Care Quality Commission

Review of Health Services for Children Looked After and Safeguarding in Waltham Forest

Children Looked After and Safeguarding
The role of health services in Waltham Forest

Date of review:	30 September 2013 – 4 October 2013
Date of publication:	11 November 2013
Name(s) of CQC inspector:	Lea Pickerill Jan Clark
Provider services included:	Barts Health NHS Trust North East London NHS Foundation Trust
CCGs included:	NHS Waltham Forest Clinical Commissioning Group
NHS England area:	NHS London
CQC region:	London
CQC Regional Director:	Matthew Trainer

Contents

Summary of the review **3**
Context of the review 4
About the review 5
How we carried out the review 6
The report 6
What people told us 7

The child's journey **8**
Early Help 8
Children in Need 10
Child Protection 12
Looked After Children 14

Management **16**
Leadership & Management 16
Governance 17
Training and Supervision 18

Recommendations **20**

Next steps **21**

Summary of the review

This report records the findings of the review of health services in safeguarding and looked after children services in Waltham Forest. 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 Waltham Forest, 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.

Context of the review

Waltham Forest is an outer London borough with a population of 258,200 persons living in over 96,900 occupied households. Population density tends to be higher in the middle and southern wards of the borough compared to the northern wards. In terms of ethnicity the middle and southern wards of the borough also tend to be more diverse whilst a higher percentage of the borough's white population is found in the northern wards.

Just over half the borough is female (50.1%) and the borough has a similar age profile to London as a whole, with a larger percentage of children and people aged 20-39 than the England and Wales average. The largest number of households in the borough is single households (29% of all households) although 41% of the borough population live in family households with dependent children (23% of all households). Data on arrivals from other countries over the last eight years show that most new migrants come from Poland, Pakistan and Lithuania.

Waltham Forest continues to be one of the most deprived boroughs in England. In terms of the overall measure of multiple deprivation (IMD 2010) Waltham Forest ranks 15th most deprived among the 326 local authorities in England. Its position has declined from 26th in 2007. Out of 33 London boroughs, Waltham Forest is sixth most deprived

Waltham Forest has one Clinical Commissioning Group (CCG) that operates within the borough. NHS Waltham Forest Clinical Commissioning Group (WFCCG) was authorised in wave four of the CCG authorisation process (March 2013) and was given a conditional authorisation with 25 conditions and 5 directions. One of the directions given to the CCG was that the CCG should use NHS Tower Hamlets CCG as its lead commissioner for Barts Health NHS Trust. (Tower Hamlets CCG assumed this responsibility from Tower Hamlets PCT). This means that from 1 April 2013, NHS Tower Hamlets CCG has the responsibility of commissioning services at Barts Health NHS trust on its own behalf, and also on behalf of NHS Waltham Forest CCG.

There are two health providers within the borough of Waltham Forest: Barts Health NHS Trust and North East London NHS Foundation Trust.

The majority of Barts Health NHS Trust's clinical services for children are based at the Children's Hospital at the Royal London Hospital in Whitechapel (based in the borough of Tower Hamlets). However, Whipps Cross University Hospital (another Barts Health NHS Trust hospital) is within the borough of Waltham Forest and provides a full range of services for paediatric, medical and surgical conditions. Whipps Cross University Hospital also provides neonatal follow up and neonatal neuro-developmental services.

North East London NHS Foundation Trust (NELFT) provides community services to people in North East London and South West Essex. Children's community health services and child and adolescent mental health (CAMH) services are both provided within Waltham Forest. CAMH services, including a CAMH service for looked after children, are provided at Thorpe Coombe Hospital. Additionally, the trust has a substance misuse service within the borough. Other children's services are provided by this Trust but are carried out in other Local Authority areas, including the adolescent inpatient unit at Goodmayes Hospital (Brookside) which provides services in Redbridge. NELFT community services are commissioned by NHS Waltham Forest CCG to provide a service for statutory health assessments for looked after children in Waltham Forest.

