

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

Children Looked After and Safeguarding

The role of health services in Redbridge

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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 Redbridge. 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 Redbridge, 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 2013.

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 56 children and young people.

Context of the review

The London Borough of Redbridge is located in North East London bordering Waltham Forest, Havering, Newham, Barking and Dagenham and Essex. Redbridge has a multi-cultural community with a population of approximately 284,400 residents, including over 78,600 children aged 0-19 years (approximately 27.6% of the total population (2012 population estimates)). Approximately 66% of its population might be from a minority ethnic background, Redbridge being the fourth most diverse borough in the country. Almost 37% of people living in Redbridge were born outside of England and 35,527 - 81% of school age children are from minority ethnic groups

Over 55% of children in Redbridge do not use English as their first language and 23% of children in Redbridge are living in poverty. Redbridge ranks 134th out of 326 local authority areas in England for indices of multiple deprivation.

Acute hospital services are provided by Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT). And Whipps Cross University Hospital, part of Barts Health Trust.

Community based services are provided by North East London NHS Foundation Trust (NELFT).

Child and Adolescent Mental Health Services (CAMHS) are provided by Redbridge Children and Families Service and NELFT.

The last inspection of health services for Redbridge children took place in January 2010 as a joint inspection, with Ofsted, of safeguarding and looked after children's services. Recommendations from that inspection are covered in this review. During the 2010 inspection both the 'overall effectiveness of safeguarding services' and the 'overall effectiveness of services for looked after children' were assessed as 'adequate.'

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

Whilst at Queen's Hospital we spoke with the parent of a five year old child who was waiting for an x-ray. We observed how the radiographer spoke to the child, explained what was going to happen and offered reassurance to both the child and parent. The parent told us that she was happy with her child's treatment and told us:

"We saw a nurse and doctor really quickly and now they are sorting her out."

We spoke with a young mother about her experiences of health visitor services. When talking about her own health visitor she told us:

"She's my friend. If I have any problems I can just call her. She asks all kinds of questions about him (her child) and as I don't speak good English she takes time to be with me and make sure everything is good."

She went on to tell us:

"She (the health visitor) suggested I go along to meetings for mothers at the children's centre. I am learning how to massage my baby which helps him settle and I meet other mothers there."

Another young mother we spoke with told us:

"I get everything I need. She (the health visitor) helps me to remember things like when my baby needs another injection (immunisation). It's reassuring to know she's around, I would get confused otherwise."

We asked a young mother if she had received enough information from the midwifery and health visitor services to help inform her about how best to provide care to her baby. She told us:

"I was given so much information it took me nearly two weeks to read through it all. It was almost too much information to take in. The health visitor I have now is very good but my first one wasn't as good. I was really nervous but I didn't see her much and we didn't talk much. I'm happy now though."

Another mother told us:

"I wish they would write in my diary in block capitals. She (the health visitor) puts things in it for me to do or appointments to go to but her handwriting is very difficult to read sometimes. I have mentioned it but she seems to forget."

We asked about how easy it was for mothers to contact their health visitors. One mother told us:

"If I need to call and she is not available someone else always puts me in touch with someone who can help me. I've never had a problem getting help or advice when I need it. There was only one time when my baby missed an appointment for his immunisation because of a breakdown in communication, but we soon made another appointment and it was sorted out pretty quickly."

We met with a group of young people and care leavers who use health services in Redbridge. When asked what area of health service provision they were most concerned about one young person told us:

"I would not feel confident in telling them (health professionals) anything personal because I would be worried that if I did they might tell my parents. I have friends that have mental health worries but they are too scared to tell anyone because they have heard people being talked about by health staff and they don't trust them."

They went on to tell us:

"It's about confidentiality. It doesn't really get explained to you what you are agreeing to, but you have to sign the form anyway, so sometimes it's just better not to tell anyone what your problems are, only then you still have the problem and you end up dealing with it on your own."

We spoke with care leavers about health information provided to them on leaving care. One care leaver told us:

"We get loads of information on loads of leaflets to look at. We get information about our immunisations and other health stuff when we leave care, but what we don't get is the really useful information like what to do about changing GP if we move to a different flat. I would have liked to have been given a little book with useful stuff in it rather than what I did get, phone numbers and things like that."

All of the young people we spoke with told us that they thought school nurses were good, but one person we spoke with told us:

"We had a school nurse drop in session at my school once but then it just stopped with no explanation. It would be good if it started up again."

Another young person told us:

“We spend half of our life at school. It’s like a second home. We need someone safe to talk to about issues that really affect us and a drop in session with the school nurse would be a good start.”

We spoke to one young person aged 10 and when asked about their school nurse they told us:

“She’s nice. She makes you feel better than you did before.”

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 professionals we spoke with told us that timeliness of responses by local authority safeguarding teams to referrals made is generally good, and on most occasions they are kept informed of the outcomes of any referrals made. Work is planned by the recently appointed designated nurse for safeguarding in Redbridge to further improving multi-agency partnership working.

1.2 The use of the Multi Agency Safeguarding Hub (MASH) was set up in Redbridge during March 2013 and is now well established. It provides confidential screening to ensure that timely and necessary interventions are considered and, where appropriate, implemented thus improving the outcomes for vulnerable children. We observed a multi-agency professionals meeting at the MASH and saw how cases referred in the previous day were discussed and signposted according to need.

1.3 One case we examined at the MASH demonstrated how a referral had been made by Emergency Department health professionals following attendance at the department of a young baby with their parents. Although there were no causes for concern identified by health professionals within the department at the time of the attendance, a detailed report was routinely submitted to health visitors and a referral made to the MASH for consideration of any other factors, such as previous incidents known to social services. Checks were then made by the various agencies at the MASH including health, and at the meeting it was decided little further action need be taken in this instance as there were no other mitigating factors that raised concern. Health visitors would be asked to meet with the family at home to discuss the incident to ensure the safety of the baby.

1.4 MASH interventions are graded one to four, with level one interventions being those that can safely be provided by universal services such as school nursing, level two interventions being mostly following domestic violence referrals made by police, level three being those cases that are referred on to a named social worker and requiring a Child In Need (CIN) plan and level four being for children and young people already the subject of child protection measures requiring the highest levels of intervention and support.

