Report on the Outcome of the Integrated Inspection of Safeguarding and Looked After Children’s Services in London Borough of Havering

<table>
<thead>
<tr>
<th>Date of Inspection</th>
<th>12th September 2011 – 23rd September 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Joint Report</td>
<td>28th October 2011</td>
</tr>
<tr>
<td>Commissioning PCT</td>
<td>NHS Outer North East London</td>
</tr>
<tr>
<td>CQC Inspector name</td>
<td>Tina Welford</td>
</tr>
<tr>
<td>Provider Services Included:</td>
<td>North East London Foundation NHS Trust</td>
</tr>
<tr>
<td></td>
<td>Barking Havering and Redbridge University</td>
</tr>
<tr>
<td></td>
<td>Hospitals NHS Trust</td>
</tr>
<tr>
<td></td>
<td>Outer North East London Community Services</td>
</tr>
<tr>
<td>CQC Region</td>
<td>London and south east region</td>
</tr>
<tr>
<td>CQC Regional Director</td>
<td>Colin Hough</td>
</tr>
</tbody>
</table>

This report relates to the recent integrated inspection of safeguarding and services for looked after children which took place in the above Authority recently.

It provides more detailed evidence and feedback on the findings from the Care Quality Commission’s (CQC) component of the inspection, and links these to the outcomes requirements as set out in the Essential Standards for Quality and Safety.

Thank you for your contribution to the inspection and for accommodating the requests for interviews and focus groups with your staff and those of partner agencies at relatively short notice.

The team provided feedback to your local Director of Children’s Services at the end of fieldwork and the joint inspection report to the authority is now published on the Ofsted website and can be accessed via this link: The joint inspection report.
London Borough of Havering Council and NHS Outer North East London

<table>
<thead>
<tr>
<th>Safeguarding Inspection Outcome</th>
<th>Aggregated inspection finding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall effectiveness of the safeguarding services</td>
<td>Adequate</td>
</tr>
<tr>
<td>Capacity for improvement</td>
<td>Adequate</td>
</tr>
<tr>
<td>The contribution of health agencies to keeping children and young people safe</td>
<td>Adequate</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Looked After children Inspection Outcome</th>
<th>Aggregated inspection finding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall effectiveness of services for looked after children and young people</td>
<td>Adequate</td>
</tr>
<tr>
<td>Capacity for improvement of the council and its partners</td>
<td>Adequate</td>
</tr>
<tr>
<td>Being Healthy</td>
<td>Adequate</td>
</tr>
</tbody>
</table>

This report includes findings from the overall inspection report, and provides greater detail about what we found, mapped where relevant to the Essential Standards, in order that your respective organisation can consider and act upon the specific issues raised.

A copy of this report is being sent to your commissioning PCT, and CQC Regional Director. This report is also being copied to the Strategic Health Authority/Monitor as appropriate and the CQC’s Regional Director, who has overall responsibility for this inspection programme.
The Inspection Process

This inspection was conducted alongside the Ofsted-led programme of children’s service inspections. These focus on safeguarding and the care of looked after children within a specific local authority. The inspection process comprises a range of methods for gathering information – document reviews, interviews, focus groups (including where possible with children and young people) and visits in order to develop a corroborated set of evidence which contributes to the overall framework for the integrated inspection.

CQC contributes to the inspection team and assesses the contribution of health services to safeguarding and the care of Looked after children relating to that authority. Our findings from the inspection contribute to the joint report published by Ofsted and also enrich the information we use to assess providers against the Essential Standards of Quality and Safety. This report sets out specifically the evidence we obtained in relation to these standards and extracts from the published report are included and identified.

CQC used a range of documentary evidence in advance of and during this inspection, and interviewed individuals and focus groups of selected staff and, where possible, children and young people, their parents and carers in order to provide a robust basis for the findings and recommendations.

This document sets out the findings in relation to the NHS organisations listed above, but includes some areas which may apply to one or more NHS bodies where pertinent.