Waltham Forest was part of the joint Care Quality Commission (CQC) and Ofsted safeguarding and looked after children's (SLAC) inspection program in September 2011.The safeguarding inspection judgement for 'Contribution of health agencies to keeping children and young people safe' was assessed as 'adequate' and the looked after children inspection outcome judgement for 'Being Healthy' was assessed to be 'inadequate'.

Recommendations from that inspection are covered in this review.

About the review

The review was conducted under Section 48 of the Health and Social Care Act 2008 which permits CQC to review all aspects of 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. 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 34 children and young people. We have included some of their stories to illustrate areas of good and poor practice or to demonstrate service provision.

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 parent of children who have a child protection plan in place told us that "*the school nurse is really good and she always shares the report for conference with me, my kids really like her*."

An evaluation form completed by carer in a pre-adoptive placement stated *"very friendly and child orientated. My son had a lovely time, very positive and professional"* about the looked after child health team.

A foster carer told us that *"the paediatrician knows my foster child well and always writes an update in his red book, which I find helpful. I feel involved in his health reviews, although I don't get a copy of the report, which I would like to have"*

We heard about

Effective liaison between the Waltham Forest LAC nurse and Kent LAC nurse in respect of getting early and appropriate support for a looked- after young woman who is pregnant. Robust midwifery and family nurse partnership support is in place.

Positive outcomes for a young person who had worked with CAMHS and other professionals in understanding the reasons for why he became looked after. Dispelling some of the myths and fantasies in his head about the past has resulted in more settled behaviours.

A case that had been allocated for routine monitoring as part of the universal service was later moved into partnership plus following its referral to the multi-agency risk assessment conference (MARAC). This case had a long history of domestic violence and identified initial poor decision making by practitioners.

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 The jointly commissioned "Best Start in Life" programme is beginning to impact positively on those families that need extra support quickly. Families in need of extra support are placed on appropriate pre-determined care pathways. Initial reports show that this approach is helping to avoid concerns escalating, although this evidence is anecdotal as the programme has only recently commenced. There is enthusiasm across the pilot sites for this multi-disciplinary, multi-agency approach, though we noted that GPs are slow to engage and, as yet, there is no formal evaluation to monitor success or identify areas for improvement.

1.2 Most women in Waltham Forest access maternity services through their GP; we observed significant variability in the quality of the information provided by the GP in their referral pro-forma. One GP gave full details of the woman's relevant health history, including mental health concerns and prevalence of domestic violence, whilst another referral contained only the basic information and failed to identify significant vulnerability within the family. This inconsistency can mean that a woman with vulnerability may experience delay in being allocated to the specialist Ruby midwifery team.

1.3 We saw considerable progress, since the previous inspection, in the work of maternity services to identify and safeguard vulnerable women and their unborn children. The new maternity notes are a considerable improvement and provide a more holistic assessment of risk.

1.4 We found that families are receiving effective support as part of the Healthy Child Programme, through a combination of visits and clinic appointments offered by health visitors, school nurses and nursery nurses. However, there are gaps in this service and currently there is no routine ante natal involvement; nevertheless, if there is identified vulnerability an antenatal is sometimes undertaken. Current commissioning arrangements mean that health visitors do not carry out maternal mood checks and, as the GPs perform the 6 weekly baby development check, some mothers with post natal depression may be missed. This gap in health visitor engagement in the early days could result in a missed opportunity to identify any emerging concerns and delay in any subsequent offer of support.

1.5 We saw good evidence of health visitors obtaining and recording details of birth father's details. This is a new initiative within the service and helps with information sharing where there is vulnerability around domestic violence, substance or alcohol misuse or other related issues. This is especially important where perpetrators of domestic violence or other behaviours that impact negatively on family life move on to live with or create new families.

1.6 All cases reviewed demonstrated close and effective communication between health visitors and school nurses. The services work in close co-operation to support families and children effectively. This means that families receive a consistent message about roles and responsibilities of health professionals and about how individual families can work to help meet their children's needs.