1.5 Multi-agency professionals who work as part of the MASH are co-located in one office. This promotes close partnership working and professional disputes regarding appropriate levels of intervention can be discussed in person to reduce delay. Multi-agency partners at the MASH include; the police public protection desk, health, education, probation, youth offending service, housing and children's social care.

1.6 Pan-London procedures regarding consent and information sharing assist in reducing delays, with most GPs reported to be pro-active in supporting the MASH. This has been facilitated by the lead GP for safeguarding taking the Pan-London procedures to GPs, and it is included as part of safeguarding training provided to them. However, the named GP is not routinely invited to MASH meetings, and they further identified a gap in that when GPs provide information to the MASH, return outcome information is not provided back to them. One GP we spoke with told us that they will often only find out that a young person has been referred to other agencies for help and support when those other agencies inform the GP of their involvement, such as Child and Adolescent Mental Health Services (CAMHS) or substance misuse services.

1.7 Domestic violence incidents are also referred to and assessed at the MASH. All domestic violence referrals made are uploaded to an electronic database and saved for future reference, whatever the decision on how to proceed. Health visitors and school nurses are routinely notified of domestic violence incidents so that they are made aware of children and young people who may be affected.

1.8 The MASH team recognise that referrals to the service do not always come from multi-agency professionals but also, for example, from concerned neighbours. These referrals generally contain limited information so professionals search their own databases to ensure relevant additional information, where available, is presented for consideration by the MASH. We were advised that GP information is routinely sought in these instances and this was confirmed by GPs we spoke with.

1.9 We were advised of one case that had been referred to MASH where a partner agency researched the name given and could not find any further information about the young person. However, checks undertaken by the specialist health practitioner at the MASH disclosed that the young person was now known by a different name to that previously recorded, and had previously been the subject of a child protection plan. This information directed those at the MASH in their decision making processes so that appropriate action could be taken to protect the young person.

1.10 Redbridge CCG actively engages via Local Safeguarding Children Boards (LSCB) with other professional agencies including police and probation services, to ensure children and young people at risk of child sexual exploitation (CSE) are identified and tracked through health. The 'Redbridge Approach' strategy to CSE includes the development of a high level action plan and training provision to front line staff in recognising and reporting CSE. Awareness training is also provided to placement providers and the voluntary sector.

1.11 A multi-agency sexual exploitation Panel (MASE) sits monthly to review current and repeat missing persons and continually evaluate arrangements and processes. The panel's priorities include establishing the extent of CSE in Redbridge, developing partnerships and raising awareness of the issues amongst young people.

1.12 The high priority that has been placed on CSE in Redbridge is seen as proactive work to help protect vulnerable children and young people from all walks of life, particularly those from the increasing number of families living in poverty and deprivation. However, across provider organisations, awareness of CSE and human trafficking is still being developed and this was evidenced in discussion with the named midwife, the specialist MASH health practitioner and GPs we spoke with. A recent CSE workshop lead by Social Care had significant numbers of NELFT school nurses in attendance. However, we saw that the infrastructure to collate local information and activity is still underdeveloped within Barking Havering Redbridge University Hospitals NHS Trust (BHRUT). Isolated cases are referred directly to social services. Implementation of MASE is new, and further developmental work to better engage health practitioners will further enforce this important area of work. (*Recommendation 1.1*)

1.13 The majority of referrals to midwifery services come from GPs who now use a template referral letter agreed across North East London. The letter contains information about risk and vulnerability, and in those cases seen documentation was completed well. Referrals to midwifery services are triaged on receipt at the service, and where vulnerability is identified clients are seen by the specialist midwives for booking where they are either accepted onto their caseloads or assigned to community midwives with consultation support provided.

1.14 There are specialist midwives for peri-natal mental health, substance misuse, learning disability, teenage pregnancy and bereavement. Cases seen demonstrated a good use of expertise in supporting vulnerable women throughout their pregnancy.

We examined a case of a Bangladeshi woman with two previous children who booked her third pregnancy via a community midwife. We saw that the GP booking form appropriately identified ethnicity and the need for interpreter and that no other risks were identified. At the time of booking there was an interpreter present to assist the expectant mother in the process. During the pregnancy the expectant mother became unwell and attended the Emergency Department complaining that she was hearing voices accusing her that she had hit her children. We saw that the Emergency Department completed a multi-agency referral form (MARF) and shared this with midwifery services.

The file showed good information sharing and co-working with joint visits taking place between different agencies and practitioners. The expectant mother's mental health continued to deteriorate and she was admitted to an adult mental health ward as an in-patient under a section of the Mental Health Act. During the in-patient stay she received regular ante natal care from the specialist midwife. There was no further deterioration in the expectant mother's mental health and the baby was delivered early. The mother was supported in the post natal ward by a registered mental nurse (RN) until her discharge home. Mother's mental health then deteriorated once again and both mother and baby were admitted to a mother and baby unit for further care and support.

1.15 All women booking their pregnancies are asked specific questions regarding domestic violence and female genital mutilation (FGM). Responses are kept confidential and stored on electronic records. From cases examined we saw that there is good availability of, and access to interpreters and midwifery services do not use family members to translate. This is good practice.

1.16 Midwives see all women alone for at least part of the session when booking in. This allows for discussion or disclosure around domestic violence and other sensitive issues.

1.17 In the records examined in midwifery we saw good evidence of father's details being obtained and recorded. In one case examined we saw how the expectant mother initially refused to disclose the father's details, but later spoke to the health visitor and the details as given were then recorded confidentially. This shows good awareness by health practitioners working within midwifery regarding the need to identify absent males, as this is a common feature in serious case reviews.

1.18 When examining case files held by health visitors and school nurses however, we saw that father details, especially when no longer in a relationship with the mother, were not always routinely recorded in either the mother or the child's records, even when an extensive criminal history was noted on the part of the father. (*Recommendation 5.1 and 5.2*)

1.19 A 'Hard-To-Reach' practitioner works within health visiting and school nursing, particularly targeting the travelling community to signpost vulnerable young people and families to appropriate services in this often difficult to engage sector of the community. This includes ensuring immunisations are provided and are up-to-date. They will also act as advocate in cases, where necessary, to ensure vulnerable young people are registered with a GP and where possible, a dentist.

