Report on the Outcome of the Integrated Inspection of Safeguarding and Looked After Children's Services in Hackney

Date of Inspection	**21st May 2012 – 1st June 2012**
Date of final Report	**10th July 2012**
Commissioning PCT	**NHS City and Hackney**
CQC Inspector name	**Tina Welford**
Provider Services Included:	**Homerton University Hospital NHS Foundation Trust (HUHFT)** **East London Foundation NHS Trust (ELFT)**

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 City and Hackney	
Safeguarding Inspection Outcome	**Aggregated inspection finding**
Overall effectiveness of the safeguarding services	Good
Capacity for improvement	Outstanding
Contribution of health agencies to keeping children and young people safe	Good
Looked After Children Inspection Outcomes	**Aggregated inspection finding**
Overall effectiveness of services for looked after children and young people	Good
Capacity for improvement of the council and its partners	Good
Being healthy	Good

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 children and young peoples' health services and primary care are undertaken by NHS North East London and The City (a cluster of seven PCTs).

Homerton University Hospital NHS Foundation Trust (Homerton) is the major provider of both acute and community based services in Hackney. Homerton provides maternity care in hospital and throughout the community for some 5,000 women and their babies each year. The Trust is also a regional neonatal intensive care centre. Homerton provides accident and emergency services for children, including a children's emergency assessment unit, a dedicated children's inpatient ward and general and specialist paediatric clinics. Community-based services for children and families provided by Homerton include health visiting, school nursing and paediatric therapies (including child and adolescent psychology).

Children and families access primary care services through one of 44 GP practices, walk-in centres including Springfield Primary Care Centre Walk-in service, and the Urgent Treatment Centre at Homerton University Hospital NHS Foundation Trust.

Child and adolescent mental health services (CAMHS) are provided by East London Foundation NHS Trust. For children with learning disabilities and difficulties and who have complex health needs services are provided jointly by Homerton University Hospital NHS Foundation Trust and Hackney Children's Social Care.

Looked after children health services are provided by Homerton University Hospital Foundation NHS Trust and Hackney Children's Social Care.

Hackney's health profile shows that the proportion of children living in poverty is twice the England average. The infant mortality rate of 5.8/1000 live births (2007-2009), is higher than the London average of 4.4/1000 live births. From April 2010 to March 2011, there were 28 child deaths recorded by the Child Death Overview Panel (CDOP). Childhood obesity is a major problem in Hackney. Child obesity rates show that both the 'overweight' and 'obesity' levels for children in Hackney are above both the London and national averages. The prevalence of obesity, as recorded by the National Child Measurement Programme (NCMP), is among the highest in England. There is an excellent contribution to the NCMP.

Teenage pregnancy/conception rates compared to targets, show that the rate fell to the lowest since 1998, in 2009 (37% reduction). In 2009,163 conceptions equating to 48.6/1000 females aged 15-17 years. In 2000 there were 79.5 conceptions per 1000 females aged 15-17 years.

The percentage of children who say they use drugs and the percentage of children who say they have been drunk recently compared to the England average, are relatively low in Hackney. In 2009, 6% of children (sampled from years 6, 8 and 10) reported that they had been drunk one or more times in the last four weeks. This compares to a national average of 15%. Only 2% of children in years 8 and 10 reported that they have taken cannabis or skunk one or more times in the last four weeks, compared to 4% nationally. Although substance misusing services report that this was under reported.

General – leadership and management

1. There is good and appropriate engagement by senior health staff and designated professionals with the local safeguarding children board (LSCB) and its sub groups. There is a track record of good partnership working which has been further advanced with the highly valued psychosocial meetings and the multi disciplinary team meetings. There are a number of jointly funded posts, who along with other posts, successfully work across organisational and geographical boundaries.

2. There is effective involvement, supportive challenge and scrutiny of both Homerton University Hospital Foundation NHS Trust (HUHFT) and East London Foundation Trust (ELFT) safeguarding services and reports through the LSCB, the Corporate Parenting Board and the council's scrutiny group. Homerton Children's Safeguarding and Regulation Committee effectively monitors the trust's safeguarding activities and is viewed by frontline staff as a key driver for change. All designated and named health professional are effectively held to account, with good scrutiny of the looked after children annual report.

