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.

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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 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 services 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.
Barking and Dagenham is an outer London borough at the heart of the Thames Gateway and is a borough with an expanding and changing population. Its population is one of the fastest growing in the country and across London, placing great pressures on early education, school places and all other services. It has a resident population of approximately 57,000 children and young people aged 0-19, representing over 30% of the population. The rise in the numbers of children aged under five is particularly high, increasing from just over 12,119 in 2001 to a projected level of over 18,215 in 2012. (Ofsted, July 2012)

Barking and Dagenham is an area with high levels of poverty and deprivation. The borough remains ranked as the 22nd most deprived local authority and has the ninth highest level of child poverty in England (Index of Multiple Deprivation 2007). Some 17% of children in the borough are living in households with significantly below average income levels. (Ofsted, July 2012)

The population is becoming increasingly diverse with over 100 different languages spoken in local schools. Some 62% of school pupils are from ethnic minority communities and over a third speak English as a second language. (Ofsted, July 2012)

The partnership arrangements of children’s services in the London Borough of Barking and Dagenham are overseen by the Children’s Trust Board which was established in 2006. The Children’s Trust is linked to the Local Safeguarding Children Board (LSCB), the Health and Well-being Board, the Community Safety Partnership and Corporate Parenting Group through shared membership arrangements. The London Borough of Barking and Dagenham LSCB is independently chaired and brings together all the main agencies working with children, young people and their families to provide safeguarding services. (Ofsted, July 2012)

Health services in London Borough of Barking and Dagenham are commissioned by NHS North East London and City (NELC). Acute hospital services providing accident and emergency services for children are part of the Barking, Havering, and Redbridge University Hospitals NHS Trust (BHRUT). Maternity health care and newborn services are provided by BHRUT. Community health services, including health visiting, school nursing and paediatric services are delivered by North East London Foundation Trust (NELFT), which also provides child and adolescent mental health services (CAMHS) and adult mental health services. (Ofsted, July 2012)
Outcome 1 Involving Users

1. Inspectors saw some good examples of involving service users in evaluating care services. In particular, within substance misuse services, there is good engagement with service users who are actively involved in feeding back on interventions they have experienced and events that they have attended. Regular newsletters are published that are written by service users and there is much interest in peer learning. This ongoing involvement helps to ensure that the service provision continues to evolve to meet the needs of young people.

2. Young people, looked after, are always asked where they would like their health review to take place. By giving the young person a choice, this helps to engage the young person in their healthcare and helps them to take personal responsibility for identifying future health need.

3. All health practitioners interviewed during the course of this inspection confirmed that they had good access to interpreters and translation services. This means that health practitioners were able to communicate effectively with service users.

Outcome 4 Care and welfare of people who use services

4. The paediatric emergency department at Queens Hospital, Barking Havering and Redbridge University Hospitals NHS Trust has 11 cubicles and cares for children from birth until their 16th birthday. Young people from 16 onwards are seen either in the minor injuries unit or adult A&E depending on their need.

5. Effective processes are in place to identify repeat attendance by children to accident and emergency. The casualty card lists the dates of the last four attendances and practitioners can access the trust’s IT system to find out the reasons for attendance and discharge information.

6. The arrangements to ensure that all attendances by children to the A&E department are triaged to identify potential non accidental injury are not sufficiently robust. Medical practitioners are responsible for completing the safeguarding children triage record which considers non accidental injury. The checklist is printed on the casualty card. The trust carried out an audit on completion of the triage record which showed that not all doctors were routinely completing the form. This audit is not repeated on a regular basis which means that variability in practice will continue. The trust, therefore, cannot demonstrate that assessment of non accidental injury is routinely being considered when children present at the department.
7. CAMHS support to A&E at Queens Hospital is predominantly through the CAMHS Interact Team during working hours and out of hours through the adult services with support from the on-call CAMHS consultant. There have been problems with accessing appropriate support out of hours because of changes in process and this had led to young people waiting in the department for an unacceptable long time. The situation is resolved with A&E practitioners now able to access CAMHS support out of hours by calling the NELFT switchboard. Young people are not routinely admitted into hospital for a period of “cooling off” as advised in NICE guidance and are often discharged following CAMHS review. This decision is normally made by the paediatric receiving team. A&E consultants report that they are unable to access or speak to the CAMHS on call consultant directly. There is no CAMHS representative at the psychosocial meetings which means that there is no opportunity to resolve operational difficulties or co-ordinate the approach to the care of young people. The Interact Team Manager told us how he has plans to start attending the psychosocial A&E team meetings to improve on liaison between CAMHS and A&E.

