

Review of Health Services for Children Looked After and Safeguarding in Essex

**(Communities served by Mid
Essex, North East & West Essex
Clinical Commissioning Groups)**

Children Looked After and Safeguarding The role of health services in Essex

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Provider services included:	North East Partnership NHS Foundation Trust South Essex Partnership NHS Trust Mid Essex Hospitals NHS Trust Colchester University Hospitals NHS Foundation Trust Provide (Registered with CQC as Central Essex Community Services Hertfordshire Community NHS Trust Anglian Community Enterprise Community Interest Company
CCGs included:	Mid Essex CCG North East Essex CCG West Essex CCG
NHS England area:	Essex Area Team
CQC region:	Central Eastern
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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 North East, Mid and West Essex. It focuses on the experiences and outcomes for children within part of 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 North East, West and Mid Essex 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 112 children and young people.

Context of the review

There are five Clinical Commissioning Groups across Essex. This review looked at health services commissioned by the three North Essex CCGs; North East Essex CCG, West Essex CCG and Mid Essex CCG.

North East Essex CCG commissions its acute services from Colchester Hospital University NHS Foundation Trust and community services from Anglian Community Enterprise, Mid Essex CCG commissions its acute services from Mid Essex Hospitals NHS Trust and community services from Provide (Central Essex Community Services). West Essex CCG commissions acute services from Princess Alexandra Hospitals NHS Trust and community health services from SEPT and Hertfordshire Community NHS Trust which have not been included.

CAMHS across North Essex are delivered at Tier 2 by the local authority and Tier 3 and Tier 4 by North Essex Partnership Foundation NHS Trust.

The last inspection of health services for North East, Mid and West Essex's children took place in July 2010 as a joint inspection, with Ofsted, of safeguarding and looked after children's services. Recommendations from that inspection are covered in this review.

23.5% of the population of Essex are under the age of twenty. 12.1% of school children are from a black or minority ethnic group. The health and well-being of children in Essex is a mixed picture compared with the England average. The infant mortality rate and the child mortality rate is better than the England average. The level of child poverty is better than the England average with 17.4% of children aged less than 16 years living in poverty. The rate of family homelessness is better than the England average. Children in Essex have better than average levels of obesity. 8.1% of children aged 4-5 years and 17.2% of children aged 10-11 years are classified as obese. 54.4% of children participate in at least three hours of sport a week which is worse than the England average.

The percentage of children in this area shows a lower percentage in reception and a lower percentage in Year 6 classified as obese or overweight compared to the England average based on 2011/12 data.

In comparison with the 2004-07 periods, the rate of young people under 18 who are admitted to hospital because they have a condition wholly related to alcohol such as alcohol overdose remains broadly similar in the 2008-11 periods. Overall rates of admission in the 2008-11 periods are lower than the England average.

In comparison with the 2006-09 periods, the rate of young people under 18 who are admitted to hospital as a result of self-harm has increased in the 2009-12 period. Overall rates of admission in the 2009-12 periods are lower than the England average. Nationally, levels of self-harm are higher among young women than young men.

A similar percentage of children (91.6%) have received their first dose of immunisation by the age of two in this area when compared to the England average. By the age of five, the percentage of children who have received their second dose of MMR immunisation is lower with 86.5% of children being immunised. This is similar to the England average. In the East of England, there were 31 laboratory confirmed cases of measles in young people aged 19 and under in the past year.

The report

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

What people told us

We heard from

A mother with a young baby waiting in the paediatric area of the North East Essex hospital who told us, *"It's nice to be able to sit and wait a bit out of the way from everybody else. My baby is asleep but she is easily disturbed and it seems a bit quieter down here."*

A parent whose child was placed on a child protection plan following escalation by a school nurse, *"We were devastated when they told us we were negligent parents but at the child protection conference everyone was focussed on the needs of our son and everyone was worried and cared about him. We were one of the success stories."*

A young person who was looked after and about to leave care had high praise for the health advisor input and told us, *"If I ever need anything, she's only a phone call away. She helped me attend medical appointments, I felt safe in talking to her"*.

Another young person, looked after, who was being discharged from the St Aubyn's in-patient unit us told us how staff had helped her and that she was now *'ready for home'*. She showed us her medals and trophies that she had won for her street dancing and told us how staff had supported her by taking her to local dance competitions. She hoped to carry on with her dancing once she went home.

Female patient K who has been on the mother and baby unit following the birth of her baby told us, *"Staff are really helpful and if they say they are going to do something then they do. However, sometimes I am left to struggle on my own when the unit is busy and messages left with the ward office are not always passed on. The payphone is in a busy corridor and there is no privacy, the worst feeling of all is being cut off from family and friends and everything is in the hands of strangers."*

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 Effective systems and protocols safeguard children and young people who attend the Princess Alexandra Hospital Paediatric Emergency Department. The inspection team found safe practice in Mid Essex Hospital also.

