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.
### NHS South Essex - Southend on Sea

<table>
<thead>
<tr>
<th>Safeguarding Inspection Outcome</th>
<th>Aggregated inspection finding</th>
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</thead>
<tbody>
<tr>
<td>Overall effectiveness of the safeguarding services</td>
<td>Good</td>
</tr>
<tr>
<td>Capacity for improvement</td>
<td>Outstanding</td>
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<tr>
<td>Contribution of health agencies to keeping children and young people safe</td>
<td>Good</td>
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<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>Good</td>
</tr>
<tr>
<td>Capacity for improvement of the council and its partners</td>
<td>Good</td>
</tr>
<tr>
<td>Being healthy</td>
<td>Adequate</td>
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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 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 CQC’s head of operational improvement, who has overall responsibility for this inspection programme.

*In respect of the recommendations in the report, please complete an action plan detailing how they will be addressed and submit this to CQC and your SHA Chief Executive within 20 working days of receipt of the final report.*
The Inspection Process

This inspection was conducted alongside the Ofsted-led programme of children’s services inspections. These focus on safeguarding and the care of looked after children within a specific local authority. The two-week 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 organisations listed above, but includes some areas which apply to one or more other NHS bodies where pertinent.
Context:

Commissioning and planning of child and young peoples’ health services and primary care are undertaken by NHS South Essex (a cluster of NHS South East and South West Essex). Universal services such as health visiting, school nursing, and paediatric therapies are delivered primarily by the South Essex Partnership University Foundation NHS Trust (SEPT). The main acute hospital providing accident and emergency services (A&E) for children is Southend University Hospital NHS Foundation Trust (SUHFT). Maternity and newborn services and acute paediatrics are provided by the same Trust; which also employs the community paediatricians for South East Essex (PCT area). Children and families access primary care services through one of 40 GP Practices, or at the St Luke’s Health Centre.

Child and adolescent mental health services (CAMHS) are provided by SEPT, together with specialist services for children with learning disabilities or for children who have complex health needs. Services for young people who misuse substances are provided by the Young Persons Drug & Alcohol Team, part of Southend on Sea Borough Council.

Highly specialist (Tier IV) CAMH services are jointly commissioned with the North Essex PCT cluster. This PCT cluster is the lead commissioner for the Essex Sexual Assault & Referral Centre in Brentwood.

There are no custodial facilities in Southend for young people.

Specialist healthcare services for children and young people in Southend are commissioned by the Midlands & East Specialist Commissioning Group. There are significant contracts with Guy’s & St Thomas’s Hospital, Great Ormond Street and the Royal Brompton & Harefield Hospitals.

Looked after children health services are provided by the South Essex Partnership University Foundation NHS Trust.
Southend’s population

The area’s population was estimated at 165,300 in 2010, with a forecast increase to 170,700 by 2015. Southend has 17.9% of its population under the age of 15, but 9.3% over the age of 75. By comparison, Thurrock has 19.7% of its population aged under 15 years old but only 6.1% aged over 75 years old. In common with many areas there is likely to be a significant growth in the number of older people. Southend is the seventh most densely populated area in the UK, with 38.8 people per hectare, compared to 3.77 in the UK. Approximately 13% of adults have no qualification, compared with 11.3% in England. In Southend, 64.9% of children gain 5 A*-Cs at GCSE (including English and Maths) which above the English average. Amongst young people, 5.1% are not in education, employment or training, compared with 6% in England. The main employment sectors are retail, financial services, real estate/renting etc and health and social care.

At the time of the 2001 Census, 95.7% of the Southend population regarded themselves as white, with the next largest group being Asian/British Asian at 1.69%. Southend schools now have just over 20% of pupils from a BME background, reflecting a period of change since the last published Census.