8. There is no specialist follow up support offered to young people who attend A&E following alcohol or substance misuse. Staff in A&E were unsure who the new youth alcohol and substance misuse providers were, although they had been notified that a new worker would be visiting the department to look at what support was available.

9. Children, young people and families have good access to a wide range CAMH services to meet identified emotional health and wellbeing support. There are a number of targeted support services in primary and secondary schools as well as in primary care. The “Listening Zone” counselling and psychotherapy service provides support for young people from 14 to 22 years of age and evaluated well by young people. This good range of support services helps to prevent the escalation of need before it becomes harder to address. Access to core CAMHS is through a weekly intake meeting with most referrals coming from GPs, schools and social care, though all referrals are triaged daily with any urgent cases seen the same day. Outcome scores are used to demonstrate effectiveness of interventions used with children, young people and families to good effect.

10. Access to specialist in patient CAMHS provision is through the Interact Team. The trust has a policy on never admitting young people into adult beds and this means that young people always receive in patient care in an appropriate environment.

11. Transition from CAMHS into adult services is improving with the creation of a newly created transition database. This database forms the initial phase in helping services plan more effectively for when a young person transfers into appropriate adult services.

12. Children, young people and families generally have access to good therapy services, however, there can be delays in for those children whose needs are not urgent, particularly in speech and language and occupational therapies.
13. There is a rapid assessment clinic set up to provide services to those young children under five who display social communication difficulties, this enables families and children to receive early support where a diagnosis of autistic spectrum disorder is being considered. CAMHS support the effective multi disciplinary assessment of autistic spectrum disorder for some children over five years and families do not have to wait to access the assessment and diagnostic pathway.

14. A specialist paediatric nurse holds a caseload of children and young people up to the age of 19 where there is particularly complex health need. This helps families to receive a co-ordinated and consistent approach from health services.

15. A school nurse works full time in the local special needs school for children from 3 to 19. He carries out comprehensive health needs assessments on all children new to the school and creates appropriate health care plans. The school is well supported by health professionals, including a community paediatrician, whose clinics are held in schools to minimise disruption to a child’s education as well as being more convenient for parents and carers.

16. The use of CAF is well embedded with those children with complex needs and some teams are piloting the use of a family CAF which is seen as being particularly beneficial by practitioners and families.

17. There are ongoing comprehensive assessments on vulnerability carried out initially when women first book their pregnancy with a midwife and throughout their pregnancy. There are good arrangements in place to follow up any women who do not attend their ante natal appointments. The assessment on vulnerability and any referrals to support services during pregnancy are not routinely shared with the women’s GP.

18. Outstanding support is available to teenagers who are pregnant from the team of specialist teenage midwives. Young people’s ante natal clinics and parent craft classes are held in children’s centres across Barking and Dagenham and these are well attended. The specialist teenage midwives continue to care for the young women and their babies until 28 days post delivery and ensure that future contraception is agreed prior to transferring to health visitor colleagues. This provides the teenage mother with continuity of care.

19. The family nurse partnership was launched across Barking in Dagenham in 2010. There has been a freeze on recruiting vulnerable families to the programme whilst an additional 2 staff have been recruited and eligible new families will be able to join in September. The family nurse partnership has supported young families well, in particular there is good user engagement in the programme and there are good links with the local employment support workers with high numbers of young mothers returning to education or work.

20. Health visitors use skill mix to effectively deliver most core contacts of the Healthy Child Programme finishing at the 2-2 ½ year check. Health visitors receive a copy of the multi agency referral form if midwives make a formal referral to children’s services. All children’s centres have a link health visitor and this is now being extended to having a link health visitor in all GP practices.
21. There are effective arrangements in place to maintain the health of children and young people in formal education. Well established arrangements are in place to transfer children from the health visiting service to the school nursing teams. Electronic and paper records are transferred across for those children where there are no concerns and either a face to face meeting or telephone conversation takes place to discuss and hand over the care where there is additional need or vulnerability. School nurses carry out the new entry into school screening and are responsible for developing and reviewing health plans for children who need additional support for their health needs in school.

