3.7 Safeguarding supervision is delivered to CAMHS practitioners as part of the Trust's clinical and management supervision offer. All staff are required to attend a one-to-one session every month where case based safeguarding supervision is a standing agenda item. However, routine safeguarding supervision is not delivered to staff outside of clinical or management supervision. In addition, managers providing the supervision have received no specialised training. As such, these arrangements could be strengthened to ensure staff have access to good quality bespoke safeguarding supervision. [Recommendations 3.1 and 3.2](#)

5.3.8 Staff in CAMHS can also access advice and guidance from the Trust's specialist safeguarding team or from the Croydon safeguarding lead practitioner in SLaM. Such advice is common in advance of any referrals being made to children's social care and we saw that all advice was recorded on the child or young person's record as is good practice.

5.3.9 Safeguarding supervision takes place during monthly case management meetings for adult mental health practitioners. The progress of every safeguarding case held by practitioners is checked during the one-to-one sessions and advice and guidance given where needed. Managers support staff with risky situations in individual cases through safeguarding management discussions, known as 'SAM' discussions. These result in case notes being added to clients' records and often result in modified plans or actions.

5.3.10 In the adult and young person's substance misuse services provided by Turning Point, safeguarding is embedded in daily practice. Leaders and practitioners attend a variety of meetings on a daily basis and safeguarding is integrated into all meetings. For example, there is a 'flash meeting' held every morning to discuss any concerns highlighted from the previous day. It is also mandatory that staff attend weekly team meetings and structured multi-disciplinary team meeting which are based on case discussion.

5.3.11 Furthermore, the weekly multi-disciplinary team meetings held in the Croydon sexual health service are utilised to discuss individual cases to share knowledge and expertise regarding case management and next steps. These meetings are consistently documented in the young person's record and demonstrate further exploration of risk. This means that practitioners in both substance misuse and sexual health services are respectfully challenged where appropriate to ensure the young person receive the most appropriate care and intervention, and a multi-agency response where appropriate in order to keep them safe.

Recommendations

1. **Croydon Clinical Commissioning Group should:**

- 1.1 In collaboration with primary care providers and the local authority, develop and implement improved systems and processes to support GPs to effectively contribute to safeguarding processes within the multi-agency safeguarding hub (MASH).
- 1.2 In collaboration with primary care providers and the local authority, establish a process to enhance multi-agency information flows to and from primary care.

2. **Croydon Health Services NHS Trust should:**

- 2.1 Ensure that referrals to the single point of contact (SPOC) for early help and the MASH, provide sufficiently detailed information and analysis of risk to inform effective decision making.
- 2.2 Establish a service model that enables health visitors to complete all of the mandatory contacts required by the Healthy Child Programme, in order to identify and respond to additional needs, risks and vulnerabilities at the earliest opportunity.
- 2.3 Establish a service model that enables health visitors to assess the needs of families new to the area, as well as the follow-up of children who 'were not brought' to appointments, in order to identify and respond to additional needs, risks and vulnerabilities at the earliest opportunity.
- 2.4 Implement a robust and effective transition pathway for children transferring between the health visiting and school nursing services, to ensure that needs are tracked, and intervention maintained as appropriate.
- 2.5 Develop effective and efficient systems to ensure timely communication with primary care and community health practitioners when a child or young person attends the emergency department (ED).
- 2.6 Devise a robust system to ensure that all practitioners providing unscheduled care in the ED and GP Hubs, thoroughly assess and analyse safeguarding risks for children.
- 2.7 Ensure that safe and effective environmental risk assessments are embedded in the daily practice in acute clinical areas, where children and young people may be admitted in mental health crisis.

- 2.8 Establish a service model that ensures all children and young people can benefit from a public health nursing service, including those who are home educated.
- 2.9 Develop and implement a robust and consistent approach to sharing information of concern, when the threshold for referral to the MASH is not reached, to ensure appropriate exploration of risk has been made.
- 2.10 Review the capacity and effectiveness of the acute safeguarding team, to enable adequate oversight and assurance of safeguarding practice, given the high level of safeguarding activity and demand.
- 2.11 Increase the capacity in the ED and public health nursing services to ensure they are able to effectively meet demand and prevent delays in identifying and responding to safeguarding risks.
- 2.12 Collaborate with the local authority to improve the links that health services have with multi-agency panels such as MACE, in order to share valuable knowledge and expertise to inform decision making.
- 2.13 Establish robust systems to ensure the timely completion of health assessments for looked after children placed out of area, to achieve an equitable service that meets the needs of all looked after children.
- 2.14 Ensure that the health representation in the MASH is reviewed to provide sufficient capacity and oversight of referrals, and expertise in supporting wider multi-agency decision-making in response to risks to children and young people.
- 2.15 Work in conjunction with the local authority to strengthen processes to ensure the timely receipt and storage of all child protection minutes and plans to children's electronic health records.
- 2.16 Improve electronic systems to support professional curiosity and increase efficient record keeping in health services.
- 2.17 Work with the local authority to expediate the multi-agency plans to further reduce the number of looked after children who are not brought to appointments.

3. South London and Maudsley NHS Foundation Trust should:

- 3.1 Establish a programme of specialist safeguarding supervision training for all staff responsible for delivering supervision.
- 3.2 Implement a safeguarding supervision policy to ensure that CAMHS practitioners have access to effective and robust safeguarding supervision.

4. Croydon Clinical Commissioning Group, Croydon Health Services NHS Trust should and North Croydon Medical Centre should:

- 4.1 Work together to improve the quality assurance, monitoring and oversight processes regarding initial and review health assessments for looked after children.
- 4.2 Collaborate with primary care providers to devise a system that supports an improved contribution from GPs into initial health assessments, to ensure holistic health needs are considered.

5. Croydon Clinical Commissioning Group and Croydon Health Services NHS Trust should:

- 5.1 In conjunction with primary care providers, establish an effective and robust information sharing agreement to remove barriers to efficient joint working in the best interests of pregnant women and their babies.
- 5.2 Collaborate with the local authority to improve the consistency of information sharing with, and inclusion of, health services in safeguarding processes.

6. Croydon Health Services and North Croydon Medical Centre should:

- 6.1 Strengthen the quality and consistency of initial and review health assessments for looked after children. Ensure that assessments are sufficiently detailed and holistic and provide a comprehensive picture of the impact of adverse childhood experiences.
- 6.2 Ensure that the voice of the child is sufficiently captured, and at the centre of health assessments and action plans for looked after children; with documented evidence of choice being given.
- 6.3 Ensure that all practitioners completing initial and review health assessments are fully cognisant of the importance of consent.
- 6.4 Improve the quality of health action plans arising from initial and review health assessments, ensuring that they fully reflect a detailed and holistic analysis. Also, ensure that health action plans are sufficiently SMART and outcomes-focused, to meet needs and reduce risks to children.

7. Croydon Clinical Commissioning Group, Croydon Health Services NHS Trust and South London and Maudsley NHS Foundation Trust should:

- 7.1 Work in conjunction with primary care providers and the local authority to strengthen information sharing agreements between the sectors and develop a sufficiently robust system that has safeguarding at the centre.

- 7.2 Work together with primary care providers and the local authority to improve the consistency of health services' contribution to safeguarding processes, including attendance at child protection conferences.

8. Croydon Health Services NHS Trust, South London and Maudsley NHS Foundation Trust and Turning Point should:

- 8.1 Further strengthen and embed the 'Think Family' approach into the work of all frontline practitioners, to support practitioners to identify and appropriately respond to 'hidden harm'.

Next steps

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