A mother had been taken to the Emergency Department by police following threats by her husband that he was going to kill her. Shortly after arrival on the unit, the husband telephoned asking after her. Information was not provided to him and staff used procedures previously put in place to protect the anonymity of Olympic athletes during the London Olympics to protect the anonymity of the mother.

Further enquiries disclosed that there were potentially two children at the family home and arrangements were made to keep them safe. The mother was placed on a female ward for further treatment and staff were made aware of what action to take should the husband try to gain access. The family were safeguarded effectively.

1.2 Currently, children are offered a waiting area away from the mainstream admissions to Mid Essex Hospital Emergency Department, but when they move through the triage area or patient bays for further assessment and treatment they can come into contact with adult patients. We were told that planning is underway to rectify this by altering the layout of the department, but currently there is a risk of vulnerable children and young people coming into contact with adults other than health professionals.

1.3 Systems to ensure that safeguarding issues are identified and responded to at the Emergency Department in Colchester Hospital are not robust. The system to ensure that all people under 18 are identified by a 'green card' that prompts questions about status and risk assessment is not being systematically used and there is no system in place to monitor this. The trust cannot assure itself about the quality of screening within the department and there is the potential that practitioners are not making sufficient enquiries to identify risk. This is a particular issue for young people aged over 16, where there are more examples of green cards not being used or completed. This indicates weaker practice in the adult emergency department as young people aged 16 to 18 are directed through that team. However the Safeguarding Children Practitioner reviews all admissions in the 16-17 age range that are admitted to the Emergency Assessment Unit. **(Recommendation 4.1)**

1.4 Where risk is identified there are robust systems for response by the paediatric liaison nurse or safeguarding team, and we saw examples of good practice where it was identified that young people were known to children's social care, information was shared and protocols followed. In one case, the paediatric consultant identified concerns about the young person's anger management and made appropriate referrals for support by CAMHS.

1.5 CAMHS support to the adult and paediatric emergency departments across the three CCG localities is variable; in North East Essex urgent care practitioners reported delays in the arrangements for the assessment, admission and treatment of young people with mental health problems. However, in Mid Essex we saw examples of prompt attendance and support by CAMHS.

Child A presented at Mid Essex Hospital following an attempt at self-harm. The flagging system on the admission's computer system highlighted that she had made multiple previous suicide attempts and self-harmed and that she had CAMHS involvement for two years. Triage took place within 30 minutes and at all times she was accompanied by a qualified nurse.

Psychiatric liaison and adolescent mental health assessment took place during the course of the morning and the young person was admitted to an adolescent mental health unit the same day for further assessment.

1.6 Where GPs are using the same information system as community health providers, such as school nurses and health visitors, this is facilitating effective information sharing about children and families with known vulnerabilities. We recognise that work is ongoing to find a solution for safe and timely information sharing where this shared IT system is not available. In West Essex, there are an increasing number of monthly local primary care meetings taking place to discuss issues on cases with the local GPs and community based staff to share cases of concern, updates and other information. This is good practice and facilitates a shared approach to supporting vulnerable families.

1.7 The named GPs are working effectively to raise the profile of safeguarding children and children looked after and there is evidence of learning from local serious case reviews in primary care, for example, the introduction of young person's registration forms recognising the importance of household composition and other agency involvement. However, there remains a vacancy for a Named GP within North East Essex CCG.

1.8 Effective arrangements are in place to identify and record vulnerability in pregnancy within midwifery teams in Essex. We read one case file that demonstrated how a mother with a history of self-harming behaviour and substance misuse had engaged well with the perinatal mental health midwife in Mid Essex, with mother and baby now in a stable foster placement. We saw many examples of joint visits being undertaken by health visitors and midwives to offer early help and support to families where pre-birth concerns had been identified.

1.9 Specialist teenage pregnancy midwives work effectively with teenage mothers to improve engagement with ante natal care and, where appropriate, signpost the young families to receive parenting support in the local children's centres.

1.10 While it was reported that midwives were able to make appropriate contact with specialist services as needed when working with mothers with specialist needs (e.g. mental health, substance misuse) this was not always supported by formal pathways or identified leads to ensure best practice and promote good outcomes. **(Recommendation 2.3)**. This was a particular challenge when working with parents living with learning difficulties to ensure that they had appropriate support in parenting. There was scope to develop multi-agency psycho-social meetings to optimise information sharing and planning for vulnerable mothers.

1.11 There is a clear referral pathway for domestic violence at Princess Alexandra Hospital, facilitated and strengthened by the 3 year Daisy Project workers based in A&E and maternity. This is facilitating engagement of mothers and families with support for domestic violence where children may also be at risk.

1.12 Participation in the Freedom programme, aimed at mothers living in West Essex who have been victims of domestic violence, is helping women to develop insight into their situation, take positive action to protect themselves and their children and is resulting in positive outcomes.

1.13 We heard some good examples of multi-health agency working with health providers outside of Essex resulting in good outcomes for vulnerable babies.