General – leadership and management

There is good engagement and partnership working at all levels between all health organisations and the local safeguarding children board (LSCB). All the designated and named staff are well engaged with the LSCB and its sub groups, although there is limited engagement with the multiagency risk assessment conference (MARAC) and with the multi-agency public protection agency. There are good health organisational based governance structures, which are replicated throughout the designated roles reporting structures. All designated and named health professionals roles comply with Working Together to Safeguard Children requirements. Safeguarding children policies are up to date and well embedded in practice. Senior managers are well engaged with a wide range of safeguarding children activities. There have been some jointly commissioned services, although at the time of the inspection some of these were under review.
Outcome 1 Involving Users

1. Ascertaining the views of service users who have used safeguarding services is not yet fully developed. Health visitors and school nurses ensure that the views of children and young people are well documented in child protection conference reports.

2. Child and adolescent mental health services (CAMHS) inpatient unit (tier IV) has achieved the You’re Welcome Young People Friendly Health Services accreditation.

3. There is very good access to interpretation and translation services, with good use made of interpreters at, for example, speech and language assessments.

4. There is proactive service user engagement within looked after children health services. This includes a recent training programme supported by the High Sheriff which has been positively received by the participants.

5. Care leavers do receive limited health history information on leaving care, although health staff recognise the need to implement a ‘health passport’ to ensure that this is fully comprehensive. There is a desire to involve care leavers in the planning and ascertaining of what provision should be provided. There is a good ‘care leaving’ health service and support provided to young people to achieve independence with their health care.

Outcome 2 Consent

6. There are embedded processes at Southend University Hospital NHS Foundation Trust A&E services to ascertain who has parental responsibility.

7. There remains some challenges when a child or young person first becomes looked after, in obtaining consent to ensure timely completion of the initial health assessments.

Outcome 4 Care and welfare of people who use services

8. The Every Child Matters health outcome being healthy is judged as adequate. There has been an historical challenge in ensuring that initial health assessments (IHA) have been completed within the agreed 20 days standard. Improvements have started since a review of the processes, with now 80% meeting the standard. A pilot project has been introduced where the Looked after Children Health Advisor completes part of the IHA for those young people over 14 years of age, before the young person sees the medical practitioner. Notification from social care of ‘new into care’ has also improved, although there still remain issues with obtaining consent for review health assessments, when there are frequent disruptions to placements and for those children and young people experiencing parallel planning processes. The notification of out of authority placed children and young people also remains a challenge.
9. The Strength and Difficulty Questionnaires (SDQ) process is administered by children’s social care and outcome data for 2010/11 shows a rate of 14.2, just above England averages. However, this information is not shared with health staff who completed health assessments and therefore it is not used within the health assessments as required by statutory guidance. The named nurse for looked after children does attend the multi agency meetings where the SDQ outcomes are discussed and individual child plans are developed to address identified needs, although this information is not recorded in the health assessment, which is a missed opportunity.

10. There is adequate access to emotional health and well being services including CAMHS. The CAMH specialist services for enduring and severe mental health needs transformational project group reviews referrals, ensuring appropriate support and advice is provided.

11. The recently established dedicated looked after children mental health worker role aims to provide quicker access to services, as well as consultation and advice for practitioners. Foster carers have access to a well used telephone advice line. The post holder is working with the ‘Voice for All’ group to encourage service user involvement in the shaping of the future service direction.

12. The review health assessment action plans are completed by the named nurse as the GPs, who undertake health assessments, do not complete these. This inhibits the involvement and agreement of the child/young person and/or their foster carer to the required actions. Action plan objectives were not always written in a ‘SMART’ manner. In one case seen the justification for the action was not evident within the assessment and in fact, was the direct opposite to the health assessment findings. There are good monitoring processes in place through SystmOne, (patient information system) of the completion of action plan objectives.

13. Health assessments seen during the inspection, took account of the ethnic, faith and cultural needs of the children and young people. There was some limited evidence of health promotion and sexual health activity recorded. However, the Looked after Children Health Advisor does provide a good service to older young people and supports them to access the range of contraceptive and sexual health services, including maternity services.

14. Health outcomes are variable; data for 2010/11 shows that: immunisation rates are 87.2% which is lower than statistical neighbours, but above England averages. Current data though shows that the immunisation rates are again declining. Dental assessments are 82.1% in line with comparators, whilst annual health assessment rates have declined to 74.4% which is inadequate and below comparators. There are increasing numbers of looked after children reported using substance misuse treatment services.