22. School nurses take part in the National Child Measurement Programme and have received training in the local initiatives on managing childhood obesity. All high schools have school nurse “drop in” sessions where health promotion advice and signposting to other services, such as contraceptive and sexual health and substance misuse services, is provided. In some schools a local community liaison post has been established and this has facilitated external agencies coming into school to carry out targeted work with groups of young people. This means that some young people are receiving targeted early support on issues around anger management and risk taking behaviours to stop them escalating into major concerns.

23. The number of teenage conceptions in Barking and Dagenham remains higher than national average and statistical neighbours as does the number of conceptions that leads to termination. Provision of SRE across the borough is variable. School nurses provide teaching in schools at the school’s request; however, the local contraceptive and sexual health (CASH) services are not involved in the SRE programme which is delivered through the Terence Higgins Trust and the local youth service.

24. The CASH services do not deliver any services in schools and are not part of the local Barking and Dagenham C Card Scheme that is delivered through the youth workers.

25. Young people have adequate access to CASH services five days a week in Barking and Dagenham, with a sixth clinic held in a neighbouring borough. The service operates a hub and spoke model, with the main clinic in Barking and satellite clinics in a number of community settings. The main clinic in Barking has been “You’re Welcome” accredited as well as being designated “Young People” friendly which is the local version. There are no single sex clinics and there has been no research with young people to find out if they would prefer a dedicated gender clinic. There is a good number of pharmacists across the borough who are able to prescribe emergency contraception. The CASH service has a young people’s lead in post; however, the effectiveness of her role is compromised by her increasing clinical commitments and there are no clear care pathways between the local substance misuse, CASH and looked after children’s health services.
26. There are adequate services available to support teenagers who do not wish to continue with a pregnancy. CASH services and the young person’s GP can refer direct to the local service provider. Any young person can access follow up counselling support for up to a year after a termination.

27. Young people and their families have good access to effective support for substance and alcohol abuse. The local provider is CRI who work under the brand “Subwize”. The team offers support to any young person under 19 who is misusing substances or is affected by someone else misusing substances. The service offer a range of interventions, including group work, parenting groups or one to one support depending on the need of the young person. Comprehensive assessments are carried out with a young person when they request support from Subwize to identify any additional need with referrals made to other agencies as appropriate.

28. High numbers of young people complete their care plan or leave the service in a planned way and non attendance is followed up through assertive outreach. For those young people that disengage, every attempt is made to bring them back into the service, including the use of re-engagement cards which young people complete at their first appointment and list the reason they sought support in the first place. The card is sent out to the young person in the hope that it reminds them of why they sought support in the first place. This is effective in some cases.

29. A substance misuse transition worker has recently been employed to develop and facilitate improved transition processes between young people and adult substance misuse services. This means that there will be targeted work with those vulnerable young people who may find it difficult to engage with adult services and may have dropped out of treatment.

30. Too much variability exists in the quality of the initial health assessments and health plans for children and young people entering the care system. Whilst most initial health assessments are carried out by the named doctor for looked after children, some are carried out by General Practitioners and these are often incomplete. This means that some health plans are not based on a comprehensive assessment of the child’s health needs. Also there are insufficient numbers of young people entering the care system who have their initial health assessment within 28 days of entering the care system. This means that a full health assessment and care plan may not be available in time for the child’s first review.

31. Health outcomes for children and young people looked after by the London Borough of Barking and Dagenham are good. Ninety five percent of children and young people had received their statutory health review, with 93.1% having had their teeth checked by a dentist and 83.8% are up to date with their immunisation and vaccinations. Health reviews are carried out by the named nurse and nurse advisor for looked after children, with the more complex reviews allocated to the named doctor for looked after children. An internal database is used to record when health reviews are due and this means that appointments can be arranged at a time and place suitable for the child, young person or foster carer.
32. Well established arrangements are in place to ensure that children placed out of the area receive timely health reviews, though there continue to be problems in negotiating access to CAMH services for these children.

33. The looked after children health team do not routinely audit the quality of initial health assessments or health reviews and this means that there is no opportunity to promote continuous improvement in the quality of assessments.

34. The arrangements to maintain the emotional health and wellbeing of looked after children are adequate. An interim mental health practitioner has been appointed to facilitate an early initial assessment of a child or young person’s emotional health and wellbeing. This assessment also considers the needs of the foster carers and other professionals working with the looked after child. However, the new arrangements do not give priority to a looked after child once the referral is made to an appropriate mental health care pathway. The arrangements are new and therefore it is not possible to comment on any impact.