Context:

Commissioning and planning of child and young person’s health services and primary care were historically undertaken by NHS Havering, from 1 April 2011 Outer North East London (ONEL) Cluster became responsible for commissioning of all services across the then four local primary care trusts. Historically, NHS Havering undertook its commissioning responsibilities supported by the London Borough of Havering and the local Children’s Trust. Universal services such as health visiting, school nursing, and paediatric therapies are delivered primarily by Outer North East London Community Services (ONEL CS) and also North East London Foundation Trust (NELFT). All health services are commissioned under NHS Standard contracts. ONEL Community Services will transfer to NELFT on 1 October 2011.

The acute hospitals providing accident and emergency services for children are part of the Barking, Havering, and Redbridge University Hospitals NHS Trust (BHRUT). All aspects of maternity health care and newborn services are provided by Barking, Havering, Redbridge University Hospitals NHS Trust.

Children and families access primary care through one of fifty three general practitioner (GP) practices, (107 GPs), 2 walk in centres including Orchard Village, Rainham, Harold Wood Polyclinic, and the Urgent Treatment Centre at Queens Hospital (BHRUT).
Child and adolescent mental health services (CAMHS) are provided across all the tiers by a number of providers including NELFT, the local authority and education, primary care and voluntary organisations.

There are no section 75 agreements in place. Children with complex needs care is commissioned on an individual care basis. However, most needs will be met under current health commissioned arrangements or through the local authority. Again this is supported by education, primary care services and a number of voluntary organisations. Joint commissioned services with The London Borough of Havering include speech and language therapy and breastfeeding. ONEL CS and NELFT commissions physiotherapy and specialist community services which include childrens community nursing team.

Looked after children (LAC) health services are provided by Outer North East London Community Services and NELFT.

General – leadership and management

1. The contribution of health agencies to keeping children and young people safe is adequate. There is good health representation, including from general practitioners, at the Childrens Trust board and on the Health and Well Being board, although this is not fully replicated at the Local Safeguarding Children Board (LSCB). There continues to be poor engagement and attendance by senior health staff at the Havering local safeguarding children board (LSCB). This is partially due to the number of LSCBs covered by the health organisations (up to five LSCBs) and a lack of capacity within the health safeguarding service. Although this has been recognised, a recently revised ‘attendance structure’ is yet to be fully embedded. Health staff report a lack of understanding by the LSCB members of the complexity of health provision and structures, consequently resulting in poor communication, poor monitoring and holding organisations to account, notably when reviewing the action plans from serious case reviews (SCR) and Section 11 safeguarding audits. Action plan timescales are not being consistently met, with some drift and a lack of effective scrutiny by both the LSCB and health trust boards, most notably at BRHUH NHST. The latter of which was, at the time of the inspection, introducing a revised governance structures.

2. Through the range of jointly appointed senior health posts (with the local authority) and the good link social care worker system within some health services, improvements in working relationships and communications have started to be realised.

3. All health organisations safeguarding policies and procedures, reflect the pan London safeguarding children policy however, their application and impact on practice has yet to be evaluated.

4. General practitioners interviewed were not aware of, or effectively utilise, the named safeguarding general practitioner.
5. The annual safeguarding reports are of variable quality and are not reported to or requested by, the Local Safeguarding Children Board (LSCB). They do not provide full analysis of areas of concern such as poor compliance with training. There is insufficient information and analysis in the annual safeguarding reports to enable the health trust boards to assure themselves that children and young people are adequately safeguarded. There is no health looked after children annual report.

6. As a result of the effective management of the patient pathways within child and adolescence mental health services (CAMHS) pathways are improving, with good and regular performance monitoring of outcomes for treatment intervention.

Outcome 1 Involving Users

7. There is an improving engagement of children and young people in service evaluation and experience activities. The regularly completed looked after children (LAC) health review satisfaction surveys show a flexible approach to appointment times and venues, which are highly valued by young people.

8. Children and young people with long term conditions and disabilities are fully involved in their health review processes. All have health care plans, which along with their personal education plans; enable all their carers, including education staff, to meet their health needs.

9. The CAMH service user group has developed their own quality standards to monitor service provision; however these have yet to be implemented. CAMH services are now planning to implement the ‘You’re Welcome’ quality criteria for young people friendly health service standards.