15. The looked after children health team receive and take appropriate action with regard to unscheduled care attendances. All looked after children and young people are flagged on SystmOne.

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16. Frontline practitioners offer individualised as well as core universal healthy child programmes, although they are not commissioned to provide sexual relationship education (SRE). School nurses support and provide education sessions for school teachers to provide SRE programmes. There is effective joint working with and through the children centres, with a range of health promotion activities provided.

17. The established Family Nurse Partnership has had limited capacity due to staffing issues, therefore has been unable to provide the full range of programmes. The impact of delivered programmes though has been positive for parents, including the raising of aspiration and re-engagement of young people with education. There are dedicated programmes for young fathers, although the ‘take-up’ is too variable.

18. There is good support for pregnant looked after young women and their partners. There is a dedicated practitioner who, supported by the sexual health outreach worker, provides dedicated services for looked after young people. There are good links with contraceptive and sexual health services, who although involving social care staff, maintain the confidentiality of the young people.

19. CAMHS have a good history of partnership and joint case working with other health providers, including substance misuse services and the looked after mental health worker. Some posts have been jointly funded with the local authority, such as the dedicated looked after children mental health worker, resulting in improved working arrangements and seamless care for service users. CAMHS representatives are active members on the acute and complex panel for those young people who are placed out of the authority area. They advice on their care as well as on ‘spot’ purchasing care.

20. CAMHS at tier 2, known locally as ‘emerging and preventative services’ are provided by local authority and had very long waiting lists, this is now no longer the case. For severe and enduring service (tier 3) waiting times are in line with national guidance.

21. The CAMHS inpatient provision for highly specialists (tier IV) services is located at the Populars Unit. There is effective joint working with the Crisis Team, which has prevented admissions and facilitated early discharge through the use of effective home treatment programmes.

22. The Mental Health Crisis Team provides a comprehensive service, resulting in fewer admissions from A&E services to paediatric wards for those young people who have self harmed or are in a ‘mental health crisis’. There is good ongoing follow up provided to young people on discharge from acute services.
Outcome 6 Co-operating with others

23. Transitions to adult mental health services commence at the age of 17½ years, effectively uses the care programme approach (CPA). However, for those young people with a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or on the Autistic Spectrum, transitions are more challenging due to the lack of provision within adult services. Commissioners currently have a number of pilots to scope and identify needs and consider how the gaps in transition can be addressed.

24. Referrals to the Early Intervention Psychosis service commences at 14 years of age, continuing until the person is 25 years old, although staff believe that this is now 35 years old, but there was no consensus. Whilst there is a CAMHS consultant for those under 18 years of age to prescribe medication, this is not a commissioned function, which is a gap in provision.

25. There is good therapeutic input for children with disabilities; however, the range of work is inhibited due to the lack of commissioned services, for example a dysphagia paediatric service. Frequently families have to attend clinics in London for assessments however, there is no follow up treatment, or local interventional treatment support available.

26. Transition to adult physical disability services remains a challenge for young people with physical disabilities due to different service structures. There are also some gaps in provision for those young people with life limiting conditions. Depending on their disability this is leaving some young adults with a shortfall in support and treatments.

27. Those young people with a learning disability or difficulty and a co-morbidity mental health condition have a commissioned service from the age of 0-12 years. However, once the young person reaches 12 years old the service is no longer commissioned. This is a South East Essex wide issue, resulting in the CAMHS team ‘holding’ cases, increasing the waiting list for new referrals to access the service. Commissioners are currently addressing this gap in provision.

28. There is good provision provided for young people who suffer with an eating disorder with well established pathways of care. This enables treatments and interventions to be provided in the community closer to the young person’s home, rather than in the dedicated inpatient services.

29. There are well established CAMHS practitioner roles within the youth offending services, resulting in timely and flexible delivered mental health assessments including for example within the court.
30. Substance misusing services are well established, with good partnership working across all agencies. Transition planning processes are robust, with only a few gaps in provision for some alcohol dependent individuals. There is good support provided to young carers of substance misusing/dependent adults, and siblings, through the CHILL and COOL groups. There is good performance monitoring of services and treatment outcomes. There is a dedicated midwife for substance misusing pregnant women, who works effectively with substance misusing services to provide support to the woman and ensures the baby is protected from harm. Many substance misusing women, who have experienced the service and become pregnant again, directly refer themselves to this midwife.