35. There is much confusion about the use of Strengths and Difficulties Questionnaires (SDQs) in measuring a looked after child’s emotional health. Current arrangements are that the virtual head sends out SDQs to foster carers; the looked after children health team complete SDQs as part of the initial health assessment on those children that are seen by the named doctor for looked after children and not by any GPs. Only the SDQ scores from foster carers are reported to the health outcome group. There is no opportunity for scores from foster carers and health to be compared and used in a meaningful way to holistically monitor the emotional health and wellbeing of a child over a period of time.

36. Young people, looked after are able to access universal services for support around contraception and sexual health and substance misuse. The looked after children health team will make appointments on a young person’s behalf with CASH services and accompany them if this is required. The local screening tool for alcohol and substance misuse is not used as part of initial health assessments or health reviews and this means that there is a missed opportunity to identify risk taking behaviours by a young person. The looked after children health team were not aware of any care pathways or identified link professionals in either service to take responsibility for working with looked after young people, despite there being a dedicated looked after children’s substance misuse worker. This means that for those young people, looked after, who find it difficult to access universal services there is no named professional for them to liaise with in CASH that has an understanding of the needs of looked after children.

37. The looked after children health team are not involved in pathway planning for when a young person is preparing to leave care. Current arrangements to provide a young person with a complete summary of their healthcare are unsatisfactory and this is recognised by the looked after children health team who are working with the Children’s Rights Service to develop a health passport.
38. There is good partnership working between the looked after children health team with the “Learn to Live” leaving care team. The Named nurse for looked after children has attended the “Fun Day” with a “health” stall to promote a healthy lifestyle and is in the final stages of negotiating attendance at a “drop in” on a regular basis to offer health promotion and information to care leavers.

Outcome 6 Co-operating with others

39. There is good partnership working to ensure that the A&E at Queens Hospital are aware of which children have a child protection plan in place. The London Borough of Barking and Dagenham provide the safeguarding team at Barking, Havering & Redbridge University Hospitals NHS Trust with a daily list of children who have a child protection plan in place. A member of the team ensures that the trust’s local IT alert system is updated and the details of any child attending the unit are cross checked with the list. However, at the time of the inspection, the local authority did not provide a list of looked after children to the service and this was addressed as a priority during the course of the inspection. The trust have recently introduced a notification form which A&E staff complete when they have treated either a child who has a child protection plan in place or if they are looked after. This form is sent to the child’s social worker and this means that professionals working with a child have access to the most up to date information.

40. Accident and Emergency staff are confident in making referrals to the local authority when they are concerned about the safety of a child, including where adults attend the department following domestic violence or self harm. Referrals are copied to the trust’s safeguarding team and these are discussed at the trust’s psychosocial meeting.

41. The Paediatric Liaison role which ensures that attendances of any child up to the age of 18 is notified to the relevant health visitor or school nurse is carried out by the Barking and Dagenham Children’s Safeguarding Service. Practitioners complete a “notification form” where they consider that the health visitor or school nurse require additional information on any attendance. Up until recently this work was supported by a paediatric liaison health visitor, however, the postholder left and had not been replaced. Barking, Havering and Redbridge University Hospitals NHS Trust’s safeguarding paediatric liaison nurse ensures that the A&E notification forms and A&E referral forms are circulated appropriately and notification forms are also discussed at the psychosocial meetings to ensure that any follow up is appropriate. However it was reported that the increasing demands of her role in the Child Death Overview Panel (CDOP) continues to impact on her ability to keep up to date with this work. We were assured during the inspection that the role of paediatric liaison health visitor had been recruited to and that the issue of capacity within the safeguarding paediatric liaison role would be addressed.
42. Funding has recently been obtained to provide a specialist practitioner to work alongside A&E services over a weekend to help provide support to those young people who attend the department through alcohol or substance misuse. However, this work has not yet started and current arrangements do not include routinely sharing information on young people who have attended A&E following substance or alcohol or misuse with Subwize for follow up contacts. This means that services in Barking and Dagenham are missing early opportunity to identify and support young people.

43. An outstanding and innovative perinatal, parent and infant health service provides effective support to a pregnant mother and thereafter to the mother and newborn baby. A whole health economy approach is taken to support perinatal mental health with clear and well understood care pathways that are linked to managing risk.

44. Good support is available to women who misuse alcohol or substances in pregnancy with close liaison between the specialist substance misuse midwives, the local adult substance misuse services and the local authority children and families team.