1.7 School nurses demonstrate sensitivity to the diversity, cultural and language needs of the community they serve, taking good care to ascertain needs for interpreters prior to first contact and in seeking consent from young people to undertake health checks and share information.

Clinical streaming within Whipps Cross Hospital is working effectively to triage patients and facilitate assessment by the most appropriate health care team. We saw how a young mother with a baby had not been able to obtain an appointment with her GP. The clinical streaming GP team were also unable to contact the GP so the baby was seen promptly by the primary care professional working in the urgent care centre.

1.8 Paediatric A&E carry out a comprehensive assessment of the child or young person on admission, including the full details of both parents, as well as establishing who has parental responsibility. The clinical triage notes indicate if the presenting injury or condition is consistent with the explanation offered. A note is also made of who is accompanying the child to the department. Effective paediatric liaison ensures that attendance of children and young people are shared with the GP, health visitor or school nurse, including those children who are not normally resident in Waltham Forest. Case file sampling evidenced consistent good practice and enabled the health professional to follow up with the child, young person or family any outstanding health issues or concerns.

We talked to one young couple who had attended the paediatric A&E a number of times over the weekend with their new baby. They told us that they didn't think the medical staff were listening to them and that they kept being sent home with conflicting advice. At the time of the visit, the decision had been made to admit the baby to the paediatric ward for a period of observation.

1.9 Practitioners in adult A&E are vigilant to the impact of parent's mental health, substance misuse or domestic violence on children in the family and take appropriate action in either escalating the concerns to the department's safeguarding lead or referring to children's social care. This early identification enables agencies to consider the needs of children and young people who are living in vulnerable families as well as how to support their parents.

1.10 Young people do not have access to dedicated contraceptive clinics. Sexual health services are now commissioned by public health. There is an on-going review of sexual health services across Waltham Forest. These services are recognised as not meeting the needs of its young people. In response to the previous inspection, a number of new satellite clinics were commissioned across the borough, however, they are not in locations that young people will access and are poorly attended. There has been an increase in the number of pharmacists who now prescribe emergency contraception and the condom distribution scheme has been extended. The rate of under 18 conceptions across the Borough has continued to decrease and is now in line with the London averages.

2. Children in Need

2.1 Midwives carry out thorough assessments of risk and where concerns are identified, these are shared early with health visitors through a paper referral system. Health visitors do not often attend pre-birth conferences apart from in cases where the family is previously known to them through older siblings and they are not commissioned to provide ante natal contact. This means that health visitor involvement with families of concern is often not until the baby has been discharged home and is a lost opportunity for the health visitor to engage early and work with a family to plan and reduce risk. Younger teenagers are referred to the Family Nurse Partnership for support from early pregnancy up until the child is two years old. For those that choose to engage with the programme, outcomes for children are good. For other teenagers, good support is available through the local authority's targeted youth support service.

2.2 Pregnant women with additional vulnerability are cared for well by the Ruby midwifery team. Joint clinics are held with psychiatry for complex cases which is in line with NICE guidance and is good practice. The drugs and alcohol team liaise well with perinatal mental health services. Both services can access the same IT system which facilitates effective communication and ensures close monitoring of perinatal and infant health. We saw good examples of how missed appointments were followed up promptly by the different professionals working together to re-engage pregnant women with maternity and adult mental health services.

2.3 Health visitors ensure that vulnerable families that transfer out of the London Borough of Waltham Forest are appropriately referred to their new health visiting team. We noted good practice in the safe transfer of a young teenage mother. The health visitor made contact with the new health visitor and confirmed with the old GP that the baby had received the 6 week review and was up to date with its immunisations.

> In one case we saw an example of how a mother and baby had clearly benefited from the support of a child protection plan on discharge from hospital. Progress was such that the plan was discontinued and the family continued to receive support as part of child in need and were then soon discharged back to universal services. The health visitor provides on-going support.

2.4 We found good practice within Paediatric A&E in the sharing of concerns around children and young people who had attended the department. The use of the communication book and weekly multi-disciplinary meetings are an effective way of making sure that any loose ends or outstanding concerns are resolved.