1.20 Young people accessing contraception and sexual health (CASH) services provided by BHRUT are safeguarded well. Practitioners working with young people under 18 years are required to complete a comprehensive risk assessment which considers lifestyle, previous sexual activity and other factors which might indicate CSE. The pro forma also looks at other risk taking behaviours, including substance misuse. We saw evidence of how the form was used to prompt sensitive discussion with vulnerable young people and resulted in appropriate referrals to other agencies including counselling services, substance misuse services and on some cases information sharing with children's social care and police.

1.21 In one case we examined, a 14 year old female had attended the CASH services and initially had not disclosed any information that would indicate risk. However, during subsequent consultations it became evident that the girl had been referred to children's social care because of concerns around potential CSE. The practitioner in the case sought advice from the departmental safeguarding lead and there is evidence of sensitive planning, advice and support about her future decision making as well as good liaison with partner agencies.

1.22 Health visitors are routinely made aware of vulnerable mothers to be attending for ante-natal care by the maternal partnership. This is where formation is shared about this vulnerable group prior to the birth so that health visitors can better prepare to offer care and support. Health visitors also reported good working relationships with GPs, with them being allocated to individual GP practices so as to act as a conduit for information sharing. This was considered to generally be working well. However, GPs we spoke with told us that communication with health visitors, school nurses and CASH services was variable. One GP we spoke with told us that they found school nurses 'difficult to get hold of' and advised that some schools do not have school nurses in place. All Redbridge schools have an allocated School Nurse, apart from private schools. However, if there is a concern regarding a pupil within a private school and NELFT is notified of this, a school nurse will be identified to manage the concern.

1.23 Families with children who attend Queen's hospital requiring paediatric emergency department attention are queuing to register details at the main adult reception area despite a dedicated paediatric emergency department reception being available. We saw that this is because of poor signage which results in some families experiencing unnecessary delay in accessing treatment. (*Recommendation 6.1*)

1.24 Children and young people up to their 16th birthday are seen in a dedicated paediatric emergency department at Queens. Receptionists obtain and check demographic details and we observed how confidentiality was well maintained during this process. A GP is available to see and treat those children and young people with minor illness.

1.25 Children who have been seen in the paediatric emergency department at Queen's hospital and who require an x-ray, for example, have to return to the main reception area and wait to be called. We observed one child aged 10 who was waiting for x-ray and became most distressed when they witnessed an adult patient in the department vomiting and calling out in pain. (*Recommendation 6.2*)

1.26 The paediatric emergency department at Queen's hospital is starting to benefit from the most recent and successful recruitment drive for both nursing and medical paediatric trained staff. Good arrangements are in place to ensure that children are seen by the most appropriate clinician and all babies under 6 months old are seen by a paediatrician prior to discharge.

1.27 Support for young people attending the emergency department at Queen's hospital following an incident of alcohol or substance misuse is available through the local FUSION service (young people's substance misuse service) as provided by NELFT. However, the numbers of young people referred to the service from the emergency department are low and the opportunity to identify and offer early support and intervention is being missed. (*Recommendation 6.3*)

1.28 The recording of children in households of adults who attend the emergency department at Queens hospital following self-harm, substance misuse, mental health crises or after disclosing domestic violence is variable. We examined some cases that did not document whether or not the adult being treated had disclosed if children were in the household. This means that an opportunity to identify children at risk may be missed. The emergency department paperwork does not facilitate the recording of this detail. (*Recommendation 6.4 and 6.5*)

1.29 Whilst reviewing adult mental health services we saw evidence of robust birth planning for pregnant women who are supported by the peri-natal mental health service. These plans help to co-ordinate the women's care during birth and in the postnatal period.

1.30 Good integration and joint working between CAMHS and social care practitioners support those families, children and young people who require CAMHS services. Effective triage arrangements have been successful in reducing waiting times for children and young people to access services. There are good links with early intervention teams and there is a seamless approach to children moving between services, e.g. step up and step down. Attendance at child protection meetings is a priority and we saw how practitioners continue to try and engage with children and families who do not attend appointments where there are ongoing concerns.

1.31 However, in one case we saw the progress notes were incomplete and did not reflect consultations with the psychiatrist and the transfer of the case from one clinician to another had not been completed safely. This meant that the receiving clinician was not aware of the current status of the case and CAMHS had also not been represented at the last core group meeting. (*Recommendation 2.1*)

1.32 We spoke with one GP practice who told us that they will register a young person attending the surgery with adult guardians even when actual parental details are not available. They will take as many details as possible and then make appropriate referrals to social care and a 'flag' will also be placed on their computer system to highlight their concerns.

2. Children in need

2.1 Both health visitors and school nurses are generally working with large case loads and they told us that in some cases it is difficult for practitioners to maintain a clear understanding of children, young people and families, particularly when those vulnerable people do not meet the threshold for child protection measures to be put in place. Practitioners also told us of their frustration in not being able to provide as much health promotion and early intervention work as they would like and they are 'firefighting' cases that are brought to their attention. This can be particularly frustrating to newly qualified staff members who see early intervention and health promotion work as a key part of their role. However, we recognise that efforts are underway to address the recognised problems of practitioners carrying large caseloads by proactively seeking to increase both staff recruitment and retention.

2.2 When health visitors are requested to provide a health report for child protection conference, we saw that the reports contained a good level of information to help those attending conference make informed decisions regarding the level and type of support to be offered to vulnerable young people. The use of a template form guides practitioners in relation to the type of information that is required to be shared at these important meetings. There was, however, variable attendance at core groups, case conferences and pre-birth conferences. NELFT practitioners demonstrate a high level of attendance at pre-birth conference, case conferences and core groups when they are informed of the date and time and any changes to arrangements.

2.3 One health visitor case we examined demonstrated how the health professional, despite not being directed to ensure a referral was made to CAMHS (it being the designated responsibility of another agency following case conference), took it on herself to check with CAMHS to see how the referral was being progressed. Subsequent checks made by the health visitor disclosed that the referral had not been made and work continues in this case to ensure the young person receives appropriate mental health care and support. This shows good work and vigilance on the part of the health visitor.