45. Where vulnerability in pregnancy may impact on the safety of the unborn child, referrals are made to the local authority children’s services. Regular multi agency partnership meetings and the creation of pre birth plans ensure a co-ordinated approach to support the new family and protect the newborn baby. Currently health visitors are not invited to the partnership meetings.

46. All health practitioners interviewed were confident in referring safeguarding and child protection concerns to children and families service, and felt that the multi agency triage team provides a more efficient and consistent response. Referrals that are not accepted as child protection are now referred to the Multi Agency Locality Teams who signpost to services that can offer additional support to vulnerable families, usually through the Common Assessment Framework (CAF).

47. Health visitors, school nurses and nursery nurses work to deliver packages of care and support as part of CAF, child in need and child protection plans. Nursery nurses are trained through a comprehensive competency framework and remain accountable to the health visitor or school nurse who remains responsible for the case.

48. Good attendance at child protection conferences by health visitors and school nurses mean that the health needs of children are discussed appropriately at these meetings. School nurses are no longer attending core groups where there is no identified health need and though this is working well, school nurses report that they are not always being copied in to the core group minutes.
49. The local authority children and families team send all invitations to child protection and child in need conferences to a nominated person within the North East London Foundation Trust who then ensures that these are sent on to the appropriate worker. However, there are no reporting mechanisms in place to monitor attendance at child in need or core group meetings and this means that the trust is unable to assure itself that mental health services are appropriately represented in these important family meetings. During the inspection we scrutinised case files and there was evidence of some important meetings where adult mental health services were not appropriately represented despite being invited.

Outcome 7 Safeguarding

50. The NHS Outer North East London and NHS North East Inner London have recently merged and a new executive lead for safeguarding children is in post. Governance arrangements, including the reporting on safeguarding practice across commissioning and the Barking, Havering & Redbridge University Hospitals NHS Trust and the NELFT are being refreshed to reflect the recent changes to health care provision across the area. However, the key performance indicators for safeguarding activity used by commissioners do not reflect the key performance indicators embedded in previous contracts or those collected by the provider NHS trusts. There is a lack in clarity over the roles, responsibilities and resourcing of some of the named and designated safeguarding professionals across Barking and Dagenham PCT and the two provider NHS Trusts. This means that named and designated professionals are not fulfilling their statutory functions as outlined in Working Together 2010 and the intercollegiate guidance 2010 and impacts on partnership working.

51. The post of designated nurse for Barking and Dagenham PCT is being covered by two interim part-time staff. The job description for the role has been finalised and the post is due to be advertised imminently. The designated nurse role is accountable to the deputy director of safeguarding. The current postholders did not feel that they had sufficient influence over safeguarding practice strategically across provider organisations, or within commissioning services.

52. The designated doctor for safeguarding children is also interim. Since taking up the post, she has concentrated her efforts on successfully clearing the backlog of sudden untoward deaths incidents (SUDI) and work for the CDOP.
53. A new named GP has been appointed in Barking and Dagenham for one session per week. This post had been vacant for a considerable length of time and it is unlikely that one session per week will be sufficient to establish good safeguarding children awareness and practice across the borough. In 2008 the Barking and Dagenham Primary Care Trust had recruited a primary care safeguarding nurse advisor. This post has since transferred to NELFT and whilst the postholder has proved immensely valuable in supporting GPs in meeting their responsibilities in child protection there is concern over whether there is appropriate governance of the role. The GP safeguarding nurse advisor has been attending child protection conferences on behalf of general practices and has accessed patient records to support her work. Governance within primary care has devolved to NELFT and it is questionable as to whether this is appropriate as this means that one provider is risk assessing and reporting on another provider’s safeguarding and child protection practices without any formal agreements in place.

54. All GP practices have a named safeguarding lead in place, although there has not been the opportunity for safeguarding leads to meet to discuss and disseminate good practice. A few GPs inspectors spoke to did not think that they regularly received copies of health plans for looked after children.

55. GPs inspectors spoke to told us how they were aware of the named link health visitors but that regular meetings with between primary care and health visitors to discuss vulnerable families did not routinely take place.

56. The named nurse for safeguarding children in Barking, Havering & Redbridge University Hospitals NHS Trust is employed full time and works across two busy hospital sites. She is assisted in the role by a paediatric liaison nurse who offers safeguarding support to the A&Es at both hospitals and covers the three CDOPs for the London Boroughs of Barking & Dagenham, Havering and Redbridge. There is a named midwife who is employed for 0.8WTE, however, there is no lead anaesthetist for safeguarding and child protection. There is a named doctor for safeguarding children in post.