10. Children centres and youth centres, visited during the inspection, have limited service user information readily available in languages other than English or other formats. There is an increasing awareness within frontline health staff of the changing demographics within the children and young person’s population; however, this is not evident within practice. Staff have access to an interpretation and translation service; however, staff interviewed had not needed to access the service.

11. There is good involvement and engagement between the maternity services and the two local traveller sites. Maternity staff are gaining some awareness of the changing diversity of the local population especially within school age children. The impact of the changing demographics on strategic level service design, risk based assessments and provision has yet to be realised.
12. There has been effective engagement of parents of young people with disabilities in planning services; however, there is a mixed opinion on the success of consultation and consideration of their views with the closure and the reprovision of the child development centre (CDC) service. The closure of the CDC has resulted in a range of 'near patient' centres to be used, with co-location of staff into multi-professional teams. Early evaluation from services users of these new arrangements has been positive. Parents of children with disabilities have been actively consulted and involved in service evaluation and the provision of the new transition arrangements. Parents are members of the recently formed children with disabilities and special needs strategy group, providing better inclusiveness and understanding of services pressures.

13. The parents’ dental focus group has been able to positively affect locations such as the provision of routine dental services into special schools following their success within mainstream schools.

**Outcome 2 Consent**

14. Consent is obtained and recorded from the person with parental responsibility before the looked after child/young person’s health assessment or review is undertaken.

15. There are effective and confidential consenting procedures for young people attending sexual health services, which has increased compliance with tests and treatment regimes.

**Outcome 4 Care and welfare of people who use services**

16. Safeguarding referral thresholds are not well understood by all health staff. The common assessment framework (CAF) is not well established, with poor engagement, initiation and use by health staff to coordinate early intervention work. Consequently some children and families are referred to children services unnecessarily because the appropriate support has not been put in place. There is good use of referral escalation procedures, which have resulted in repeat referrals being accepted, even though there has been no change in the referral information.

17. The weekly CAMHS clinical meetings, involving the dedicated social care link staff, have improved the understanding of thresholds for referral to social care, with more referrals being accepted first time. A further benefit from these meetings has been the improved sharing of learning opportunities from serious case reviews.

18. As a result of the limited capacity within the safeguarding health teams’ attendance at the social care monthly referral panel meetings has been compromised, therefore the review and appropriateness of referrals from health staff is not always effective.
19. Health outcomes for looked after children and young people are adequate. Health reviews for all looked after children and young people meet statutory timescales. All initial health assessments are completed by medical practitioners. However, the results from the looked after children (LAC) completed strengths and difficulties questionnaires (SDQs) are not shared by social care with the health staff who undertake the LAC health assessments and reviews, resulting in incomplete emotional wellbeing assessments. None of the health assessment files seen during the inspection contained up to date SDQ information. Whilst looked after children and young people have a basic assessment of their cultural and diversity needs, this area remains undeveloped, with no evidence of addressing identified concerns.

20. There is good consideration given by the medical advisor to the adoption panel on the range of health needs that potential adoptees may have. CAMHS looked after children team staff report that frequently their advice regarding placement for fostering is not considered by the adoption panel, with examples given of early placement breakdowns. There is limited health promotional activities in place for looked after children, with some educational sessions held in the private children homes at weekends and evenings only, due to the lack of capacity within the health looked after children team.

21. There is no effective monitoring of access to universal health services by children and young people who are leaving care. Care leavers do not receive copies of the health history, which restricts their ability to make future health life choices.

22. There are highly accessible sexual health services, with good support provided within the Youth Zone and the walk-in clinics, further supported by health promotion provided in schools by school nurses. However, those young people who leave school at 16 years to go to the local colleges have less college based support, increasing their vulnerabilities and risk taking behaviours. School nurses report a correlation between this and the increase in the teenage conception rate. There is a dedicated youth worker providing sexual health services within the local colleges, and at sixth form open days, however, no evaluation of the effectiveness of this service has been undertaken.