2.4 We spoke with GP practices in Redbridge and were told that their practice staff are updated on any child/family where there is a safeguarding concern at monthly practice meetings. Staff bring new cases to the meetings and also discuss known safeguarding cases. These meetings are not routinely attended by health visitors which is a missed opportunity for them to obtain updates on known cases and also to improve communication between services.

2.5 School nurse and health visitor cases examined demonstrated good multi-agency partnership engagement to ensure best service provision to vulnerable young people. One case examined demonstrated continued information sharing even when the young person concerned was being educated other than at school and then dropped out of education altogether for a period of time. However, we did examine cases where minutes from case conferences had not been uploaded to computer databases and detailed explanation of roles and responsibilities from those meetings had also not been documented with an associated, clear health action plan put in place. Although individual practitioners were able to explain their perceived role in providing support to young people, if they were unavailable to provide that support due to sickness or other unavailability, it would not be clear to other health practitioners how to 'step in' to provide the necessary support. (*Recommendation 5.3*)

2.6 Young people we spoke with told us that 'drop in' school nurse facilities vary from school-to-school. One young person told us that at her school a drop in service had been arranged to take place once a week but that after the first week the service 'just stopped'. All of the young people we spoke with who had accessed school nurse facilities told us that they valued the service but would appreciate the accessibility of regular drop in services. (*Recommendation 5.4*)

2.7 Appropriate arrangements are in place to safeguard young people who attend the emergency department at Queen's hospital following an incident of self-harm. CAMHS practitioners attend promptly within working hours to carry out psychiatric assessments and detail the outcome of their assessment on the casualty record. This is good practice. Arrangements for out of hours work well though we were told there can be some delays. In cases seen however, all the young people were seen quickly and appropriate arrangements made for follow up prior to their discharge.

One case we examined was of a young person who attended the emergency department with a teacher following a disclosure of overdose. The young person was seen quickly by emergency department practitioners and a referral was made to CAMHS. The INTERACT team attended the emergency department and recorded the outcome of their assessment in the casualty record. The INTERACT team is a team of mental health practitioners who are able to support young people at home. A referral was made to children's social care which is standard protocol and information was shared with the young person's school nurse.

The young person in this case was admitted to the paediatric ward for a period of observation and discharged soon after. We saw that the young person has since engaged well with CAMHS.

2.8 We were told how sometimes there can be a delay in arranging an acute CAMHS psychiatric bed for those young people who attend the emergency department at Queen's hospital in acute mental health distress. Emergency department practitioners recognise that the department is not the appropriate place to care for these young people who are often admitted to the paediatric ward, however, this is often without specialist registered mental health nursing support. (*Recommendation 2.2*)

2.9 All attendances by children and young people at Queen's hospital emergency department are notified to the health visitor or school nurse and the GP. Emergency care is well supported by paediatric liaison practitioners both internally within the trust and externally by a paediatric liaison health visitor. All attendances of concern or referrals to children's social care are notified separately to the health visitor or school nurse through a completed 'information sharing form'.

2.10 Weekly multi-disciplinary, multi-agency psychosocial meetings take place at Queens hospital for all cases where referrals have been made to children's social care or where staff have felt referrals to other agencies were necessary (including those young people who self-harmed or in mental health crises). Cases are discussed and actions agreed. We examined minutes of the meetings and saw how agencies took responsibility for following up individual cases to ensure that children and young people were safeguarded appropriately.

2.11 However, the psychosocial meetings at Queen's hospital only considers those referrals made from the paediatric emergency department and not referrals or concerns identified by the adult emergency department when treating adults following incidences of domestic violence, mental health concerns or substance misuse where children were known to be in the household.

2.12 Whilst at Queen's hospital we saw evidence of good liaison between emergency department practitioners and the London ambulance service. Ambulance staff shared information appropriately about children in households where adults had been transported and also about potential risk to children because of adult behaviour or other concerns such as housing conditions.

2.13 Printed casualty cards used at Queen's hospital identify those children who are subject to child protection plans and also identify any repeat attendance. Medical practitioners are expected to follow the printed algorithm for checking for non-accidental injuries. However, there is no safeguarding risk assessment carried out by nursing staff at initial triage or by medical staff for any presentation other than physical injury. This means that opportunities to identify potential safeguarding concerns are being missed; especially as not all attendances by children are seen by clinicians within the emergency department, some being signposted to the departmental GP instead. (*Recommendation 6.6*)

2.14 The values of the psycho-social multi-disciplinary group meeting held weekly at King George hospital are felt to be extremely beneficial by staff working there. All cases that have been referred to social services are discussed. The Sister, who is also the hospital safeguarding link, attends this group and takes positive and negative feedback to the individuals who have referred cases of concern. We examined a case awaiting review at the next meeting and saw that it included details of a child of an adult who had attended the emergency department following self-harm. We were also informed that if a child attends the emergency department three times within one year they will automatically be referred to the psychosocial meeting.

2.15 The clinical team in the emergency department at King George hospital has been enhanced by the appointment of a dedicated paediatric emergency department consultant, able to provide specialist clinical knowledge to children and young people, and also to support to staff members within the department.

3. Child protection

3.1 Where vulnerability is identified in pregnancy, or where there are other serious concerns, midwives can complete a pre-CAF (common assessment framework tool) to initiate early help. Referrals are made to children's social care using the multi-agency risk form. The referral forms are shared appropriately with other health practitioners, including GPs and health visitors. All referral forms are copied to the named midwife and the safeguarding team and there are good safeguards in place to ensure that children's social care responds to the referral and that timely action is taken.

3.2 The implementation of pre-CAF in midwifery services is in its early stages and its use is being monitored closely. We did not see any use of the pre-CAF in files inspected.

3.3 Midwives regularly attend child protection conferences and strategy meetings. The safeguarding team monitor the submission of reports for conference and recognise the need for closer monitoring of core group attendance. It was reported that health visitors do not always attend initial child protection conferences for unborn children, a fact recognised by health visitors we spoke with who told us that this can be due to not receiving notification in a timely manner or due to current high workloads. We were told that work is underway to improve health visitor attendance at initial child protection conferences.

3.4 GPs we spoke with told us that they use a variety of systems to identify looked after children (LAC) children and those subject to child protection measures. This includes highlighting children living in families where domestic violence and substance misuse is known or suspected to take place.