57. The named nurse for Barking, Havering & Redbridge University Hospitals NHS Trust receives copies of all referrals to children’s social care and these are reviewed in the regular multi agency psychosocial meetings which provide an excellent opportunity to ensure a co-ordinated approach to safeguarding children. However, the nominated representative from the London Borough of Barking and Dagenham has recently left and attendance at the weekly meetings has become less consistent.

58. The NELFT has reviewed the organisations safeguarding structures and has created a new borough focused named nurse. The overall increased capacity supports safeguarding in both adult mental health services, CAMHS and Community Services. The named doctor for NELFT is also the LAC designated doctor. Updated job descriptions for both roles are not available.
59. The named nurse is employed full time and is supported in her role by a GP Liaison Nurse, and an additional nurse who sits with the multi agency triage team in the local council. There is a vacant post for paediatric liaison health visiting operating out of Barking, Havering and Redbridge University Hospitals NHS Foundation Trust. Arrangements to appoint to the vacant post are near completion.

60. The NELFT has a network of safeguarding link staff that attend the trust’s integrated safeguarding network. The named nurse is unsure if the safeguarding link practitioners have a role description and how this is linked into their performance appraisal. It is therefore not possible to comment on the effectiveness of the safeguarding link role within the organisation. The named nurse has recognised the need to strengthen links with health visitors and school nurses and has dates in her diary to attend health visitor meetings.

61. The named nurse for looked after children is employed full time and is line managed by the named nurse for Barking and Dagenham Community Services within the North East London Foundation NHS Trust (NELFT). The line management and accountability arrangements for the role do not sufficiently prioritise and raise the profile of the care of looked after children within this large organisation. In addition, there is one full time nurse advisor for looked after children. The designated doctor for looked after children does not have any specific resource allocated to the role or an up to date, comprehensive work plan. There is a named doctor for looked after children that has six sessions allocated to working with looked after children and carrying out initial health assessments and adoption medicals.

62. Good awareness on the impact of domestic violence on children in families means that all practitioners we spoke to were vigilant when working with families. The process for receiving police notifications on incidents of domestic violence (MERLINS) was updated in January 2012 and all new notifications are logged on the IT system and filed in safeguarding records. Notifications are discussed at the MALT meetings at which either a health visitor or school nurse attends and is responsible for communicating with the appropriate health care professional. However, members of the focus group were unclear on this new process.

63. Work between NHS Barking and Dagenham, Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) and Refuge the national domestic violence charity has led to the successful implementation of an effective whole system change to how maternity services respond to pregnant women who are experiencing domestic violence. The BHRUT have introduced “Time to Talk” to support the routine enquiry process. This has helped to ensure that all women are seen on their own for the first 15 minutes of their booking appointment to provide a safe and confidential space to be asked about and disclose domestic violence. The numbers of pregnant women who are disclosing domestic violence has significantly increased as a result of the new processes and enhanced awareness through training.
64. To support routine enquiry for domestic violence, the Polyanna Project was commissioned to revise the women’s wheel (used locally) to create a maternity wheel. This is a universal resource given to all women and includes the domestic violence maternity service telephone number. This resource has been recognised as an example of best practice by NICE in their Care of Socially Complex Women guideline (2011).

65. Good processes are in place to ensure that the details of children in the family of adult mental health service users are recorded. Details are first taken when an adult service user enters the adult mental health service during assessment and are updated as part of the care planning process. There are appropriate processes in place to assess and escalate risk if a service user expresses any desire to harm children as part of psychoses.

66. Children visiting their parents on adult mental health wards now benefit from seeing them in a new purpose built environment. Appropriate risk assessments take place prior to any visit to ensure that any child is appropriately safeguarded. These arrangements are being strengthened by further discussion with children and families services to ensure that there are no restrictions on visiting if a child is subject to a child protection plan and are as a result of a serious incident.

67. Community Paediatricians complete child protection medicals, however, they do not routinely attend child protection conferences; instead this support for child protection is from the GP safeguarding nurse advisor. NELFT are not able to report on practitioners attending conference, instead they rely on reporting by the LSCBs performance and quality group. Appropriate arrangements are in place to ensure that children who have been subjected to acute alleged sexual abuse are seen in the specialist, child friendly facility at the local Haven.