23. There is good access to termination of pregnancy services, although some staff report that sexual health contraceptive services post termination are not effective due to the number of young people having repeated terminations (some reported to be within weeks of the previous termination). There has been no analysis or further exploration of this hypothesis. The rates of teenage conception in the under 16 year old group based on the 2010 data is at 7.2/1000 and in the under 18 year old cohort the rate increases to 42.1/1000, compared to (the England average of 40.9/1000, and the London average of 44.6/1000). There has been no analysis as to the sudden increase in rates from 16-18 years. The teenage pregnancy board funded a dedicated teenage pregnancy worker; however, since the restructuring this post lost its funding but this has recently been re-awarded. The previous post holder had worked alongside the LAC nurse to provide dedicated contraceptive services to LAC; this gap in provision is being partially met by staff within universal services, although there has been no evaluation of the effectiveness of this provision in reducing conceptions, staff report that the rates remain high.
24. The dedicated teenage pregnancy midwife is ensuring that safeguarding referrals are made for young pregnant women, proving good support throughout the pregnancy and up to one month post birth. Safeguarding thresholds for those pregnant women who are substance misusers have recently improved with a greater understand of the risks and the need for proactive early interventions. Audits of referrals show that risks are being identified and appropriate action taken.

25. Children community nursery nurses, who deliver the healthy child programmes, are currently being co-located within children centres to improve access for parents. Parents have access to a wide range of support from children’s centres and access to parenting programmes, including one to one tailored parenting support for harder to reach families. Staff nurses working with health visitors are providing a valued universal health screening support programme and with the immunisation teams, are enabling the health visitors to focus on the most vulnerable families.

Outcome 6 Co-operating with others

26. CAMHS have a dedicated link social care worker which has enabled effective joint training and working relating to both the escalation of referrals related to emotional abuse. The effects of hidden harm due to adults with mental health and/or substance misuse needs, on children and young people is not always addressed through the wider partnership promptly enough to ensure that the child is safeguarded. There is a dedicated CAMHs worker within the youth offending team, which is effectively identify offending young people who require emotional well being or mental health support.

27. There is good joint working between young people mental health services and adult mental health services for those suffering with early psychosis, resulting in smoother transitions. Although the young person and adult mental health and learning disabilities pathway thresholds are seen by health as being too high and not meeting the needs of service users. Young people with mental health needs who are admitted to adult medical acute wards, (at their request), may experience a delay in accessing CAMHS advice, as the focus on the CAMHS team is primarily on the children wards.

28. Accident and emergency department (A&E) staff based at Queens Hospital (part of BHRUH NHS Trust) receive inconsistent feedback on referrals made to childrens social care. Community practitioners and midwives report that they frequently have to chase responses to referrals and are often informed that the case is yet to be allocated delaying the safeguarding response.

29. There is effective communication between ambulance services and both the adult and children A&E services, when identifying young carers or where there are concerns regarding the home situation. Joint referrals are made when necessary, ensuring that children are appropriately safeguarded.
30. The common assessment framework (CAF) is fragmented, not embedded or robust. The CAF is viewed as a ‘gatekeeper’ for initial referrals by some health staff who report that the paperwork is unmanageable and the lack of administration support is a barrier to using the CAF. This has now been recently revised and training is currently ongoing and therefore any improvements have yet to be realised. School nurses have good involvement with CAF in schools, which are led by education staff; they report that these are effective at addressing the needs and improving outcomes for young people.

31. The Domestic Violence Forum is very well established with good participation across most agencies. A wide range of support is available for families affected by domestic violence. Multi agency risk assessment conference (MARAC) take place regularly and agencies value the opportunity to share information and ensure that co-ordinated plans are in place. Notifications of incidents of domestic violence in households with children are not currently sent by the police to health providers or schools. This misses an opportunity to ensure that information is appropriately shared on lower risk cases. There is a dedicated midwife for domestic violence with good flagging of cases known to involve domestic violence.

Outcome 7 Safeguarding

32. The contribution of health agencies to keeping children and young people safe is adequate. The LSCB section 11 safeguarding audit identified a number of concerns regarding the capacity of the BHRUH NHST to deliver a high quality safeguarding service in partnership with the other agencies. However, it recognises that recent and significant improvements have been made. For example, accident and emergency services are now identifying and acting on safeguarding concerns earlier.