3.5 Pregnant women with significant vulnerability around perinatal mental health or substance misuse are seen in dedicated clinics by obstetricians and midwives who have a specialist interest. From cases seen, women receive intensive, supportive and well-co-ordinated care. In one case where the woman had disengaged from services, the specialist midwife made significant and enduring attempts to re-establish contact and engage the woman in her ante natal care with some success.

3.6 Midwifery staff did not always respect the confidentiality of new mothers in the post natal ward. We spoke with one new mother who told us that a midwife disclosed personal and distressing information in an open bay in the presence of other women who it was believed overheard what was being said. (*Recommendation 6.7*)

We spoke with a new mother who had herself previously been a looked after child. Early in her pregnancy she had suffered an incident of domestic violence and this had been reported to the police. When she booked her pregnancy she did not disclose the domestic violence to her midwife. Later in the pregnancy she was advised that her unborn baby was to be allocated a social worker and that there would be a change in the midwife named to support her. The expectant mother went into labour early and required an emergency caesarean section to be performed. She asked the baby's father to accompany her to the hospital and stay whilst the baby was delivered. However, this breached an agreement reached between the expectant mother and her social worker.

When we spoke with the new mother she was distressed and told us that she was frightened and confused about whether she would be allowed to keep her baby. She knew about a 'meeting' which had been cancelled, but didn't know what the meeting was to be about or why it had been cancelled. She told us that she had received conflicting information from her social worker and the midwife as to whether she would be allowed home with her baby. We escalated concerns to the named midwife who told us that she would follow this up with professionals involved so that clarity could be provided to the new mother.

3.7 One case examined involved a pregnant mother with a history of substance misuse who had recently completed a detoxification programme. She booked her pregnancy with a midwifery services at 12 weeks. The GP referral examined was comprehensive and identified her substance misuse and other risks. There was also good recording of partner details, ethnicity and risk.

She attended her initial ante natal appointments and during this time was discharged from the local substance misuse service. At one ante natal appointment she tested positive for substance misuse and a referral was made to children's social care. She then went missing and did not attend ante natal appointments. The midwife made strenuous attempts to find her and the file shows evidence of good information sharing and liaison with agencies across Redbridge to locate her. She was eventually found and the case was discussed at the maternity partnership meeting.

The specialist midwife attended strategy meetings and also all child protection conferences and core groups. A comprehensive birth plan was created and shared across maternity services to ensure a co-ordinated approach to the management of both mother and baby during and after labour. A pre-discharge meeting was held prior to mother and baby going home. Midwives continued to visit for an extended time to provide additional support. This case demonstrated excellent practice and tenacity on the part of healthcare staff to ensure the safety of both the expectant mother and child.

3.8 Another case we examined was of a young person who lived with her mother and her mother's partner and siblings. The family had lived in a different part of London and were well known to children's social care. The young person was on a child protection plan for neglect which continued following the move to Redbridge. The young person booked her pregnancy with midwifery services at 14 weeks pregnancy. She was seen by the teenage pregnancy midwife for her ante natal care and an initial child protection conference agreed that the unborn baby should be placed on a child protection plan. The baby was delivered safely and a discharge planning meeting took place at which it was agreed that mother and baby would continue to live at home.

3.9 Substance misuse workers demonstrated a good awareness of the 'hidden child' within families that often lead chaotic lifestyles. We saw good recording of mother and father details and also siblings and significant others including grandparents and other persons who might be living in the family home. Where risks to unborn children and other children and young people were recognised, appropriate and detailed referrals were made to social services for their consideration of further action to protect vulnerable people. Where little risk was considered substance misuse workers still routinely called colleagues at social services to discuss cases with them should they have any further information that might influence the decision making process.

3.10 In adult mental health services we saw that appropriate arrangements are in place to identify and record children in households of clients who are accessing mental health services. Cases seen indicate that practitioners are recording full demographic details and are effectively assessing risk to children. The risk assessments on the IT system are being updated regularly when change occurs. However, we did see examples of where mental health staff are using family members to interpret on behalf of the patient. GPs we spoke with told us that they would utilise the telephone interpretation service and also use staff at the practice to interpret on behalf of service users. One GP we spoke with told us that they would also sometimes use family members to act as interpreters. Using family members to act as interpreters is not good practice and can result in the voice of the child not being heard appropriately. (*Recommendation 7.1*)

3.11 Adult mental health staff attend child protection conferences as required and submit reports where they are unable to attend. Files seen indicate good liaison and appropriate information sharing with other practitioners when working as part of a network meeting or team around the child. Joint multi agency visits are a regular feature in managing some complex cases.

3.12 GPs we spoke with told us that they had systems in place to follow up non attendances at their surgery, including those children that do not attend for inoculations and other health consultations. Flags would be placed on the systems to prompt staff at the surgery to follow up the reasons for non-attendance and make further enquiries and referrals according to individual needs.

3.13 Child protection medicals are now undertaken in the community at a health centre with a single point of contact used to coordinate them. This is considered a more appropriate environment in which to undertake child protection medicals and was a recommendation from the 2010 joint CQC/Ofsted report.

4. Looked after children

4.1 The local authority commission a CAMHS service for looked after children provided by North East London (NHS) Foundation Trust (NELFT). Practitioners provide direct intervention with children and young people looked after, as well as working with foster carers and other professionals to support a young person in their placement and in their education. A dedicated LAC care leaver CAMHS worker supports young people who are looked after and who need to transition into adult mental health services. The specialist CAMHS workers are able to refer directly to core CAMHS and act as a conduit between CAMHS and the children looked after specialist nurse.

4.2 Initial health assessments are carried out by the designated doctor for looked after children who are under 5 years at the time they come into care. Assessments examined demonstrated good collation of health information which results in robust health planning. However, we did see that there is often a lack of specific timescales for actions to be completed and although associated health plans did generally contain appropriate information about the young person's health, they were not specific, measurable, attainable, realistic and timely (SMART). (See *recommendation 5.3 below*)

4.3 Initial assessments for children and young people aged 5 and over are less robust, and whilst the designated doctor reviews all assessments and completes the health plan for these children, there is variability in the quality and robustness of the assessments on which the health plans are derived. The local authority and designated doctor recognise this and we are aware that plans are well advanced to source and train a number GPs to carry out all assessments for children aged 5 and over to improve quality and consistency.