3. All health trusts have contemporaneous safeguarding policies and supportive embedded operational documents.

Outcome 1 Involving Users

4. Results from the improving service user engagement shows that they highly value the range, and flexibility of, their looked after health review assessment appointments. Developmental work with care leavers is well advanced to 'rebrand' the 'looked after' health service. City and Hackney Young People Service Plus (CHYPS Plus) has gained the You're Welcome Quality Criteria for Young People Friendly Health Services accreditation.

5. CHYPS Plus children services are highly appreciated by both service users and professionals. This service actively supports young people and promotes good sexual health practices. Further, there has been very successful engagement with the local communities, including those with a strong gang based culture, whose members do not normally cross postcode boundaries. Through dedicated group work, CHYPS Plus has successfully engaged young men and young fathers, effectively promoting good health practices and raising career aspirations. The recently appointed assertive outreach worker has been able to gain the trust of young people and ensures that they remain engaged with services for example, that they continue to attend their sexual health screening appointments.

6. The HUHFT Department of Sexual Health has undertaken a range of consultation and participation events with young people to assist with the future planned redesign of this service. This service is currently working towards the You're Welcome Quality Criteria for Young People Friendly Health Services accreditation.

7. The ‘Prescription of Happiness’ questionnaire has been used to ascertain what activities young people would like to do, in an attempt to promote healthy living. There has been some limited success in engaging young people with the wide range of activities available.

8. There is very good access to interpretation and translation services, with a number of bilingual health staff used, rather than family or community members.

Outcome 2 Consent

9. Looked after children are ‘flagged’ on the accident and emergency and the urgent care centre electronic patient information system, which effectively supports the well embedded process for ascertaining parental consent.

10. Consent is obtained from a young person before information is shared between practitioners and services.

11. The local authority commissioned and provided substance misuse services effectively ensures that all service users understand confidentiality, and when disclosures are made that require a safeguarding referral service users are aware of what action staff will take.

Outcome 4 Care and welfare of people who use services

12. The looked after children and young people outcome *being healthy* is judged to be good. There are good future need assessments which are effectively incorporated into the Joint Strategic Needs Assessment (JSNA).

13. The looked after children’s health files seen during the inspection were of variable quality. There was no evidence of the strength and difficulties (SDQ) results or analysis being used with the health assessments as required by statutory guidance[1]. The health care plans were not always fully completed and the outcome measures were not written in a measureable way. In one file seen, there was no evidence of actions being completed within the prescribed twelve month period. There was no evidence of the Independent Reviewing Officer (IRO) reviewing outcomes in the health files, although frontline health staff regularly receive review information and are held to account for action plan progression. Health information and health promotion activities, including sexual health information, were not fully recorded in the looked after children health files seen. The looked after children health team aims to promote the use of universal services, although this is not fully monitored.

[1] Department of Health Department for Children, Schools and Families (2009) Statutory Guidance on promoting the health and Well-being of Looked After Children.

14. Referral to specialist looked after children, child and adolescent mental health services (CAMHS) are mainly through the social work units for low level interventions (tier 2), although the designated doctor does have the right to directly refer to other services. However, feedback on referral status is not received or followed up by the looked after health team. There is no waiting list for this service. Access to core CAMHs (tier 3) and treatment is swift, within five weeks. Referrals are accepted from a wide range of practitioners and are assessed through the joint access resource panel with childrens social care for appropriate intervention level. This cross organisational and partnership working is effective. There is an established early interventional psychosis service in place, with good joint working at transition points.

15. The looked after children occupational therapist, through good working relationships with the virtual school, ensures that education needs are being met and that any concerning emotionally linked changes in behaviour are addressed. This service includes Hackney looked after young people who are placed outside of the authority boundary. The occupational therapist provides supportive development sessions for care leavers focused on developing functional skills to support independent living, including cooking skills.