31. There is a dedicated midwife for teenage mothers (up to the age of 17 years), who effectively works alongside, and refers new mothers to the Family Nurse Partnership practitioners.

32. Sexual health services have targeted the teenage conception/pregnancy 'hotspot' areas, with some effect. Overall there has been a reduction in teenage conceptions. However, the rates remain higher than comparators at 42.9/1000. Rates of second conceptions are reducing. There is good support provided to teenage parents to be who choose to terminate their pregnancy. There is good contraceptive and sexual health support post termination, supporting the reduction in second conceptions.

33. Contraceptive and termination of pregnancy services are very accessible and delivered in flexible ways. However, as yet the condom distribution scheme is not comprehensive or embedded in those areas where condom distribution is already occurring. The performance monitoring of the condom distribution service is not yet robust.

34. There is good support for pregnant looked after young women and their partners. There is a dedicated practitioner who, supported by the sexual health outreach worker, provides a good dedicated service for looked after young people. There are good links with contraceptive and sexual health services, who although involving social care staff, maintain the confidentiality of the young people.

35. Domestic violence processes are well established within frontline practitioner services. Domestic violence notices are well disseminated from MARAC representatives and appropriate follow up action taken.

Outcome 7 Safeguarding

36. The contribution of health agencies to safeguarding is judged as good.

37. Designated and named staff for both safeguarding and looked after children have a good understanding of their responsibilities. Although there had been a gap in designated roles for some time, resulting in a lapse in annual reporting, individual trust governance structures have ensured effective performance monitoring process have been maintained.
38. Health staff report that safeguarding thresholds are inconsistently applied by social care staff. Community health staff and CAMHS staff report this is specifically noticeable with neglect and emotional neglect referrals. Further CAMHS staff report that there remains some challenges, with children’s social care staff, regarding the understanding and alignment of definitions of emotional neglect and abuse between mental health and social care services. Many of the health staff interviewed reported good use of and have confidence in, the referral escalation process. The use of the common assessment framework (CAF) as a referral tool is viewed by some practitioners as unwieldy for safeguarding referrals due to the size of the document. Staff also feel that the information is ‘frequently lost on the form’ due to the length of the form. There are often multiple copies of a CAF with a lack of version control which causes confusion. CAMHS staff report not using the CAF form for their referrals as they do not consider these apply to their work.

39. Midwives report that the CAF form is not fully relevant to unborn baby referrals which are made at twenty weeks gestation. Despite this, there has been a consistent increase in the number of CAF safeguarding referrals made by midwives over the last three years. Unborn baby planning has improved and is mostly effective, although there are delays in discharges especially over bank holiday weekends. Well embedded processes ensure that high risk maternity and vulnerable unborn baby cases are reviewed and frequently discussed ensuring all staff are aware of the birth and discharge plans.

40. Ascertaining if pregnant women are victims of domestic violence is recognised as an area for development and plans are in place to improve the current adequate practice. Safeguarding cases are discussed through the supervision processes and discussions recorded on SystmOne. Frontline health practitioners report an increasingly quicker response to arrange strategy meetings, although meeting details are not always well communicated.

41. Feedback on safeguarding referrals is not received by frontline practitioners and/or GPs, other than when the referral is rejected. Further, the progress of referrals is not always well communicated by social care staff. This is inhibiting health care staff in supporting the child and family and in some cases causing a breakdown in the therapeutic relationship. Staff report that messages left on the social care telephone consultation line, used to discuss safeguarding concerns, are frequently not responded to in a timely manner. This results in CAF forms being generated and increasing the workload for staff.