We looked at the case of one young man who had attended A&E following an incident of self-harm and, though he had been seen by the on call psychiatric team and discharged, the case was discussed at the multi-disciplinary meeting and a referral subsequently made to the children and families counselling service.

2.5 Support for young people attending A&E with emotional, behavioural and mental health is inconsistent. Young people who attend A&E following an incident of self-harm are usually admitted to the medical admissions unit for a period of observation. This is an adult environment where the majority of patients are elderly and nursing staff may not be trained in the assessment and care of young people. The paediatric ward does not admit young people over 16 or where younger adolescents are known to have behavioural problems. A meeting has been arranged within Barts Health to address deficiencies and inconsistency in practice in meeting the needs of this group of young people.

2.6 Adult A&E staff demonstrate good practice in the identification and follow up of child protection concerns. We examined one case where a practitioner had identified well the implications of the patient's substance misuse on her ability to safeguard her children. A referral was made to children's social care even though her children were being cared for under a special guardianship arrangement. The midwifery team was also contacted as the woman disclosed she was pregnant.

2.7 Across the London Borough of Waltham Forest there has been an increase in the number of children and young people accessing mental health services and we are told that this is because of the improved assessment process. The cases we reviewed showed that children and young people were accessing the service in a timely way and were receiving an effective service.

2.8 CAMHS professionals are aware of potential for cultural beliefs and norms to have a negative impact on young people's willingness to engage with services and take appropriate steps to address this. More positive engagement has resulted from recognition of these issues in several cases. To support families where English is not the first language, we found that independent interpreting services are used to facilitate assessments and consultations with young people and their families. We were told how GPs across Waltham Forest do not routinely respond to contacts from CAMHS when they were seeking further information about the child, young person or their family and this could impact on the accurate assessment of the child and subsequently on the effectiveness of any care intervention.

2.9 Where concerns about the mental health and wellbeing of a young person have been identified and referred to CAMHS, practitioners are persistent in endeavouring to engage the young person. Cases are only closed after a prolonged period of trying to engage and closing letters contain appropriately tailored strategies to help the young person along with contact details of local services. Practitioners within the 722 substance misuse service continue to try and engage with a young person until they are 19 years of age.

2.10 There is improvement in the notification of children being discharged from tier four provision back to community services. Paediatric liaison now routinely notifies community services of the event and this facilitates a child's effective and seamless transition to community health support.

3. Child Protection

3.1 We found that most professionals understood the thresholds for referral to children's social care though they experienced some variability in how these were applied when making referrals.

3.2 We saw evidence of appropriate escalation to named nurses for advice and support when there were areas of professional disagreement. In all the cases we saw there had been satisfactory resolution. However, health professionals would benefit from further training on how to assess and articulate risk when completing referrals to social care. This would enable children's social workers, who are not health experts, to understand the implications of what the issues are, rather than receiving a chronological description of events.

3.3 In some cases we examined there was delay in agencies working together to protect children either through formal child protection procedures, child in need or early help. In one case we looked at there had been good identification of child protection concerns by the adult A&E worker. However, there was a degree of complacency about the safety of the children, who it was assumed were well cared for by the father, despite there being serious allegations about his behaviour.

3.4 The attendance and participation in child protection processes by adult mental health practitioners continues to improve but remains an area for development. The child plans are not easily accessed on the IT system, therefore it can be difficult for practitioners to easily identify the key elements of the child protection plan and their role in delivering it.

3.5 A lack of consistency in how adult mental health professions reports to child protection conference means that not all key issues are addressed in the report. Managers of adult services cannot yet be confident that practitioners are routinely and consistently using a "Think Family" approach and prioritising child safeguarding. This is improving, however, as more robust governance and quality assurance is being introduced. A risk remains that the health and support of the adult receiving support overrides the needs and protection of the child within that family.