4.4 There is an unacceptable delay in some initial health assessments taking place for children and young people coming into care. The LAC health team investigate and report on the reason for delay, and in part this will be addressed by the new initiative of dedicated GPs carrying out initial health assessments on children and young people aged 5 years and above.

4.5 Some review health assessments are also subject to delay in their implementation by health visitors. Despite these being prioritised, we saw that the reason for reviews being delayed was not routinely reviewed and the potential impact of such delays is not assessed. (Recommendation 5.5)

4.6 We spoke with GPs in Redbridge who told us that they were not routinely asked to provide information to initial or review health assessments if they were not themselves completing them. GPs were unaware of any quality process regarding the completion of health assessment documentation. (*Recommendation 1.5*)

4.7 The use of strengths and difficulties questionnaires (SDQs) to inform practitioners working with children and young people looked after is underdeveloped. The IT system currently in use does not support accurate recording of scoring. The outcome from the individual young person's completed SDQ is not used to inform the initial health assessment or ongoing health reviews. This is a missed opportunity to assess and monitor the emotional health and wellbeing of children and young people looked after in Redbridge.

4.8 In cases examined we saw that there was good recording of engagement with children which included discussions held with them about placements and emotional support requirements. The voice of the child was seen to be heard and this resulted in robust care planning with timescales set for actions to be undertaken.

4.9 Review health assessments we examined for LAC were seen to be effective in maintaining and, where necessary, improving the health of children and young people looked after. The looked after children's specialist nurse had a robust system of quality assurance for all reviews carried out for children being cared for by the London Borough of Redbridge, including those placed out of borough. This is good practice.

4.10 We saw evidence of how those reviews that had information missing or were incomplete were returned to the practitioner for further detail to be added. This is leading to a continuous cycle of improvement in the quality of reviews carried out. However, whilst the timeliness of reviews carried out for children and young people placed within and near to Redbridge is good; there are often delays in their completion for those placed out of area.

We examined one case of a young female aged 13 who was in the care of the local authority. We saw that the initial health assessment had been carried out by a GP. The assessment contained no detail of the girl's previous health history and did not note any concern regarding her emotional and behavioural development. On further examination of the notes we saw that some of the reasons for the girl being in care was as a result of absconding behaviour, being at risk of child sexual exploitation and having assaulted a police officer. Opportunities for the accurate recording and subsequent sharing of important information had been missed in this instance.

4.11 Commissioners are not linking payment to performance in completion of initial health assessments and health reviews for children and young people placed out of area, and this is a missed opportunity to ensure that those children and young people are not further disadvantaged by late and/or poor quality health reviews.
(Recommendation 1.2)

4.12 Health promotion is discussed as part of the targeted support offered by health visitors and school nurses. Risk taking behaviours are considered as part of annual health reviews, and in some cases seen we saw evidence of sensitive discussion and recording. However, practitioners do not use any formal risk assessment tools as part of the reviews to identify potential concern and this could mean opportunities to identify and respond to risk early are missed.

4.13 We spoke with a group of young people who told us that confidentiality and consent was an important issue that often prevented them from engaging with health professionals when they did not fully understand the implications involved in relation to the type and amount of personal information that might be shared between different agencies. They told us that this was particularly relevant around issues of mental health, but also where familial and cultural issues might prevent young people consenting to information sharing as they were concerned that their families might hear about personal issues that could affect their status within the family.
(Recommendation 1.3)

4.14 We spoke with care leavers who told us they thought did not receive enough relevant health related information on leaving care. This included not only information about their own physical and mental health, but information such as the need to register with a different GP should they move to another catchment area and. All young people, and in particular care leavers, said they would appreciate a broader range of health information contained in a single document as opposed to an increasing range of leaflets which they often find confusing. Whilst all appreciated the health input they did get, they told us that the scope of information could be improved and that they should be consulted further to help develop this.
(Recommendation 1.4)

4.15 Arrangements to provide young people leaving care with a full summary of their healthcare are in the early stages of development. Currently young people leaving care are provided with a copy of their final health review, health plan and a copy of their immunisation status. The letter is also copied to the young person's GP.

4.16 The co-location of the LAC specialist nurse with the children's social care looked after teams actively promotes information sharing and a joint approach to children and young people's care. In one case we examined, the review assessment of a young person who had started to disengage from school and had a worsening relationship with their foster carer demonstrated how the LAC nurse had liaised with the foster carer, specialist LAC CAMHs worker, school nurse and the social worker to share information and limit the potential for placement breakdown.

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 Recruitment of paediatric staff has been difficult at King George hospital. To improve retention various innovative practices have been developed. Staff rotate between King George and Queens hospital to ensure staff maintain their clinical skills at all levels. A paediatric nurse development role has been implemented and there has also been some over-recruitment of staff to ensure there is always enough appropriately skilled and experienced staff available to ensure the safety of children and young people. The trust is also seconding their own staff to undertake paediatric training.

5.1.2 Barking and Dagenham, Havering and Redbridge CCG were seen to actively seek the views and participation of children and young people in the planning and development of integrated service provision for children's care at King George's hospital (KGH).

5.1.3 In February 2014 a workshop took place with children and young people where their views were actively sought in relation to the type of services they would like to be provided at the planned new centre at the hospital. It is now planned to present the outcomes of the workshop to the KGH steering group and then to establish a working group dedicated to the children's element of the KGH vision. We saw that there are plans to refer to the Children and Families Bill 2013 during the consultation and to action changes contained within it.

5.1.4 Active involvement of children and young people in the planning and development of services promotes improved working relationships and trust between vulnerable young people and health professionals. We spoke with members of Redbridge Youth Council and care leavers. They told us how much importance they placed on being involved in decision making processes within Redbridge when invited to do so.

5.1.5 There is good support for the named midwife through the pan London named midwife forum. This is an excellent forum to share good practice and learning from serious case reviews and other national findings. The named midwife is also an integral part of the trust's safeguarding children governance structure

5.1.6 Monthly maternity partnership meetings take place with multi-disciplinary and multi-agency attendance. Cases of concern are discussed, birth plans for complex and vulnerable women are reviewed and any issues around information sharing or communication are resolved. Until recently the domestic violence advocates attended these meetings. However, due to recent changes in commissioning this service will no longer be available in its current format and practitioners are concerned about the impact this may have on victims.