16. The looked after children health outcomes have significantly improved and continue on an upward trajectory. All outcomes are above statistical neighbours and England averages. Review health assessment rate is 95%, dental assessments rate is 84% and immunisations rate is 94%, these rates are better than within the rest of the local children and young people population.

17. Care leavers are not provided with a comprehensive leaving care health information pack, although preparation to introduce young people to universal health provision generally commences at their fourteenth birthday health review. Not all care leavers are given their birth history information on leaving care, even when known; they do receive their full immunisation information. A care leaver's passport to address the deficit is being developed.

18. Although rates of teenage conception remain high (above England averages) there has been a significant reduction of 38.2/1000 reported in the latest data (May 2012). There is, however, a higher than England average use of termination of pregnancy services. The use of long acting reversible contraception (LARC) and ongoing support for young women is recognised as not well embedded. There has been targeted action in known 'hotspot' areas for teenage conceptions, which has been partially successful. However, since the removal of the sexual relationship education (SRE) from the educational/school curriculum there has been a gap in provision. This has very recently started to be addressed, with a standardised programme for all education services being developed in conjunction with the Learning Trust. Ongoing engagement and data analysis related to the large local Orthodox Jewish population is well underway to review data and practices and understand the impact on the overall teenage conception rate.

19. There is good support for young women when they first become aware that they are pregnant, their choices and options are explained in a supportive, non judgemental way. There is a good awareness of the cultural and faith impact on sexual health practices of young people. Those young women who choose to terminate their pregnancy are well supported throughout the process, with contraceptive advice actively promoted. As a result of this provision, there is a significant correlated reduction in the second termination rate.

20. Looked after pregnant young women are well supported by the public health midwives, who along with CHYPS plus, provide good ongoing support after the baby is born, and contraception to prevent further unwanted pregnancies. The well developed and embedded joint working with the Virtual Head and Virtual School is ensuring that the looked after young women can continue with their educational activities. Although support for 'looked after' young fathers is less well developed.

21. The work of the public health midwives with vulnerable women and teenage pregnant women is highly valued. There are embedded models of joint and shared care with, for example, the specialist midwife for substance misusing women and with other health and youth service professionals, supporting the women through out her pregnancy, and after birth.

22. Community midwives do not always asked pregnant women alone or during all their antenatal appointments if they are victims of domestic abuse. The use of the 'red dot' system is currently under consideration as a way of improving practice.

23. There is limited support for male partners, to enable them to provide encouragement to new mothers to continue to breastfeed. The restrictive maternity department visiting hours, as reported by the midwives, acts as a deterrent to male partners visiting, where this support would be encouraged. The neonatal unit visiting hours are better, the unit staff positively encourage the use of expressed breast milk for both fathers and substance misusing women to feed baby. There is a good range of skills based training, as part of the discharge planning process, provided by neonatal unit staff for parents and/or foster carers to support them to care for the baby post discharge.

24. There is a wide range of accessible sexual health services for young people. The condom distribution scheme is widely accessible, although the monitoring of the service is less well developed. There is good support provided for the gay, bisexual, lesbian and transsexual (GBLT) population, through a range of programmes provided within education settings, linked to the children and young people plan priority to address homophobic bullying. There is a recognised gap in health staff training related to child sexual exploitation, plans are in place by Homerton for the provision of bespoke training.

25. There is improving cognisance being paid to substance misuse issues which is of growing concern within the general children and young peoples' population. Nationally reported data shows that no looked after young people are accessing substance misuse services, although both the looked after health staff and substance misuse staff state that this is currently not the case. Looked after children health staff have recently received training in the drug use screening tool (DUST), although this is yet to be implemented.

26. It has been recognised that the substance misuse transition protocol to adult services needs reviewing. There has been no requirement to use the protocol in the last 3 years. There are national recognised effective joint working protocols with childrens' social care and the drug and alcohol teams, which include the use of learning sets and joint training, increasing the level of competency within the workforce to address concerns. There is good joint work with the safer community partnerships, local police and Young Hackney with proficient use of intelligence. However, it is recognised that more work is required to identify and meet the needs of, young carers of substance misusers and the hidden harm cases. This provision is currently being recommissioned.