42. Following a recent change in procedure GPs requiring a child protection second opinion from a community paediatrician, now have to access this through the social care ‘first contact’ service. GPs report that this is not effective as the process is causing delays, especially when immediate advice is required, when the patient is in the surgery. GPs report challenges to get safeguarding children referrals accepted by childrens’ social care for young people between 16 and 19 years old. Primary care staff are well supported with these referrals and case work, and value the support provided by the named safeguarding professionals especially from the named GP. There are increasingly robust performance monitoring and audit processes in place within primary care to ensure that children and young people are protected from harm.
43. The use of the risk management meetings for those children who ‘step-down’ from child protection plans and who have behaviour concerns, are not well understood by health staff. There is mostly good attendance at child protection conferences and meetings. However, notes from these meetings are not always distributed in a timely manner, inhibiting timely actions from being taken. There is good engagement with, and effective monitoring of, serious case review and action plan processes.

44. Sexual assault and referral centre (SARC) provision is good. Work is ongoing to ensure the pathway is well established and effective performance monitoring is put in place through the Safeguarding Children’s Clinical Network (SCCN). The service at Oakwood place is managed by a private company. They provide localised sexual assault referral services across five authorities through a single Essex-wide pathway, commissioned through the SCCN represented by the designated doctor and designated nurse from SW Essex. SARC is run by a forensic examination qualified nurse and a second specialist nurse is being recruited. There have been some delays in achieving a full staff compliment resulting in the service currently being restricted to police referrals only. A new paediatrician rota has been in place since April 2012 encompassing all the local authorities served. There are Independent Sexual Violence Advisors (ISVA) in place for Southend. Partners recognise there is more to do to ensure the pathway is fully established.

45. Southend University Hospital A&E and the paediatric assessment unit information and patient management systems are robust, with good identification and flagging of children known to social care. A&E access to SystmOne is due to take place shortly with the aim to further strengthen these processes.

46. Child Death Overview Panel (CDOP) processes are well established, with adequate monitoring of campaigns. Rapid response teams are well established, with a full designated doctor rota. There is no lay representation on the local area CDOP, although there is on the strategic overview CDOP. There is good monitoring of quarterly reports, by the LSCB. Maternity staff are well engaged with the CDOP process when a baby dies, with a dedicated bereavement midwife specialist providing support for bereaved parents. This midwife provides additional support to fathers, through the many local support groups. There is an established care of the next infant (CONI) scheme in place. CDOP campaigns such as ‘back to sleep’ are well promoted to the new mother and partner, although not always to the wider family/carer support network.

47. Health staff who work with children with disabilities and life limiting conditions benefit from the co-location with the social care disability team. Weekly meetings to discuss core referrals and complex case for those children under five years old are highly valued by practitioners, however, there is poor attendance and the omission of social care staff reduces effective multiagency working. There is good therapeutic input for children although the range of work is inhibited due to the lack of commissioned services, for example a paediatric dysphagia service.
Outcome 11 Safety, availability and suitability of equipment

48. Environmentally, Oakwood Place (the sexual assault referral unit - SARC) is of good quality, giving some choice to young people attending about which room they are seen in, although there is a single reception point to both chronic and acute cases, requiring careful management by the staff. Police are required to telephone ahead to ensure the facility is able to receive young person. Thurrock and Southend consultant paediatricians hold, at the SARC, weekly chronic case clinics for non-forensic cases, as there is no colposcope at either local acute hospital.

49. The children and young people’s A&E at SUHFT, the childrens' waiting area, ‘majors’ area and child and baby resuscitation area, which contains a new resusitairre, are not fully compliant. These areas are not audio-visually separate from the adult area and do not fully protect the dignity of service users. The waiting room is small and sparsely furnished and it is not suitable for older children and young people. There are fully equipped dedicated paediatric resuscitation bays, however, the dedicated area for babies was also being used as a storage area. Staff reported that this was usual practice. There is a dedicated mental health assessment room mental health self harm pathways are robust.

Outcome 12 Staffing recruitment

50. Nearly all staff reported that they had a current enhanced criminal records bureau (CRB) check in the last three years. However, staff at SUHFT, unless they have recently commenced in post or changed their roles internally, they have not had their CRB status checked. There was no evidence to show that this decision is robustly risk managed in line with the NHS CRB standards.