33. There has been a high turnover and a number of temporary posts over the past year in the designated and named health safeguarding team, limiting their ability to fulfil the full range of their safeguarding responsibilities and work in a proactive way. At the time of the inspection there still remains a lack of capacity within the health designated and named safeguarding health professionals to discharge their safeguarding responsibilities, despite the very recent recruitment of a new named nurse. The job descriptions and reporting structures do not adhere to statutory guidance, ‘Working Together to Safeguard Children’ and the intercollegiate guidance from the Royal Colleges. The designated nurse, who provides cover to the three other local boroughs, does not directly report to the safeguarding executive lead. The named doctor role remains filled by a locum, with no protected time for the role, resulting in a lack of time to undertake individual management reviews (IMRs) and other safeguarding activities. The designated doctor has been an interim appointment for the past year, on a three month rolling contract; the reporting structure for this role remains unclear and inconsistent. There is no allocated time for the designated doctor to attend the LSCB, resulting in time being taken out of clinical commitments, whenever necessary. There remains a lack of clarity as to the future of the designated doctor role within the team, during the current service reconfiguration.
34. Whilst there is a named general practitioner (GP) in post, the role has a low profile and GPs interviewed were not aware of this role. The time allocated for the role of 5 hours per week, does not enable sufficient capacity for support to be given to GPs when they have concerns, or for the post holder to work in a proactive manner and provide support to other GPs when writing case conference reports or for individual management reviews (IMR). Although a case conference report template has been introduced to improve the quality and consistently with case conference reports, these are not well used. There remains poor attendance by health professionals, most notably by GPs at case conferences and LSCB meetings, with only a recent increase in attendance at LSCB to 50%. GPs report only receiving five days notice of a case conference, limiting their ability to respond in a timely manner.

35. There is good joint case work of children and young people with mental health and learning disabilities, with effective regular monitoring of risks, including during times of transition. There is good access to mental health services for those children who self harm, however, there have been occasions when child mental health advice has been required and this has not been readily available out of hours. There is good access to tier 4 CAMHS beds, with effective use of the ‘Interact team’, (providing outreach and home treatments) as well as the early psychosis teams, reducing the length of hospital stay by supporting early discharge.

36. There is good pre-birth planning meetings, with identified social workers, however, there are some delays in social workers obtaining court orders (on average 7 days) resulting in the woman and baby having to stay in hospital for longer than medically required. This is increasing the security risks and the safeguarding concerns which midwives find challenging to manage especially with a reduced staffing capacity or at peak activity times. Staff report that there is frequently late night transfer of the baby to foster carers, often at 10pm or 11pm, resulting in disruption for the whole ward and distress for the other mothers.

37. Accident and emergency services (A&E) have an electronic ‘flagging’ system in place to identify children with child protection plans. However, they have insufficient information regarding the purpose of the plans to inform their decision making. Some staff report that out of hours there are frequently delays in obtaining this information. Accident and emergency care settings send notifications of a child or young person attendance to general practitioners and community health staff, which includes information relating to number of visits and reasons for the visits, as well as Identifying if a safeguarding referral has been made. However, those general practice staff spoken to report that this information does not contain details regarding the child protection status, or in some cases the reason and number of attendances at A&E. Notification information received from the walk-in centre is perceived by GPs as being more useful, as consistently it is more detailed and individualised to the child’s circumstances, assisting them when prioritisation and follow up of any concerns.
38. There is sustained and improved identification by adult substance misuse services of hidden harm concerns although the identification and needs of young carers is not yet fully identified and addressed. Adult substance misuse services effectively monitor safeguarding concerns through a risk based database, which ensures that safeguarding concerns are reviewed at clinical meetings and progress to address these is monitored and maintained.

39. There is good access and effective referral pathways to the local sexual assault referral centre (SARC), which is outside the borough. Some staff have received feedback on referrals, although this is inconsistent due to the confidential nature of the service.