27. There has been effective flexible supportive working with the 'hard to reach' young people, with staff reporting that some groups in the local population are no longer 'hard to reach'. The 'Younger Hackney' model has been effective at signposting young people to substance misuse services.

28. There has been some preventative substance misuse work with young people over 18 years of age, and those on youth offending orders. Schools, residential associations and housing providers have valued the provision of training seminars, and the brief intervention techniques. There are well accessed weekly harm reduction drop-in clinics within colleges. There remains a challenge for services in providing and reducing substance misusing behaviours of young people, due to the local gang and drug cultures. Staff report that parents are ill-equipped to deal with children and the peer pressure that children and young people face in relation to substance misusing behaviours.

Outcome 6 Co-operating with others

29. All health staff have a good understanding of safeguarding thresholds ("Hackney Child Wellbeing Model") and report an improvement in the consistency of application within the last eighteen months. Most staff report receiving feedback on referrals within 48 hours. There is good engagement with child protection conferences and other safeguarding and common assessment framework meetings, including the wider health professional group in unborn baby planning. However, GPs report that they are not invited to strategy meetings and frequently do not receive minutes of meetings in time for actions to be taken within the specified timeframes.

30. There is good information sharing from the multi agency referral and assessment conference (MARAC) and low level domestic violence cases, with alerts being raised on record systems. There is an adequate health contribution to the multi agency public protection arrangements (MAPPA).

31. There is a range of innovative and culturally focussed campaigns through public health and school nursing services to reduce childhood obesity. There has been good dedicated work with the Rabbanit to increase the level of and range of physical activity that is undertaken by Jewish young people. The impact of these campaigns is yet to be realised.

32. The multi professional team located in the Hackney Ark hold daily referral meetings where referrals are promptly assesses and reviewed by the team. GP referrals are noted to be lacking information to make an informed decision despite further requests for better referral information. There is good organisation and information sharing ensuring that referrals are all promptly assessed and agreed action taken. Any cases of concern are effectively discussed at the multi professional meeting.

33. The disability social care team is co-located with health staff enabling good partnership working and a higher awareness of safeguarding issues. However, the two separate databases (health and social care) are not compatible and this restricts the immediate sharing of key information. Good use is made of joint appointments reducing repetition for families. The Young Hackney team through the family support meetings (similar to the team around the child) provide good advocacy and support for families.

34. Cultural expectations of families who have children with disabilities or life limiting conditions are respected and the different service expectations are well mitigated against through the use of advocates, such as with the Orthodox Jewish, Turkish and Kurdish populations. Good consideration is given to equality and diversity issues when placing children with either foster carers or new adoptive parents, along with the provision of good individualised support and training.

35. The children's community nursing team provide a highly valued service. There is effective use of the end of life plans for those children and young people with life limiting conditions; health staff are effective advocates on behalf of families. An example is the joint complex care panel, where staff navigate families through the benefit system to obtain financial support for equipment and other items. There is good resilience building and emotional support provided for families.

36. There still remain challenges with the provision of services for young people with high function Autism. CAMHS staff report that not all young people who require specialist services (tier 3) are able to access the services, through lack of understanding of needs and thresholds. However, no action has been taken to rectify this to date.

37. Community practitioners remain concerned that immigrant families with 'no leave to remain' status, are frequently the most vulnerable families and in need of health interventions. Practitioners report that these families require a place of safety for their children and that they frequently present themselves at the local police stations, all of which restricts the health and safeguarding interventions that can be provided.

38. There is effective discharge planning for babies, children and young people, with complex needs, disabilities and life limiting conditions from hospital with discharge ward rounds undertaken by the community children nurses.

Outcome 7 Safeguarding

39. The contribution of health agencies to keeping children and young people safe is judged to be good. The designated health professionals for looked after children fully fulfil their statutory duties. The designated and named safeguarding health professionals adhere to statutory guidance. There is good capacity within the team, championed by the executive trust leads, although succession planning is less well developed. A named GP is very shortly due to commence this role.