3.6 We found that communication between multi-disciplinary professionals outside of the formal child protection process does not always support families well. For example; in one case the school nurse trusted the child to inform CAMHS of side effects of medication. When the child had run out of antidepressants the nurse did contact CAMHS who advised if there were difficulties the mother should take child to A&E as no clinician was available to write new prescription; there was no engagement of GP to avoid possible presentation at A&E.

3.7 Health professionals across all health services demonstrated tenacity in following up families of concern, refusing to accept non-attendance at appointments or not being available for home visits. The health visitors, school nurses and midwives document clearly any concerns and make repeated efforts until they are successful in carrying out an appropriate intervention or consultation ensuring that the wellbeing and safety of children remain their priority.

3.8 We observed much good practice within midwifery services in supporting vulnerable pregnant women and protecting the unborn child. Vulnerable family liaison notification forms are completed and shared with local A&E services as well as other professionals involved in caring for the pregnant woman, including the labour ward. The use of these forms ensures a consistent message and details of who to contact in case of concern. In addition, when a newborn is placed on a child protection plan, the details of the plan are shared with the local A&E to help co-ordination of care and appropriate sharing of information to safeguard the newborn baby.

Women with perinatal mental health concerns have perinatal mental health plans in place to help make sure that labour ward and post natal midwives understand the risks and triggers around the new mother's mental health. We saw one case that demonstrated careful and sensitive management of induction of labour which helped to keep the mother well and baby safe. On discharge from hospital there was a planned transfer to the local mother and baby mental health unit where both are doing well.

3.9 Health visitors do not routinely carry out ante natal visits or attend pre-birth conferences for vulnerable families and often rely on the midwife notifying them of the birth. We did see occasional examples of health visitors attending discharge planning meetings resulting in a more co-ordinated approach which benefits families and professionals. However, on one occasion, a vulnerable mother and baby who had a child protection plan was discharged prior to notifying either the health visitor or community midwife.

3.10 Attendance at child protection conferences and core groups by health visitors and school nurses is good and their reports make clear recommendations to conference about the safeguarding needs of the child. Non-attendance of school nurses due to school holidays has been addressed through service reorganisation in the past 12 months and a school nurse presence is now achieved during school holiday periods. This is a positive development. However, health professionals need to contribute to the SMART planning of child protection plans to avoid working to timescales that are described as "on-going" and do not articulate measurable goals.

3.11 Some health professionals told us that there was occasionally confusion and miscommunication about the exact nature of meetings relating to a child resulting in key professionals not attending initial meetings at which child protection plans are formulated giving that professional a specific role. This means that not only may practitioners not fully understand the reason for their subsequent involvement but the opportunity for their input into early discussion has been missed, with the health needs of the child not being properly articulated or represented.

3.12 GP engagement in child protection is underdeveloped and GPs do not routinely respond to repeated requests from school nurses and other professionals for information relating to the health of children subject to child protection plans. There is no evidence of GP attendance at case conferences in the child protection cases reviewed. Anecdotally, children's social care receive reports and feedback from GPs but their attendance at child protection conferences is very rare. The GP reports to case conferences that we saw contained very basic information only and little that would inform the case conference of the parenting capacity of the adult or the child-parent interaction observed. In the GP practice we visited, although GPs had recently completed updated level three safeguarding training and were keen to improve their practice, they lacked confidence in how to respond in some cases where they had concerns and expressed the need for additional support.

3.13 We found that the local shared policies for the identification, response and support to young girls attending the sexual health clinic for contraception and termination services does not sufficiently safeguard these vulnerable children who are legally unable to consent to sexual intercourse.

4. Looked after Children

4.1 Improved arrangements to assess and review the health of looked after children in Waltham Forest are resulting in more comprehensive health plans being developed to improve their health.

4.2 Most initial health assessments are carried out within the 28 day statutory timescale. Although progress in meeting the 80% target has been slower than anticipated, there has been a significant increase in Initial health assessments (IHAs) since 2011. Rates of initial health assessments within the statutory timescale improved from 44% in 2011/12 to 69% in 2012/13. Assessments are generally of good quality and identify the health needs of the child well. Regular audit ensures consistency in practice and improvement in quality. Appropriately qualified paediatricians carry out the assessments and make significant efforts to obtain details of the parent's health to inform assessments of the child's current health and also implications for the future.