1.14 Awareness of Female Genital Mutilation (FGM) across Essex is variable. There is good awareness of FGM in maternity services at Princess Alexandra Hospital, although numbers of presentations have been low to date. Within Colchester Hospital risk assessments forms and practice need to be updated to ensure that issues around FGM and sexual exploitation are explored and responded to. The existence of sexual exploitation forums across Essex has been identified as an area for development, to promote increased awareness and ensure issues around FGM and exploitation are fully explored in risk assessment. It is expected that presentations of FGM and increase in exploitation will manifest itself because of changes in population. Practitioners therefore need to be fully trained and vigilant.

1.15 Health visitors in Mid Essex are not routinely informed of pregnancies until after the birth unless there is an identified vulnerability when the midwife would telephone the health visitor to make them aware. This means that health visitors are not able to routinely carry out ante natal visits and are not able to share information during the ante natal period. **(Recommendation 3.1)**. Being routinely notified of all expectant mothers would allow health visitors to assess the need of families and potentially refer them to the Maternal Early Childhood Sustained Home Visiting Programme (MESCH). This scheme provides up to 25 early interventions during the child's first two years of life. If notified, pre-birth interventions can take place prior to the child being born. The service is particularly aimed at providing enhanced support to teenage mothers, those living with mental health problems and those with drug and alcohol dependency. Early indications are that mothers are benefitting from the intense, early support.

1.16 Health visitors who identify potential problems with new mothers forming attachments with their baby can refer the family to the parent infant service for psychological support. The service is highly regarded by families who have accessed this support and they report significant improvement in their relationships with their child.

1.17 Practitioners in the Contraception and Sexual Health Services (CASH) across the three CCGs are skilled in establishing trusting relationships with young people who access the service so that they return to use services on future occasions. The services are flexible in their opening hours, locations and are successfully increasing the engagement of schools and colleges across the patch in the promotion of sexual health.

1.18 However, the approach to risk assessment within CASH services across all three CCG areas is not robust. For example, there is some good practice within Mid Essex. This service has a clear proforma used for young people's assessment which prompts questions to identify current or previous looked after status as well as support by other statutory and non-statutory agencies. The use of this assessment is routine and looked after children are identified within the service. However, in the West Essex service they are lacking any formal template to ensure risk assessment is comprehensive, properly recorded and can be monitored. IT systems require strengthening to support timely awareness and management of risk. There was insufficient curiosity and questioning about sexual partners in the case observed where there was a possibility of child sexual exploitation. Within the North East Essex service we were told that there is no system for referring children under 13, and recording practice within the services is also poor and not always accurately reflective of actions taken or liaison with other services. Children who are care leavers or looked-after children are not routinely identified. There is no clear protocol about what cases should be referred to children's social care and in the West Essex service no cases have been referred for safeguarding in the past 18 months since the service's inception. CQC will be writing to the Commissioner of these services to advise on these findings.

2. Children in Need

2.1 Effective systems are in place at Princess Alexandra Hospital to ensure that trust on-call managers are aware of vulnerable children attending the Emergency Department outside normal hours.

2.2 CAMHS across North Essex are delivered at Tier 2 by the local authority and Tier 3 and Tier 4 by North Essex Partnership Foundation NHS Trust. All referrals for CAMHS at Tier 2 and Tier 3 are assessed by a single gateway assessment by practitioners working from both services. North East Partnership NHS Foundation Trust are meeting their internal target of assessing all new referrals, where accepted, within 8 weeks, though some young people are experiencing increased waiting times for some care pathways due to staff sickness absences.

Child T was from a minority group and had been referred to CAMHS for behavioural difficulties. The case file demonstrated ongoing liaison between CAMHS and school staff with rapid access to psychiatry assessment along with cultural awareness issues that may be impacting on his behavioural presentation. Practitioners demonstrated a sensitive and proactive approach when working with this family with additional needs, including use of telephone appointment system and discussion rather than via letter due to carer's literacy difficulties.

2.3 CAMHS service provision to young people aged between 17 and 18 years has been highlighted as an area of need and we note this is currently being discussed as part of the review of CAMHS services. Children, young people and their families are being consulted with to obtain their views on a preferred model of service.

2.4 North Essex Partnership Foundation Trust provide an early intervention psychosis service across North East, Mid and West Essex to provide support to young people between the ages of 14 and 35 with first onset of psychosis. Case records seen indicate good practice in sharing information and working with other agencies to keep children and young people safe with good outcomes for service users.

2.5 We saw evidence of how some North Essex Partnership Foundation Trust adult mental health workers employed a 'Think Family' approach and have targeted part of their intervention based on early identification of the risk to children. On one case we sampled demonstrated how the adult mental health worker had considered and identified potential risk to children following the deterioration of the mother's mental health and possible relationship breakdown with the father. The practitioner is working with the father to develop his understanding of his partner's mental health needs and to raise his awareness of their children's emotional wellbeing.