40. Good use is made of 'alert forms' when there are low level safeguarding concerns that do not meet the referral thresholds. These are discussed at the weekly psychosocial meetings and appropriate action then agreed. Feedback from social care referrals made by accident and emergency (A&E) staff is rarely received; staff are unaware of the action being taken by social care. The highly valued named nurse and safeguarding team will action these and follow up and escalate issues with children social care. Ambulance staff routinely share safeguarding referral information with A&E staff.

41. There are systems in place to assess vulnerabilities of pregnant women, although practice is not fully in line with national serious case review outcomes. Safeguarding referrals for unborn babies are made in good time and frequently at initial booking. However, there are frequently delays, partially due to the lack of court dates and detailed court reports, to protection orders being granted, delaying the discharge of the woman and the baby.

42. Unscheduled care notifications are shared with the looked after children health team, who take appropriate follow up action. This also includes the notices received when a young person fails to attend A&E for follow-up appointments. Looked after children are 'flagged' on the A&E and the urgent care centre electronic patient information systems. There are good links with CAMHS for those young people who self harm. There is an out of hours CAMH services, however, there is no next day appointment/assessment available over weekends or bank holidays, which results in the young person remaining in hospital longer than medically required.

43. There is a very active participation and engagement with the child death overview panel (CDOP), with a broad representation from all relevant sectors, with the exception of the coroner. There has been outstanding analysis of the child deaths and action to prevent further deaths has been successfully implemented. However, the campaigns such as co–sleeping and back to sleep are less apparent within front line services, with their importance not being fully recognised, which is a missed opportunity. The CDOP reports on a regular basis to the LSCB with the work subject to an adequate level of scrutiny.

44. There is good support for A&E staff who are involved in a child/baby death. There has been a revision of the required paperwork which has reduced duplication. Where there has been a serious case review, the findings are shared with the staff involved. Staff debriefing sessions are effectively used. The learning from child deaths is not fully demonstrated in maternity practice. There have been some initiatives with the bilingual workers with families to reduce the risk of co-sleeping although the impact has not been measured.

45. There is good use made of the GP practice meetings to discuss vulnerable families. However, GPs remain unclear as to how to include school nursing services which is a missed opportunity for sharing information and following up unscheduled care notifications within the older children age group. GPs and primary care staff have a varied experience in the quality of engagement with children social care and safeguarding processes. Frequently GPs report that they are not invited to attend children strategy meetings and that notification for case conferences is not always timely. The notes of these meetings are frequently not received within timescale, resulting in GPs not being aware of the outcomes and delaying any interventions required.

46. The risks of hidden harm are very well understood and embedded in adult mental health services. Identified needs are well addressed in the care programme approach (CPA), with outcomes closely monitored. Audit results consistently show an improving recording of hidden harm concerns. There is a highly rated mother and baby unit, which effectively provide care for both the mother and the baby. Babies are given their own key worker, a nursery nurse, who with the allocated GP ensures that there are no developmental delays due to the mother's mental health. There are robust processes in place should a baby be taken into care, with good sensitive support for the mother and staff.

47. There is good access to highly specialist (tier4) CAMH beds, and a dedicated psychiatric intensive care unit. The transition process and 'step down' provision is well embedded.

48. There still remain challenges with the provision of a robust and comprehensive sexual assault and child sexual abuse historical examinations service, despite ongoing engagement with the local police force and other agencies resulting in a lack of appropriate provision for children and young people.

Outcome 11 Safety, availability and suitability of equipment

49. The HUHFT children's A&E department is secure with appropriately coded locked doors. There is a high police presence in the department, with good working relationships and information sharing especially related to the high number of knife related injuries.

Outcome 12 Staffing recruitment

50. All health staff seen during the inspection, with the exception of the urgent care centre staff, have three yearly reviews of their enhanced criminal records bureau (ECRB) status.