4.3 Review health assessments, again, show improvement in timeliness and quality. The local A&E notifies the looked after child health team of any attendances by a looked after child and these are considered as part of the review. The assessments are age appropriate, though do not always involve a comprehensive assessment for substance misuse (DUST) or Strengths & Difficulties Questionnaire. This is a missed opportunity to engage and involve young people. Peer review and audit continues to drive a continuous programme of improvement.

4.4 We saw good evidence of young people engaging with their health review and health assessment, with the specialist health LAC nurse employing a range of techniques to keep a young person motivated.

We saw good involvement of a young person in her annual health review. The review was held on time and, at the young person's request, it was held in her home. To help engage the young person in the review, she was asked if she wanted to complete her own health plan which she did and this was then supplemented by the notes from the specialist health LAC nurse; this is good practice.

4.5 We saw good processes in pace for audit of assessments and reviews carried out on Waltham Forest children placed out of area. The audits for these vulnerable children were often a 'snap shot', rather than a review of the child's overall journey and experience, and is therefore limited in its effectiveness to identify where improvements can be made. . Where looked after child health professionals have significant concerns over the quality of assessment for children placed out of area, these are fed into the corporate parenting board to ensure that no further children or young people are exposed to poor practice.

4.6 GPs are aware of any looked after child registered at their practice and the majority of looked after children in Waltham forest are permanently registered with a GP. However, GPs do not contribute to the initial health assessments or health reviews. This is a missed opportunity to enrich the quality of information used to inform assessments and reviews and contribute to the improvement of a child or young person's health.

4.7 The monitoring of actions arising from health reviews by the multi-disciplinary team is not always sufficiently robust and we saw recommendations of health plans that were not actioned in a timely way.

We also saw evidence of agencies working together to develop a support plan for a young person consisting of both practical and therapeutic support. The young person has been willing to engage and there is evidence of improved mental health and wellbeing for the young person as the quality of life is improved. E.g. "Coping through Football" service and funding for mobile phone and support for asylum application.

4.8 The fast track pathway for improving the emotional health and wellbeing of looked after children in Waltham Forest is effective. Professionals respond quickly to referrals and young people are seen promptly for multi-disciplinary assessment. Positive direct work with foster carers is carried out by the Fast Track team to increase carers understanding of behaviour by looked after children to secure long-term stability of the placement. We found creative use of SDQs in multi-disciplinary meetings when there are concerns about a looked after child's mental health. This could be further developed by using or adapting SDQs or other evidence based tools in review health assessments with competent young people to track their own emotional growth instead of stopping their use when a young person reaches 16 years of age.

4.9 The looked after child health team are working with young people and a participation officer to develop a calendar of health promotion events. A number of previously advertised health promotion events were cancelled at very short notice and this has impacted numbers attending events that have taken place since then.

4.10 The looked after child health team recognise that the health support provided to care leavers is poor. The specialist looked after child nurse told us about how she met young people who had left care who were engaging in risk taking behaviours and required assistance to access services. The team are not currently commissioned to support young people once they leave care at 18 years. We have noted that there have been improvements in the quality of the leaving health care summaries since the previous inspection.

4.11 We observed good support from a health visitor to a new foster parent and looked after newborn infant who was placed into Waltham Forest by a neighbouring London borough. The health visitor was persistent in chasing up the baby's health file and made regular visits to the family which were much appreciated. Improvements in the health of the baby were evident in an increase in its weight, consistent with that expected.

5. 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 CCG has had a difficult start and is still working with seven conditions and four directions in place. The CCG recognises, and is meeting, the challenges faced by commissioning high quality services for the children and families of London Borough of Waltham Forest from two very large NHS provider trusts that are, themselves, in the midst of extensive change. Good progress is being made and the CCG is demonstrating strong leadership, particularly in relation to safeguarding.