2.6 Ex-service men who live in North Essex and require mental health support can access the North Essex Partnership Foundation Trust Veteran's First service. We saw how this service has had a positive impact on the emotional health and wellbeing of their clients but had also facilitated children in the household accessing appropriate support.

Patient B was an ex-serviceman who had children from a previous relationship and his children were on a child protection plan for neglect. When the Veterans First Service became involved they obtained charitable funding to support the family. They also arranged for a support worker to make regular visits to the family. B has made good progress, the VFS have continued to regularly attend core groups and recently a decision was made to step down from child protection to child in need. B is attending his psychiatric appointments and plans are well advanced for the children to return to the family home.

2.7 North Essex Partnership NHS Foundation Trust are able to offer adults with mental health problems the opportunity to participate in family group conferencing. We saw how this had effectively helped families manage better, how children and young people had been included in discussions and had their voice heard. However, the team is small in number and is closely managing demand for the service as there is not the capacity to provide Family Group Conferencing for all adults with families who are discharged from in-patient care across Essex.

2.8 Support to vulnerable families at Level 3 of the Essex thresholds is fragmented and not well understood by health practitioners we spoke with. The use of the Shared Family Assessment with lead professionals is not yet established. In a number of cases where a team around the child or partnership approach has been adopted to support the child and family, meetings are not properly minuted, recorded or an agreed plan formulated and shared. This is resulting in a lack of clarity about the level of support being offered and the roles and responsibilities of the services involved. Without the provision of an agreed SMART plan, progress in the family or elevated risk cannot be effectively assessed. Some cases demonstrated little or no positive change over significant periods of time to the detriment of children's wellbeing. **(Recommendation 2.1 & Recommendation 2.2).**

3. Child Protection

3.1 Good arrangements are in place in the local Emergency Departments to identify children who are on a child protection plan. Records seen indicated clearly where a plan was in place to alert health practitioners and information was being shared appropriately.

3.2 Simple but effective systems are in place to identify in-patients on mental health wards who have children in the family. This means that all staff working on the ward and the safeguarding nurses are made aware of potential safeguarding issues within the family. However, the current recording of risk to children by clinicians is not always robust and the updating of risk assessments can be delayed whilst waiting for paperwork from community based teams or other professionals.

A pregnant mum suffered a psychotic episode and following admission to A&E was detained and admitted to the Rainbow Unit (Mother and Baby Mental Health Unit). She later was discharged and supported at home for the remainder of the pregnancy and a pre-birth plan was put in place. The adult mental health worker continued to intensively work with the pregnant mum and attended the labour ward to support midwifery staff. Post-delivery, the adult mental health practitioner facilitated the new mum's transfer to the Rainbow Unit where she received extensive support until she was well enough to go home. The new family are doing well and are being supported by the health visitor who is providing enhanced visits.

3.3 We observed good practice by adult mental health practitioners in identifying and recording relapse indicators and sharing these with other professionals appropriately. This is especially useful where there are children in the family and can form part of the arrangements to keep children safe.

3.4 The local SARC for Essex is now fully operational and provides an acute children and young people's service with appropriately trained paediatricians or forensic practitioners with additional paediatric training in attendance. Pathways of care for children and young people who require specialist examinations have been developed with community, acute and primary care providers and these are working well providing children and young people with a sensitive and comprehensive service at what can be a very difficult and stressful time.

3.5 Health practitioners are not always vigilant in recording details of fathers and significant males in households. This is a common feature in serious case reviews.

3.6 We observed good 'transfer in' arrangements when a family who had a child on a child protection plan moved into Mid Essex (Provide), with the allocated health visitor attending the first Core Group meeting planned within the locality and providing an update to the meeting. This ensured that the child was kept safe.

3.7 Attendance at child protection conference by most groups of health practitioners is good.

3.8 Midwives told us that referrals to children's social care for pre-birth concerns are generally responded to promptly and pre-birth planning supported safe discharge arrangements in most cases. However, there is no formally agreed pre-birth protocol in place to ensure a clearly identifiable pathway. **(Recommendation 2.3).**

3.9 There is dispute between Colchester Hospital University Foundation Trust and Children Social Care regarding responsibilities and roles when an infant is being cared for on the neo-natal unit and supervision is needed for parental contact. This lack of agreed accountability could mean a breakdown in communication and confusion around maintaining the safety of a vulnerable baby. We were assured that this issue had been resolved at the end of 2013, however, not all practitioners were aware of this.

3.10 The North Essex Partnership Foundation Trust Adult Substance Misuse Service prioritises child safeguarding in their work with parents and expectant mothers. They identify risks to unborn children and make prompt, well-articulated referrals to children's social care and are actively engaged in pre-birth planning and child protection procedures. Reports to conferences are quality assured prior to submission and supported routinely by the presence of the worker at conference. Where there are professional differences with children's social care in whether cases are taken up, the service is able to offer appropriate challenge to resolve the situation and safeguard the child.