5.1.7 The safeguarding lead for the BHRUT works strategically across the trust to support and implement safeguarding. The trust works across a number of local LSCBs and has two busy acute hospitals. In discussion with the post holder there was some doubt as to their capacity to fulfil all the responsibilities of the named nurse for child protection and work strategically to implement newly emerging initiatives, such as the local Redbridge arrangements for child sexual exploitation, awareness of female genital mutilation and the 'Prevent' agenda which aims to develop the capacity of women to challenge. The role of the safeguarding lead for BHRUT would therefore merit further review.

5.1.8 A named GP for Redbridge provides one session per week on an interim basis and has done since November 2012. The named GP is strengthening links with the CCG and now has regular meetings with the designated doctor and Chair for the CCG. Although the role is currently provided on an interim basis, the named GP realises the potential the role has to offer if made a substantive post. She has had an impact in raising awareness of safeguarding within the GP role through different modes of delivery. One area in particular is that she now feels the GP's know that it is acceptable to share information regarding vulnerable families.

5.1.9 Adult mental health team managers' report monthly on safeguarding activity by mental health practitioners. They report where there are any concerns raised about the impact of the parental mental health on a child, or where a child has a child in need or child protection plan in place. These cases are discussed in supervision, in monthly team meetings and in zoning meetings (risk meetings on individual clients).

5.1.10 In line with Royal college of General Practitioner (RCGP) guidance we were advised that all GP practices had safeguarding leads and this was confirmed by two GPs we spoke with. This has led to a raised profile of safeguarding awareness within GP practices. GPs went on to tell us that they had safeguarding policies in place and a flow chart/pathway to direct staff members what actions to take in relation safeguarding concerns.

5.1.11 GPs we spoke with told us that general communication between them and other multi-agency professionals was 'hit and miss' and they may be placed in 'difficult situations' when children and young people attended their surgeries for consultation and the GPs were unaware of other professional interactions with them.

5.1.12 A 'Redbridge wide' leadership approach has been adopted by the CCG with all organisations in the area prioritising the safeguarding of vulnerable children and young people, including improved partnership working. We recognise the high level of transparency and engagement provided by management staff in all areas inspected and also the commitment to learn from the inspection to improve outcomes for children and young people in Redbridge.

5.2 Governance

5.2.1 We were advised that there is good health representation at senior management meetings and appropriate challenge is made to information provided to them, such as Redbridge health priorities. Health was considered to have a 'strong voice' at board level.

5.2.2 The Redbridge Local Safeguarding Children Board (LSCB) annual report dated 2012/13 highlighted the significant priority around the issue of CSE for 2013/14 and that resources from the LSCB budget would support this work. Also highlighted was the need for robust performance monitoring of key indicators across health agencies that can be regularly interrogated and challenged by the board.

5.2.3 However, there is currently no NHS England representation at LSCB meetings specifically for Redbridge. We were advised that it is intended that appropriate representation will take place but it is anticipated that logistically it will not be possible for attendance to take place at each monthly meeting. By not attending local LSCB meetings it is difficult to see how NHS England can assure themselves regarding the quality of services that they oversee. (*Recommendation 3.1*)

5.2.4 NELFT recognise the need to refresh the role of the safeguarding link role which currently does not have any formal governance or performance management arrangements to evaluate the post holders effectiveness in supporting safeguarding children practice across the organisation.

5.2.5 The London Borough of Redbridge Youth Council meetings is a forum where children and young people are encouraged to actively engage to highlight issues that concern them, including issues around health and health service provision. More considered health input at these meetings would provide young people with a point of contact within the area and reassure them of the seriousness with which their views are considered by health in Redbridge.

5.3 Training and supervision

5.3.1 Redbridge CCG have embedded quality assurance processes to ensure safeguarding supervision is provided to staff working with Looked After Children (LAC) and children and young people subject to child protection measures. Where the provision of safeguarding supervision was considered inadequate, such as within North East London NHS Foundation Trust (NELFT), measures have been put in place to ensure intercollegiate guidance is being adhered to in relation to the amount and quality of safeguarding supervision provided to staff members. However, we found that safeguarding supervision within BHRUT needs strengthening (see 5.3.9 below)

5.3.2 Access to training and supervision to support the specialist LAC nurse is good. There is good peer support for the LAC nurse as NELFT provide LAC health services for a number of London Boroughs and this means that there is a good network of LAC health professionals who benefit from shared learning, advice and support. Likewise, the LAC nurse provides training, support and advice to foster carers, health visitors and school nurses on the health of looked after children. This ensures that professionals working with this vulnerable cohort of children are up to date on the importance of health assessments and reviews and also the latest legislation.

5.3.3 Within health visiting and school nursing, we saw that safeguarding supervision is provided separately to any general, line management supervision. We also saw that case rotation is routinely used to ensure an appropriate diversity of safeguarding roles and responsibilities are discussed at safeguarding supervision. This allows management oversight of cases that might be overlooked by health professionals as being relevant to supervision processes. However, health practitioners should not be solely relied upon to bring cases to supervision. Regular dip-sampling of case load material might bring to light cases that are suitable for safeguarding supervision that could easily be overlooked by the case holder.

5.3.4 We were advised that when any health practitioner accesses safeguarding supervision they advise safeguarding managers that they have attended either 1:1 or group supervision by way of a dedicated email. We have been further advised that NELFT are currently developing an automated system for recording and evidencing safeguarding supervision.

5.3.5 We were pleased to note the arrangements made by NELFT in investing in external NSPCC supervision training for supervisors. Feedback from practitioners is that they welcome the professional challenge using the child's voice.