Outcome 13 Staffing numbers

51. There are 7.8 whole time equivalent health visiting vacancies. These 'vacant posts' have been offered to student health visitors who are due to qualify in September 2012. There is good use made of skill mixed community teams to deliver universal services.

Outcome 14 Staffing support

52. The childrens' A&E is staffed by registered children practitioners and paediatricians, all of whom have protected time for safeguarding supervision. All A&E staff (including junior doctors) receive safeguarding training, paediatric resuscitation and trauma training relevant to their job role.

53. There are effective and robust systems for good safeguarding and looked after children supervision for designated, named and all health staff, with the exception of hospital which are not robust. Good supervision arrangements are in place for public health midwives.

54. Safeguarding training rates at HUHFT are variable, from adequate to good, with good progression in improving compliance being made. 89% of GPs are trained to safeguarding level 3. There are good to very good training compliance rates at ELFT. Training data for NHS City and Hackney was not available partially due to the organisational restructuring; this also includes independent contractors' data. The LSCB lunchtime training session have proved to be of a high standard, relevant to current practice, and are well attended by practitioners, including GPs who make time to attend these targeted sessions. These sessions are not accredited or mapped to a safeguarding training level, to enable practitioners to develop a portfolio of training which is a missed opportunity.

Outcome 16 Audit and monitoring

55. There is good sharing of information regarding the status of looked after children and young people by social care the databases regularly reconciled. This has improved significantly the timeliness of the initial health assessments (IHA). All IHAs are not completed by a medical practitioner in line with statutory guidance[2] although a medical practitioner is available during the clinic should advice be required.

[2] Department of Health Department for Children, Schools and Families (2009) Statutory Guidance on promoting the health and Well-being of Looked After Children.

56. There is a wide range of clinical audits related to both the looked after children health services, safeguarding children services and adult mental health engagement and involvement in safeguarding children. Results show a continuous increasing trend of compliance. There is improving use of metrics and dashboards to monitor compliance of services. Dashboards have only recently been developed by commissioners, linked to the newly produced safeguarding contractual requirement policy to monitor action plans from serious case reviews and significant incidents, or section 11 safeguarding audit action plans. It is planned that the recently established health advisory group will monitor the health elements of the dashboard, as there is no health sub group of the LSCB.

57. There are well embedded governance systems and processes within the adult mental health and CAMH services, linked to the ELFT trust wide safeguarding processes.

Outcome 20 Notification of other incidents

58. All health organisations effectively use the serious untoward incident procedures, with investigations undertaken depending on the risk category.

Outcome 21 Records

59. The A&E electronic patient record management system enables ‘flags ‘to be placed on children records that are known to social care. There are effective quality control measures in place to ensure that information relating to children and young people is accurate.

60. The looked after children’s health files seen during the inspection were of variable quality, and did not always conform to professional record keeping standards, the majority were adequate. Chronologies were apparent in some files, although they were not contemporaneous.

Recommendations

Safeguarding

Within 3 months

- Hackney Borough Council and NHS City and Hackney must ensure that there is a fully operational sexual assault referral and physical examination services for all children and young people.

- NHS City and Hackney and Homerton University Hospital NHS Foundation Trust must ensure that all pregnant women are asked alone during their pregnancy of they have been subject to domestic abuse and take appropriate action.

- *NHS City and Hackney and Homerton University Hospital NHS Foundation Trust must ensure that all midwives have regular safeguarding supervision (Ofsted 2012)*

- *NHS City and Hackney and Hackney Borough Council must ensure that GPs are invited to and receive minutes in a timely manner from strategy meetings and child protection conferences (Ofsted 2012)*

- NHS City and Hackney must ensure that there is robust monitoring of safeguarding training compliance for all City and Hackney staff and independent contractors.

Within 6 months

- NHS City and Hackney must ensure that those young people with neurodevelopment conditions have a smooth and appropriate transfer to adult services.

Looked after children

3 months

- *NHS City and Hackney, Hackney Borough Council and Homerton University Hospital NHS Foundation Trust must ensure that all initial health assessments, use of SDQs and care leavers health information are in line with the statutory guidance (Ofsted 2012)*

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.