3.11 The St Aubyns Unit is an child and adolescent mental health in-patient unit for young people that require a period of in-patient care. The building is new and purpose built, with obvious consideration made in its design to protect young people's privacy and dignity and it dedicates space for faith based worship.

3.12 At the St Aubyn Centre we observed well established reporting arrangements are in place to escalate and assess any safeguarding disclosures made by young people and we saw evidence of how these are acted upon promptly and shared, where appropriate, with other agencies. When a young person is discharged, there are now robust arrangements in place to ensure that the young person is followed up by the unit and that a package of care and support from the crisis team is in place. We observed a mealtime on the unit, and we saw staff eating with the young people. There was a good atmosphere with lots of chatting and laughing. Young people were helping with the clearing and washing up. A young forum takes place weekly facilitated by an independent advocate and outcomes from the meeting are displayed on a noticeboard. We also saw how the unit management respond to any issues raised demonstrating their commitment to responding to the voice of the young people they care for.

3.13 However, the unit is often at capacity and availability of in-patient facilities for young people who become mentally unwell are inadequate to meet the needs of the area. During the inspection we became aware of two young people who were being cared for in an adult environment, and whilst appropriate assessments had been made adult wards are not the most appropriate environment for young people to be cared for. On one of these occasions, the trust had not completed the CQC notification although this has since been addressed. **(Recommendation 1.1).**

Patient S is a 17 year old female who was admitted to a designated adult mental health in-patient ward because there was no adolescent CAMHS bed available. The age appropriate care assessment and risk assessment were completed and the CQC notification sent. S was nursed on Level 3 observations in view of significant self-harm risk and suicidal ideation. The age appropriate care assessment determined that it was appropriate for S to remain on the adult ward, though she remains on a waiting list for transfer to the CAMHS in-patient ward when a bed is available. S is keen to transfer to the CAMHS ward as she is anxious to maintain her studies and young people on the CAMHS unit have access to education staff and resources.

3.14 Health professionals would benefit from further training on how to assess and articulate risk when completing referrals to social care, as the children's social workers are not health experts and may not always understand the implications of what was often a chronological description of events. Some referrals seen were more of an 'information sharing' event and some health practitioners were phoning the Initial Response Team for consultation and not recording details of conversations held. **(Recommendation 2.1 & 2.2)**

3.15 The inspection team found significant challenges in resolving inter-professional disagreement in the assessment of risk. Health staff are using escalation policies and are supported by their safeguarding team in doing so, but this had required persistence and has not always secured satisfactory outcomes. This was felt by health professionals to be an increasing challenge following the agreement and dissemination of the threshold documentation issued by LSCB. We saw cases where health professionals are holding cases where children are vulnerable, with no multi agency plan in place to protect them. This was compounded by an over reliance across agencies that each professional is accountable for their own professional role to a family or child without limited evidence of a shared goal, governance or partner responsibilities for the wider team around a child arrangements. This means that some children are not being adequately safeguarded. **(Recommendations 2.1 & 2.2).**

3.16 Overall, there is good attendance at child protection conference and core groups by health practitioners and most health practitioners spoke enthusiastically of the new 'strength based conferencing' approach to child protection planning. Mid and West Essex GPs are taking part in a pilot project to strengthen their contribution to child protection work through enhanced reporting. Early feedback from the local authority is positive with more meaningful reports helping to better inform social workers on the levels of risk within a family.

4. Looked after Children

4.1 The CCGs, through the Safeguarding Children Clinical Network (SCCN) and its strategy for improving outcomes for looked after children in care and after care, has responded well to the challenge of improving the awareness of the health needs of looked after children and the responsibilities of the CCG and provider organisations in responding to and meeting those needs. However, there is still much work to do to enable accurate identification and reporting on the specific health needs of looked after children and to demonstrate improvements in their health following intervention and support.

4.2 Service level agreements and key performance indicators have been drawn up for Looked After Children by the Designated Nurses as an Essex Wide arrangement and are shared with commissioners across Essex. Training in the health needs of looked after child is ongoing throughout provider organisations with varying levels of progress.

4.3 We saw examples of improvements in the quality assurance and monitoring arrangements for CLA through local quality assurance and monitoring by the SCCN. This has led to improvements in outcomes for young people including improved discharge planning from Tier 4 CAMHS services. A joint health and social care audit is about to be undertaken to assess the quality of joint working for children looked after.

4.4 The multi-agency pilot inspection of November 2012 highlighted 3 key areas requiring improvement in the health of looked after children: quality and timeliness of health assessments, provision of health information to care leavers and SDQ information contributing to health assessments. There has been progress in some areas.