Outcome 13 Staffing numbers

51. There are no health visiting or school nursing vacancies, services are at establishment levels. Staff reported no concerns with capacity.

Outcome 14 Staffing support

52. Whilst there is good access to safeguarding training for designated and named health professionals, this is limited and not at an advanced appropriate level. There are a range of systems in place to review the outcome and impact of training in practice although outcomes are not well communicated. Health trainers reported declining rate in attendance at the LSCB training, although reasons remain unclear.

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2 NHS criminal records check January 2011
53. There is good access to safeguarding supervision, with good use made of professional, peer and regional networks for designated and named health professionals. Peer safeguarding supervision for midwives remains ad hoc, with structured supervision only recently being given to the teenage pregnancy specialist midwife.

54. All looked after children health staff have access to regular supervision, although this is not robustly replicated with other health staff involved with looked after children.

55. GPs’ engagement with safeguarding has improved, with at least 60% of practices now having a named safeguarding lead, 90% of GPs trained to level 2 and 60% trained to level 3. Effective use is made of protected learning time to improve safeguarding practices. However, there remains a challenge for GPs to attend child protection meetings, due to the timing, notice period and a number of single handed practices with no staff cover available. To ensure information is presented to conferences in a consistent high quality manner, a report template is under development.

56. Training rates at SEPT- South East Essex area are outstanding with Level 1 99%, level 2, 98% and level 3, 100% of staff trained. These rates are better than the trust wide rates which are good. Since the community health staff have merged with SEPT, there has been a wider range of relevant safeguarding training programmes and better access to flexible safeguarding supervision. There has been an increase in the use of e-learning materials enabling staff to choose relevant programmes to their practice. Dentists have good access to safeguarding training, which includes domestic violence training.

57. At SUHT safeguarding staff training rates for level 1 are 100%, and level 2 are 92%. However at level 3 rates are only 77%, which is recognised as inadequate. All non medical staff in the A&E department have access to and are trained in a range of safeguarding and emergency medicine programmes; however this is less structured for all grades of medical staff, especially those on rotational placements.

58. Training data collection problems within the NHS commissioning cluster (partially due to the merger) resulted in the safeguarding training data showing inadequate levels of compliance.

59. Looked after children health staff training is minimal due to the recent restricted capacity within the health team.

Outcome 16 Audit and monitoring

60. SEPT has a range of safeguarding audits, the outcomes of which are used to inform future training programmes. Section 11 safeguarding audits and action plans are well monitored through the individual trust children safeguarding governance structures.
61. The lack of administration support within the looked after children health team affects practitioner capacity. Whilst performance monitoring tools have been implemented, the lack of capacity is inhibiting service developments and attendance at looked after children Independent Reviewing Officer (IRO) review meetings. Frontline practitioners report that frequently minutes from the meetings are not circulated and dates of the future meetings are not shared in a timely manner. Practitioners also report receiving little information regarding the activities of the corporate parents meetings.

**Outcome 20 Notification of other incidents**

62. There is good use made of statutory notification processes regarding safeguarding concerns.

**Outcome 21 Records**

63. The health records seen during the inspection complied with professional record keeping guidance.
Recommendations

Those from the joint report are in italics

Safeguarding

3 months

*NHS South Essex and Southend on Sea Borough Council must ensure that safeguarding referrers receive feedback on the status of their referral in line with the agreed standard.*

6 months

NHS South Essex and South Essex Partnership Trust must ensure that all transitions for young people with learning disabilities and mental health conditions are smooth and meet the individuals’ needs

*Southend University Hospital NHS Trust and NHS South Essex must ensure that the children and young people accident and emergency provision are safe, audio visually separate and fit for purpose.*

Looked after children

3 months

Southend on Sea Borough Council and NHS South Essex must ensure that the outcomes of the strength and difficulty questionnaires are use in the looked after children health assessment process.

Southend on Sea Borough Council and NHS South Essex must ensure that care leavers receive a full copy of their health histories.

Southend on Sea Borough Council and NHS South Essex must ensure that all 'new in to care' have an appropriate consent and changes to placement are notified to the LAC health team in a timely way to ensure that health assessments are completed within the required timeframe.

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.