5.1.2 The CCG are well represented across the partnership with representation on the Local Children's Safeguarding Board, Child Death Overview Panel and Corporate Parenting Board. There is good engagement and increasing representation of the community on the CCG, with the Healthwatch manager recently appointed to the Governing Body board and good liaison with the Maternity Services Liaison committee. Although a member of the adult safeguarding board, Healthwatch do not currently attend the LSCB. The generally close working with Healthwatch and the announced joint visits and peer reviews to explore and report on the patient experience from a service user perspective is a good initiative.

5.1.3 NHS England, who host the designated professional forum across London, as well as the quality surveillance group, aim to promote consistency and good practice in safeguarding children through these groups. Both forums are in early stages of development, however, the designated safeguarding professionals and Director of Nursing for Waltham Forest are attending.

5.1.4 Governance and scrutiny of safeguarding practice has strengthened across agencies. Strong leadership and direction from the new chair of the LSCB is welcomed and individuals and agencies are being held to account more rigorously for safeguarding performance.

5.1.5 The team of named and designated professionals across Waltham Forest is not yet mature due to re-organisation and changes to key postholders and uncertainty within both NHS providers. Some stakeholders expressed concern around the on-going consultation on staffing within Barts and the impact that this may have on staffing within paediatric nursing. There has been good progress made in appointing a named GP who potentially demonstrates effective leadership in the role.

5.1.6 We observed a multi-agency safeguarding discussion on recent cases of concern. The named GP attended and presented the format and content of the forthcoming training on the recent learning from a safeguarding multi agency review. The outcomes from the LSCB serious case review panel, as well as national findings from serious case reviews, are brought to this multi-agency safeguarding meeting to explore implications for the local health economy and to decide how best local providers can respond to recommendations.

5.1.7 Both NHS providers had submitted annual safeguarding reports to their trust board, however, the annual report for safeguarding within North East London Foundation Trust did not evaluate progress, outcomes for children or identify areas for development. It does not set out measurable objectives for the coming year against which progress can be measured in this year's annual report. This is in direct comparison to a good example of an annual report for the looked after children in Waltham Forest submitted to the CCG earlier this year which clearly sets out the priorities for the forthcoming year.

5.1.8 It is positive that no under 18s have been admitted to adult beds when requiring in patient mental health treatment. The North East London Foundation Trust's policy requires notification to the Chief Executive in the event of this happening.

5.1.9 We were told that the looked after children health team have collected raw data on the health of looked after children and young people in Waltham Forest when they enter care. This is good practice. However this is not yet being used to inform commissioning of specialist services or to evidence the impact of health intervention they undertake; this is a missed opportunity.

5.2 Governance

5.2.1 Good progress is being made in commissioning services based on outcome measures on which key performance indicators are based and used to monitor performance and quality.

5.2.2 Safeguarding is a clear priority of the CCG Governing board and all members receive safeguarding training. Progress and monitoring of safeguarding children practice throughout Waltham Forest is reported on through a formal sub-committee of the main governing body board. This committee receive regular updates on issues raised through the clinical quality review meetings and on any concerns listed on their rag rated risk register.

5.2.3 Effective challenge at clinical quality review meetings hold NHS providers to account and we were able to see progress in local targets on safeguarding training and implementation of child protection supervision.

5.2.4 The LSCB multi agency audit how long children have a child protection plan in place and why a child may be returned to the protection of a plan once discharged. This work is having a positive impact in ensuring timely and effective support to families and avoiding drift in decision making. The focus of child protection planning is much improved and professionals from organisations are better at holding each other to account and minimising drift.

5.2.5 Monthly partnership meetings between the CAMHS service manager, Head of Safeguarding and the senior practitioner in child protection, social care discuss cases referred to safeguarding in the intervening month in order to seek feedback on outcomes from referrals and to discuss cases where there is lack of progress. This is positive and again demonstrates a commitment to improving outcomes for children and families. Further examples of joint working across the partnership which contribute effectively to risk reduction and child safeguarding include the monthly meetings across social care, looked after child health, adult substance misuse and perinatal mental health services, weekly maternity network meetings and the weekly paediatric A&E meetings. All are well attended and highly valued by participants. Practitioners engaged in these meetings were able to demonstrate how they had supported vulnerable families in a co-ordinated and planned way.