4.5 In the North East, the quality of initial health assessments has improved since they have been completed by the medical advisor for adoption. However, there remain areas of concern over the unacceptable and avoidable delays in completing initial health assessments because of late notification and poor information sharing between partner agencies. **(Recommendation 2.4)**

4.6 The quality of initial health assessments undertaken in some areas was poor, covering basic information only and giving little sense of the personality, character and voice of the child. There was no information about parental health histories on most of the IHAs sampled in the West. This represents the loss of essential information, necessary to the child going forward in life into adulthood. There is often only a single opportunity to gather and record this information and the fact that most cases reviewed had lost this opportunity is of concern and may have significant impact on the young person in the future. **(Recommendation 2.4).**

4.7 We found that medical practitioners undertaking assessments of unaccompanied asylum seekers do not have specific training or support in working with this minority group, and initial health assessments seen did not demonstrate awareness of issues relevant to their asylum seeking status that may impact on physical or emotional well-being. This could undermine effective care planning.

4.8 Information about a child looked after's ethnicity is not always accurately recorded. This could have implications for health care delivery not being culturally appropriate and is an area for development to ensure that ethnicity, language, religion and all appropriate diversity issues are correctly identified. **(Recommendation 2.4).**

4.9 GPs are not being routinely asked to contribute to the initial health assessments and health reviews about looked-after children registered with their practice. Therefore, the opportunity for health practitioners to carry out comprehensive and well informed health assessments and reviews may be missed. Where children are looked after and are in receipt of CAMHS support, the review health assessments are not informed by any progress report from CAMHS or any identification as part of the review as to the reason and purpose of the CAMHS intervention. In one case where the foster carer was worried about the child's tendency to engage with strangers in an over familiar way, it was not clear whether this was a new concern which was not subsequently addressed in the health plan, or whether this was an issue already being addressed by the CAMHS intervention. **(Recommendation 2.4).**

4.10 In some teams robust quality assurance was driving consistency and improvements in the quality of health reviews and embedding more detailed assessments linked to SMART care planning, however, this is not consistent across all three CCGs. In all cases seen in the West the quality of health plans were poor. Health plans were not SMART. Timescales and accountabilities are vague making it difficult to identify how progress would be measured or failure to deliver addressed. **(Recommendation 2.4).**

4.11 In most cases we saw young people are being asked about risk taking behaviours and substance misuse in their health assessments and reviews although this is not routinely addressed through the use of a standardised screening tool. We saw cases where concerns had been identified through assessment but there was no evidence seen which demonstrated that these concerns had been followed up, potentially leaving the young person at continued risk and remaining vulnerable. **(Recommendation 2.4).**

4.12 The use of Strengths and Difficulties Questionnaires (SDQs) within the looked-after child health process is intermittent, and opportunities for SDQs to routinely inform health reviews and for the young people themselves to map their own emotional journey over time using SDQs, are being lost.

4.13 Children looked after are referred for emotional health and wellbeing support to the single gateway where their looked after status is considered along with other risks and vulnerability. Data seen by the inspectors shows that not all referrals into the service are identifying a child or young person as being looked after. This could mean that clinicians carrying out the screening are not in possession of all pertinent information. We note that discussions are taking place on reconfiguration of CAMHS and that designated nurses are advocating for priority to children looked after.

4.14 There are now robust arrangements in place to ensure all practitioners and agencies involved with any child who is looked after and an in-patient at the St Aubyn's Unit, are informed of their care and treatment and included in discharge planning. A recent internal trust audit on learning from a serious case review found compliance and good practice

4.15 Where children looked after have moved areas within Essex, it is not always easy to track their journey on the IT system. When children and young people come into a CCG locality from other areas, a chronology of significant health and life events entered onto the IT system could facilitate the tracking of a child's journey

4.16 Children looked after health teams are experiencing difficulties in ensuring that Essex children placed out of area are able to access health services as needed, especially as some areas are refusing to do health assessments. Work is ongoing with children's social care before placements are made to ensure that services will be in place. There are also recognised difficulties in Essex children accessing CAMHS if placed out of area. This could mean that some children are not accessing timely support and are therefore disadvantaged by being placed out of their home county. The named nurses are aware that any concerns regarding access to health for children placed outside of Essex are to be escalated to Designated Nurses for escalation and resolution.

4.17 The training of looked after children nurses in child sexual exploitation has had a positive impact and has already led to increased awareness and risk assessments taking place on recent care leavers to ensure their ongoing safety.

4.18 We saw some case examples where the young person had signed their own consent giving them a greater sense of control over the assessment. This is positive practice.

4.19 Where review health assessments were undertaken by health visitors and school nurses, we saw a greater prominence of the voice of the child and attention being given to bringing out the personality and character of the child through the review process.

4.20 Specialist looked after nurses for older young people, where they are in post, demonstrate flexibility and commitment to encouraging young people to attend a final health review and the nurse in West Essex is actively engaged with the Children in Care Council looking at how engagement can be increased.