40. There is a well established child death overview panel. Good work by the Child Death Overview Panel (CDOP) has been undertaken to raise awareness among parents, carers and the public of the dangers of co-sleeping and blind strangulation through ‘My sleep my space campaign’ following a serious case review. Posters, leaflets and embroidered blankets were given to all new born babies, and widely distributed through hospitals, shopping centres, children’s centres and maternity services. Good quality CDOP annual reports containing benchmarked data and analysis are presented to and scrutinised by the LSCB.

Outcome 11 Safety, availability and suitability of equipment

41. There is a dedicated purpose built, children A&E (including dedicated resuscitation facilities and waiting areas) at Queens Hospital, which ensures that all urgent care, GP referrals and children attending A&E are triaged and assessed by qualified children health staff. There is an embedded referral protocol in place from A&E department and the walk-in centre to the sexual assault and referral unit (SARC).

42. There is good access to children with disabilities who use mental health services with good support from physical healthcare staff, who provide continual specialist support when the young person is admitted to a CAMHS tier 4 bed. The health professionals working with a child who has a disability and who is also a looked after have good access to services and a range of therapists to meet their enduring health needs.

Outcome 12 Staffing recruitment

43. Health staff report undertaking a criminal records bureau check (CRB) on employment, and with some report repeating this every three years. Safer recruitment policies are in place however, managers at North East London Foundation NHS Trust CAMH services had employed clinical staff before receiving clear enhanced CRB checks and risk mitigation was used, such as ensuring that there was no lone working to safeguard the children and young people using the services.
44. There is a lack of succession planning within both the safeguarding health teams and the community health services, resulting in a number of posts being vacant for some time. Newly appointed safeguarding staff have not received the training required to develop their competence and confidence to undertake their roles, with some staff reporting that they felt unsupported in their roles.

Outcome 13 Staffing numbers

45. The CAMH service has a stable workforce, with good retention rates. There are long term vacancies within the community practitioner service, resulting in high caseloads in the health visiting service, that often include high numbers of complex families, (Examples of caseload complexities, given by practitioners included 22 looked after children, 20 children on child protection plans 75 children with disabilities and a high number over 200 with child in need status. Some posts also cover the 2 local traveller sites which are over and above on their core caseloads). Concerns had been escalated to chief executive level, resulting in some additional staff being appointed. Plans are in place to continue the recruitment of staff with the move to the new provider organisation October 2011.

Outcome 14 Staffing support

46. The named nurse for looked after children along with the CAMHS LAC team provide valued foster carer training to support placement stability. There has been limited training provided for health staff working with and undertaking the health assessments for looked after children due to lack of capacity within the health looked after children service.

47. There is good access to level 3 multi agency safeguarding training. Maternity staff report that safeguarding training is no longer mandatory, (although the Trust policy states that it is mandatory), as training is not seen as mandatory there has been a loss of protected time to attend the training sessions. The recently revised level 3 multi agency safeguarding course is highly valued by staff enabling them to enhance and reflect on their knowledge and skills. However, there still is a lack of thematic training sessions for all levels and staff groups. There is no robust monitoring of attendance at safeguarding training and the impact of training on practice.

48. The designated and named nurses have access to and some have completed, the SHA leadership programme, with ongoing supervision and support at a regional level and in some cases through their local health organisation. However, for some named safeguarding staff there has been a lack of induction and a lack of skill development time to enhance their competences. It was reported that all GPs were up to date with safeguarding training; however, no evidence of the monitoring of compliance was available during the inspection to evidence this.
49. BHRUH NHST has only recently realigned the safeguarding training strategy in line with Working Together to Safeguard Children; A guide to inter-agency working to safeguard and promote the welfare of children (March 2010), resulting in a number of staff who have yet to comply with the guidance. Training data shows that only 23.3% of staff are in date with level 2 training and only 43.19% are level 3 compliant (March 2011).

50. Within CAMHS service the rates of compliance are outstanding at level 1 with 100%, then dropping to 85% at level 2, however only 77% at level 3.

51. Outer North East London Community Services latest rates of compliance with safeguarding training are inadequate, with only 76% of staff trained to level 1 requirements, dropping to 50% trusts wide, and 71% for children staff at level 2 and at level 3 compliance only at 73%. There has been some analysis of the poor compliance rates, which has been attributed to a new safeguarding strategy being introduced.