5.3 Training and Supervision

5.3.1 We note an improving picture in child protection training and supervision across both NHS Trusts and in primary care for those practitioners working in Waltham Forest.

5.3.2 In North East London Foundation Trust managers and supervisory staff acknowledge that while awareness of child safeguarding and “Think Family” is increasing, these issues can get lost as the focus is on the parent’s mental health. Other than discussing safeguarding as a standing item in one to one supervision, managers do not routinely dip sample records or reports by adult practitioners going to child protection conferences. There is no group supervision focused on child safeguarding and governance of child safeguarding in adult mental health to ensure good frontline practice is underdeveloped. As identified earlier, such practice can lead to the needs of the adult receiving support overshadowing the needs and safety of their child or children.

5.3.3 CAMHS practitioners working directly with young people are trained to level 3 safeguarding. Safeguarding supervisors are NSPCC accredited which is good practice.

5.3.4 The safeguarding supervision in 722 young people's substance misuse service is currently recorded on hard copy files. The supervisor and supervisee each have a copy, however, supervisory discussion is not routinely evidenced on the child's RIO record. This is being addressed.

5.3.5 All midwifery staff access child protection supervision on a regular basis. Midwives who work as part of the Ruby team attend one to one supervisory sessions. Although all midwives attend Level three safeguarding training, midwifery assistants are only assessed as needing Level two training. However, we were told that midwifery assistants, in fact, had accessed Level three training. The intercollegiate guidance recommends that practitioners who have significant contact with children and families should be trained at level three.

5.3.6 Supervision for health visitors and school nurses is prioritised and takes place on a regular basis. Practitioners report finding this very helpful to improve practice, reflective in nature and valuable. We noted good recording in the patient records with clear plans for action by the professional.

5.3.7 Foster carers receive training on the health needs of looked after children. This is delivered by the specialist nurse for looked after children and is provided at their request. This helps foster carers to better understand the health inequalities of this vulnerable group of children and young people and contributes to improved participation in statutory health assessments and reviews.

Recommendations

1. NHS England and Waltham Forest CCG should work with General Practitioners to ensure that they fulfil their responsibilities in safeguarding children and young people by:-

1.1 Ensuring that GP referrals to midwifery services contain the most up to date and relevant information.

1.2 Contributing effectively to child protection conferences by either attending the conference and/or submitting a detailed report on the child and their family to support effective planning.

1.3 Participating in the initial health assessment and health review for looked after children who are registered with their practice.

2. NHS England and North East London Foundation Trust to:

2.1 review the contract for health visitors to increase their involvement in ante natal support for vulnerable families

3. Waltham Forest CCG, North East London Foundation Trust and Barts Healthcare to:-

3.1 ensure that practitioners demonstrate appropriate identification of risk in their referrals to children's social care and contribute effectively to SMART planning in child protection conference and core groups.

4. Waltham Forest CCG and North East London Foundation Trust to:-

4.1 review performance metrics to include safeguarding children practice to evidence improved front line practice around "Think Family."

4.2 continue to collect data on the health of looked after children and use this to evidence improvement in the collective and individual health outcomes for this group of vulnerable of children and young people.

4.3 review the use of the Strength and Difficulties Questionnaire or other evidence based tools to monitor the emotional and mental health of looked after young people.

5. Waltham Forest CCG and Barts Healthcare to:-

5.1 review the training of midwifery assistants to ensure that it fully meets the requirement of the intercollegiate guidance

6 North East London NHS Foundation Trust to:

6.1 review the protocols and working arrangements within the sexual health service to ensure that children who access the service are appropriately safeguarded and protected from harm.

Next steps

An action plan addressing the recommendations above is required from the Waltham Forest CCG Director of Nursing, Quality and Governance 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 inspection arrangements.