4.21 Variability continues in the quality of health summary information provided to young people leaving care. The health passport has been introduced in West Essex but not in the other two CCGs. While there was evidence that some children looked after had indicated that they did not want formal health passports, the lack of clear plans and recording relating to their final health assessment and identification of any ongoing health need could undermine effective support to young people at transition and later into adulthood

Management

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

5.1 Leadership and management

5.1.1 The NHS England Local Area Team (LAT) is fulfilling its statutory responsibilities in safeguarding; funding for 2013/2014 for named GPs and financial contribution to LSCBs has been agreed with the CCGs. There is clarity around governance and assurance through the Health Executive Forum, the Safeguarding Business Meetings and the Child and Young People Safeguarding Forum which takes place jointly with East Anglia CCGs. The LAT recognise the lack of specialist safeguarding children experience within the team, however, this is mitigated by the support provided by the designated professionals through the SCCN.

5.1.2 Clinical Commissioning Groups, through the SCCN, provide clear leadership on safeguarding children practice across Essex. The arrangements put in place by the CCGs are providing the Boards with robust assurance on safeguarding children practice across the local authority area.

5.1.3 The SCCN has positively impacted on safeguarding children practice across North Essex, bringing a consistency in approach but allowing for local flexibility. Work continues to strengthen the SCCN as it drives forward the safeguarding children agenda, with the re-drafting of Collaborative Agreement and budgets to reflect national and local changes and to ensure readiness for 2014/2015

5.1.4 Senior health leaders told us of an improving working relationship with the Essex County Council. They felt that safeguarding is 'woven into the fabric of new ways of working.' Deputy Directors of the council are now aligned to the CCGs and sit on their boards, demonstrating a commitment to partnership working to help better meet the needs of local populations. An example of this was how the local authority and CCGs are working together at a senior level to explore an outcome focused early intervention model to support children and families in Essex. However, there remains a significant amount of work at operational level if this is to be successful.

5.1.5 The voice of young people continues to be underdeveloped in the commissioning of services. A designated nurse within the SCCN takes a lead on the voice of the child within safeguarding/LAC services. However, the individual CCGs recognise this gap and are starting some early work to identify and promulgate good practice across the County.

5.1.6 North East Essex CCG and providers have gaps in current named and designated professional arrangements due to one vacancy and also long term sick leave. Cover is being provided from across Essex teams. There was no evidence that this had undermined the effectiveness of arrangements relating to children looked after, but it had contributed to difficulties in addressing problems relating to ensuring GP compliance with safeguarding training.

5.1.7 The safeguarding team within North Essex Partnership NHS Foundation Trust is significantly under resourced. The team provide services and support for vulnerable adults, safeguarding children, Prevent agenda, Multi Agency Risk Assessment Conference, Mental Capacity Assessments and Deprivation of Liberty Safeguards. The recently developed 'barometer' to record safeguarding activity across the trust is effectively identifying areas of concern, however, there is no capacity within the team to explore these areas in detail (**Recommendation 5.1**).

5.2 Governance

5.2.1 One of the successes of the SCCN has been the development of key performance indicators used with provider organisations to drive improvement in safeguarding children practice, with close monitoring of contracts to ensure compliance. We heard how one CCG had used the contract query process to hold a provider to account for an unexplained and continued breach of its performance on training. This has now been resolved and the trust is back on trajectory to meet end of year targets.

5.2.2 Performance against Essex's looked-after child strategy is reviewed in the quarterly meetings of the CCG designated leads for looked-after children. This meeting is helping the leads to identify trends and common areas for development to focus their improvement agenda. CCGs are engaged positively as a member of the corporate parenting board, keeping health of children looked after high on the agenda.

5.2.3 The named GP for the hub is working collaboratively with the named GPs for Essex to effectively raise the profile of safeguarding children and children looked after. There is evidence of learning from local serious case reviews in primary care and we saw how the introduction of the young person's registration form had raised the profile of household composition and other agency involvement with the family to enable the GP to have a much more detailed profile of their patient.

5.2.4 The lead for primary care has also been successful in negotiating a Section 11 type audit within primary care as well as issuing guidance for GPs in caring for children looked after. This has been noted as good practice by the Royal College of GPs.

5.2.5 We also saw good learning from a recent serious case review through the development of a significant events sheet used in case notes across Mid Essex Hospitals. This sheet is kept at the front of all children's files and is used to log significant events including fractures or missed appointments which are unexplained. The form brings such events immediately to the attention of health professionals and acts as a log of events that might inform any future action being considered to safeguard the child.

5.2.6 Colchester Hospital University Foundation NHS Trust has a well resourced safeguarding team who provide an effective screening system where practitioners have identified concerns or safeguarding issues. However, the lack of any QA system to review cases to ensure that all relevant issues are identified means that the trust cannot assure itself of the standard of practice in this area

5.2.7 The North Essex Partnership NHS Foundation Trust has very recently transferred to a new IT record system. During this transition, staff are having to access two IT systems as well as having a paper file. On some records we inspected risk assessments around the safety of children are difficult to find, and paper records did not contain details of the professionals meeting or copies of referrals. This lack of a complete set of records in one place is high risk when dealing with vulnerable patients.