52. Speech and language therapist have good access to multi agency training and safeguarding supervision. Supervision for frontline community staff is variable, dependent on capacity within the safeguarding health team. There is no formal safeguarding supervision within accident and emergency care settings for all staff.

53. There is limited training relating to culture and ethnic populations and their health needs, despite the changing diversity within the local population. Consequently staff have limited knowledge of the safeguarding risks issues relating to the cultural differences.

54. The health workforce demographics match that within the general population; however, it does not reflect the changing diversity within the children and young people population.

Outcome 16 Audit and monitoring

55. Health outcomes for LAC are in line with and better than England averages, with outstanding rates of take up with immunisations and vaccines. The rate of health assessments and dental checks is 94.5%. However, there are still discrepancies within the local data between agencies. Recently reviewed databases have been introduced with the aim of improving the monitoring of health action plans; however, it is too early to monitor the effectiveness of the new system.

56. Dedicated dental provision for looked after and children with disabilities, as part of the sedation and dental anxiety services, are provided in a range of locations which is improving access for service users. There is a wide range of age appropriate oral health and dental health promotion activities provided however, effectiveness has not been measured.
Outcome 20 Notification of other incidents

57. Health trust board reports show that there is an adequate use of significant incident reporting to the relevant organisations, with relevant learning identified. However, the trust board and governance minutes seen do not demonstrate the evaluation of the application of learning in practice.

58. Staff seen are aware of whistle blowing procedures with some staff having used these effectively.

Outcome 21 Records

59. All looked after children health files seen, including general health, mental health and out of area health files are complied with the relevant professional guidance. Chronologies were recorded, with variable evidence of monitoring of health action plans. CAMHS health files show that risk assessments have taken place, with actions to mitigate or reduce risk being identified and communicated to other professionals.

Recommendations

Looked after children health services

3 months

London Borough of Havering Council and NHS Outer North East London must ensure that care leavers receive a copy of their health histories and have access to universal health services to equip them to make effective future health choices.

London Borough of Havering Council and NHS Outer North East London must ensure that the outcomes from the strengths and difficulties questionnaires are used within the looked after children health assessments.

NHS Outer North East London must ensure that the capacity within the looked after children health team is sufficient to meet the needs of the local population and the statutory requirements of the roles.

NHS Outer North East London must ensure that there is an annual looked after children report, which is presented to the Havering local safeguarding children board and corporate parenting board and that the reports provide assurance that the respective health trust arrangements comply with national guidance.

NHS Outer North East London must ensure that young carers are identified by all adult health services with appropriate action taken to both meet their needs and safeguard them.
Safeguarding children health services

3 months

NHS Outer North East London must ensure that general practitioners follow the local children safeguarding procedures and attend child protection meetings.

NHS Outer North East London must ensure that the capacity within the safeguarding children team is sufficient to meets the needs of the local population and the statutory requirements of the roles, to ensure that children are safeguarded and all health staff have access to timely advice and support.

NHS Outer North East London must ensure that the children safeguarding annual reports are presented to the Havering local safeguarding children board and that the reports provide trust board assurance within the respective health trust that safeguarding arrangements comply with and met national guidance.

NHS Outer North East London and the Havering local safeguarding children board must ensure that there is consistent and appropriate health organisation representation and the LSCB and subgroups.

6 months

NHS Outer North East London and the Havering local safeguarding children board must ensure that the effective systems are in place which demonstrates that the completion of safeguarding training complies with guidance and that the effectiveness and impact of training on practice is monitored.

NHS Outer North East London must ensure that the capacity within the community practitioner teams (health visiting and school nursing services and nothing impedes the timely recruitment to vacant posts) matches the case complexity and skill mix required to ensure that children young people and families are safeguarded.

Next steps

An action plan is required from the commissioning PCT within 20 working days of receipt of this report. Please submit the action plan to your SHA copied to CQC through childrens-services-inspection@cqc.org.uk and it will be followed up through the regional team.