5.3.6 Both Redbridge CCG and BHRUT recognise that the number of staff members within BHRUT who have received safeguarding training at level one and level three does not meet intercollegiate requirements. Although we are aware that measures are underway to increase the numbers of staff members attending and successfully completing safeguarding training, we saw that the training package currently provided at level three is inadequate and in need of revision. *(Recommendation 4.1)*

5.3.7 Inspectors reviewed the Level 3 training package which is currently delivered in half a day and predominantly through a PowerPoint presentation within BHRUT. This does not meet the requirements of the Intercollegiate Guidance and has not been endorsed or accredited by the local LSCBs. Whilst at Queen's hospital we spoke with a radiographer who told us that she had only received her Level 1 safeguarding children training. As a health practitioner working regularly with children and families this practitioner should have undertaken level 3 training and, along with 5.3.7 above, could indicate that BHRUT's training needs analysis is incomplete. *(Recommendation 4.2)*

5.3.8 BHRUT has recently carried out an audit on the effectiveness of its arrangements for practitioners to access supervision on safeguarding children. However, inspectors found that the arrangements for supervision require strengthening. All practitioners working with children who have a child protection plan should access regular supervision and this should be fully documented and a record kept in the patient record. In addition, there should be a formal record of all advice provided by the safeguarding team and although the named nurse has developed a paper template this will need to be supported by IT to provide an audit trail. Poor and incomplete record keeping of safeguarding supervision is a common feature in serious case reviews. *(Recommendation 4.3)*

5.3.9 We examined a health visitor case regarding a complex case where the subject and siblings were all children in need. The health visitor told us that they had received safeguarding supervision in October 2013 and actions were decided at that supervision regarding interventions to take to ensure the safety of vulnerable children. However, the practitioner had not accessed supervision since that date and she was as yet unsure who her new supervisor was, her previous supervisor having moved on. We saw that there had been developments in the case that could pose a safeguarding risk to the children involved and the practitioner agreed the case should now be taken to supervision and the delay in further assessing risks was seen as unacceptable. Ad-hoc discussions about the case had not been recorded and as such could not be evidenced.

5.3.10 GPs we spoke with told us that all clinicians within their practices were trained to safeguarding level 3 in accordance with intercollegiate guidance and reception staff trained to level 1. Courses managed by the LSCB and other specialist subject courses, for example CSE and MASH are attended by some GPs where possible.

5.3.11 We were told by two GPs that we spoke with that individual safeguarding supervision takes place during general practice group meetings and staff can take individual cases to the safeguarding lead within the practice for supervision if they feel they need to, from which individual strategies can be developed according to need.

Recommendations

1. NHS Redbridge Clinical Commissioning Group should:

- 1.1 Ensure that the purpose and function of the MASE and the establishment of a referral process is fully developed in policy so that all practitioners who suspect CSE clearly understand their own roles and responsibilities in protecting vulnerable young people.
- 1.2 Ensure full consideration is given to the quality and timely completion of review health assessments for children placed out of the London Borough of Redbridge so that those children and young people are not disadvantaged by late and/or poor quality health reviews.
- 1.3 Ensure clear information as to what it is they are consenting to is provided to children and young people when asking them to provide consent to share information with other health professionals and partner agencies. Also, further ensure that consent is reviewed continually with young people and not assumed to be on-going.
- 1.4 Consult with and actively engage care leavers to improve the quality, content and style of information given to them on leaving care.
- 1.5 Ensure GPs are routinely asked to provide information to inform initial and review health assessments.

2. NHS Redbridge Clinical Commissioning Group and North East London Foundation Trust should:

- 2.1 Ensure quality assurance systems are in place to ensure the accurate recording of clinical notes within CAMHS.
- 2.2 Ensure appropriately trained health professionals are available to provide support to young people who are admitted to paediatric wards when in mental health distress following attendance at emergency departments.

3. NHS England Area Team should:

- 3.1 Ensure appropriate representation is maintained by NHS England Area Team at Redbridge LSCB meetings.

4. NHS Redbridge Clinical Commissioning Group and Barking, Havering and Redbridge University Hospitals NHS Trust should:

- 4.1 Assure themselves of the content and evaluation of Levels 1 and 3 safeguarding training are commensurate with the Intercollegiate Guidance and meet the requirements of the LSCB.
- 4.2 Assure themselves that training needs analysis is robust and identifies staff training needs appropriately.
- 4.3 Ensure appropriate documentation is made and retained in relation to the provision and uptake of safeguarding supervision within the Trust

5. North East London Foundation Trust should:

- 5.1 Ensure that all parent and significant adult and child details are routinely requested and recorded in both the records of adults in their care and also, where necessary in children and young people's records.
- 5.2 Where it is considered not appropriate to record parent and 'significant other' details in children's records for data protection reasons, consideration should be given to how those details can be flagged to health professionals so that they can assure themselves of the family make up.
- 5.3 Ensure, where appropriate, that there is clear reference to health professional roles and responsibilities resulting from clearly defined, SMART health action plans contained within the files of children and young people who are provided services by health visitors and school nurses.
- 5.4 Assess the availability, continuity and, where they are not already provided, the feasibility of school nurse drop in facilities being provided at all schools across Redbridge.
- 5.5 Ensure quality assurance procedures are in place to assess the reasons for delays in the completion of review health assessments so as to reduce those delays and the potential impact on looked after children and young people.

6. Barking, Havering and Redbridge University Hospitals NHS Trust should:

- 6.1 Improve signage at Queen's hospital emergency department to clearly signpost children, young people and families to the paediatric assessment unit so that they do not report to the adult waiting area.
- 6.2 Improve arrangements for children and young people who are directed to other areas within Queen's hospital to reduce their contact with adult service users and visitors.
- 6.3 Ensure health professionals at the emergency department at Queen's hospital are aware of how to refer young people for early intervention support provided by the young people's substance misuse service.
- 6.4 Amend documentation within Queen's hospital emergency department to ensure appropriate recording of children in households of adults that attend the department following incidents of self-harm, mental health crises, substance abuse and domestic violence.
- 6.5 Ensure staff members are trained to recognise and appropriately record details of the 'hidden child' within the families of adults who attend Queen's Hospital emergency department following incidences of domestic violence, mental health concerns or substance misuse
- 6.6 Ensure safeguarding risk assessments are routinely carried out during triage at Queen's hospital emergency department following all attendances of potentially vulnerable children and young people and not just when presenting with injury.
- 6.7 Ensure staff members are appropriately trained and aware about how to protect patient confidentiality in open settings such as maternity wards.

7. NHS England Area Team and Barking, Havering and Redbridge University Hospitals NHS Trust should:

- 7.1 Ensure all health professionals are aware of the risks in using family members as interpreters and that they use alternative, readily available services seen to be available in Redbridge.

Next steps

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