5.3 Training and Supervision

5.3.1 A primary care resource pack has been developed to include safeguarding and looked-after child responsibilities, advice and guidance for GPs. This has been reviewed and revised and updated as required. However, compliance in GP's attending safeguarding training remains a concern in North East Essex, with ongoing dialogue with NHS England, named GPs and the SCCN to try and improve the numbers of GP appropriately trained..

5.3.2 A training workshop is planned for West Essex safeguarding commissioning and provider staff on FGM in February. A training package and the learning outcomes will be available through the SCCN to other areas at the end of March 2014.

5.3.3 Designated professionals from the SCCN had worked closely with the local university providing nurse training to support delivery of Level 3 safeguarding children training to Year 3 graduates. This meant that new nurses employed by the provider trusts from this university were already competent in safeguarding children practice.

5.3.4 Compliance with safeguarding training across midwifery services in Colchester Hospital University NHS Foundation Trust is improving from a low base and recently has required all midwives to be retrained to Level 3 to support the intercollegiate guidance. The trust report that they are on track to meet their target.

A nursing assistant employed by the North Essex Partnership Foundation Trust on an adult in-patient mental health ward had recently attended her Level 3 Safeguarding Training. During a shift, the nursing assistant was speaking with a patient who disclosed to her that she wished to end her life; further and sensitive questioning by the nursing assistant elicited additional information that the lady had also thought about how she would do this and how she would include her children in her plans. The nursing assistant directly related this to the content of her training and quickly escalated her concerns through the clinical and safeguarding routes. Arrangements are now in place to safeguard the children.

5.3.5 The Provide named nurse for health visitors advised us that safeguarding level three training now includes training in the use and benefits of genograms to effectively map family make up and relationships. Genographs are also being used routinely within mental health services across North Essex. This can be useful when referring cases to social services as it was easy to better understand the family relationships. This is good practice.

5.3.6 Anglian Community Enterprise have been successful in achieving 100% compliance for Levels One to Three.

5.3.7 Routine safeguarding supervision across providers within the three CCGs is underdeveloped. In some providers there are no arrangements for key staff groups such as midwives, to access routine safeguarding supervision and there is no process to check practice to identify that all risks are being identified or the quality of assessment. Supervision is not always being provided by practitioners who have been trained appropriately and we saw no evidence on how supervision is being used to support health practitioners in understanding and implementing family support as agreed in the Essex threshold document. **(Recommendation 2.2)**

5.3.8 Princess Alexandra Hospital has introduced a more structured model of supervision for midwives in line with national guidance. Midwives' feedback indicates this more rigorous model is being well received and they feel more supported.

5.3.9 One of the strengths of supervision across Essex is the development of peer review for medical staff, including the SARC. This allows for the continued professional development of medical practitioners in safeguarding children practice.

Recommendations

1. **NHS England Area Teams , Mid Essex CCG, North East Essex CCG and West Essex CCG should:**
 - 1.1 *Review the capacity of in patient facilities and arrangements available to children to ensure that children and young people who require an in-patient stay are able to be cared for as close to their home as possible.*

2. **Mid Essex CCG, North East Essex CCG and West Essex CCG, in conjunction with NHS providers should:**
 - 2.1 *Support and work with front line practitioners to promote their understanding and implementation of the Essex LSCB threshold document.*
 - 2.2 *Review the arrangements for safeguarding children supervision to ensure it is delivered by appropriately qualified supervisors on a regular basis with outcomes that support practitioners to deliver high quality packages of care in line with the Essex LSCB threshold document.*
 - 2.3 *Develop and implement pathways of care, including pre-birth protocols, to support vulnerable women in pregnancy to ensure best outcomes for the woman and child.*
 - 2.4 *Work with providers to embed a continuous programme of quality assurance to ensure that all initial health assessments, health reviews and health planning for looked after children are carried out in a timely way and with the appropriate consents, contain:-*
 - a) *Parental histories, where possible.*
 - b) *Contributions from General Practitioners where children and young people are registered.*
 - c) *Culturally appropriate details, including ethnicity, religion and language.*
 - d) *SMART health plans that reflect the child's ongoing health needs.*

3. **Mid Essex CCG, Mid Essex Hospital Services NHS Trust and Central Essex Community Services should:**
 - 3.1 *Review and establish robust sharing of information around notification of pregnancies between midwifery services and health visiting services to ensure that pregnant women who are vulnerable are known as early as possible to health visitors to provide early intervention and support.*

4. North East Essex CCG and Colchester Hospital University Foundation NHS Trust should:

- 4.1 *Review the safeguarding arrangements within its Emergency Department to ensure that the green cards are fully completed for young people between the ages of 16 and 17.*

5. North Essex Partnership NHS Foundation Trust should:

- 5.1 *Review the capacity of the named safeguarding professional team to ensure that safeguarding professionals are able to fulfil their roles as outlined in “Working Together to Safeguard Children 2013” and the Royal College Intercollegiate Guidance 2010.*

Next Steps

An action plan addressing the recommendations above is required from Kathie Clibbens 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.