68. The child death overview panel (CDOP) is appropriately constituted and has had its membership refreshed, with improved notifications of child deaths now in place. Rapid response works well and is compliant with “Working Together To Safeguard Children”, 2010. However, the panel has not yet had the opportunity to evaluate the effectiveness of the bereavement support offered to families. (Ofsted, July 2012)
Outcome 13 Staffing numbers

69. Appropriate arrangements are in place to ensure that staff within the paediatric emergency department at Queens Hospital have received some paediatric training. The trust try to schedule a paediatric qualified nurse on each shift, however, this is not always possible. To mitigate the risk in using adult trained practitioners, all nurses working in the department have carried out additional training, including paediatric life support. The trust have recently committed to funding a number of A&E nurses to carry out their paediatric training to resolve the situation. Processes are in place to ensure that where potential safeguarding concerns have been identified, a child should not be discharged home until a registrar has sought advice from a paediatric consultant. However, this has not been audited and therefore it is not possible to demonstrate compliance with trust policy.

70. Health visitors describe their caseloads as high, each health visitor has their own caseload which averages around 500 per full time member of staff. NELFT are in the midst of recruiting additional health visitors and this will reduce caseloads to a more manageable level.

Outcome 14 Staffing support

71. Training on the health needs of children looked after is provided through the LSCB. The named nurse for looked after children has historically provided training to foster carers though this has lapsed recently.

72. The named nurse for safeguarding children for Barking has recently revised the training needs analysis to reflect the changes as outlined in the Intercollegiate Guidance 2010 and is making very good progress in ensuring that practitioners attend the level of safeguarding children training appropriate to their role. The trust report that in excess of 80% of all staff have been trained appropriately at Levels 1, 2 and 3.

73. A new supervision policy on safeguarding children practice is going through the BHRT’s ratification process. The policy is supported by an implementation plan which should see supervision introduced across the trust from September 2012. There is, however, some concern that nominated practitioners did not attend the recent training event and that the resourcing of supervision has not been finalised. If not resolved, these issues will significantly impede the success in rolling out supervision in child protection to key groups of staff.

74. Adequate progress is being made within NELFT to ensure that staff receive safeguarding children training appropriate to their role. Eighty five percent of staff have been trained at Level 1, 65% at Level 2 and 74% at Level 3.
75. Health visitors and school nurses access supervision on safeguarding children practice regularly every three months and there are robust processes in place to monitor compliance. However, the practitioner chooses the cases they wish to bring to supervision and this means that some child protection cases or child in need cases are not discussed in supervision and that there has been no management oversight of the case.

76. Child protection supervision is improving within CAMHS. Nominated individuals will be receiving additional training and the plan is for supervision to be offered from August 2012 onwards. Safeguarding is a regular standing agenda item in all team meetings and in clinical supervision.

77. The Barking and Dagenham LSCB has recently held their annual conference on how services can support complex and resistant families and looked at the learning from the Serious Case Review and how this can be incorporated into practice. This was facilitated and supported by the NELFT named nurse and was well attended by trust staff and partner agencies, both statutory and voluntary. The conference was evaluated highly with most delegates reporting increased confidence and learning on working with vulnerable families.

Outcome 16 Audit and monitoring

78. The NHS Outer North East London and NHS North East Inner London have recently merged and a new executive lead for safeguarding children is in post. The executive lead is now the Director of Nursing and Quality. Governance in the new NHS PCT cluster is through the monthly children safeguarding commissioning meeting which is attended by leads from commissioning and the designated nurses. A new dashboard on safeguarding has been introduced and it is the responsibility of the designated nurses to discuss performance on safeguarding children with each provider and to update the dashboard. Non compliance will be supported by a clear escalation governance route and there is a risk register in place to monitor safeguarding activity across the cluster. These arrangements are new and it is not possible to comment on the impact of this work.

79. Adequate board assurance on safeguarding children activity within the BHRT is obtained through the work of the safeguarding children committee that is chaired by the Director of Nursing who is the lead executive for safeguarding children across the trust. The trust board also receive the annual report on safeguarding children. The safeguarding committee report to the Quality and Safety Committee which is a formal sub committee of the trust board. The safeguarding committee has formal representation from the local authority, the North East London Foundation NHS Trust and the designated nurse from Havering who represents the three designated nurses from Barking & Dagenham, Havering and Redbridge. However, the safeguarding committee does not include membership from other directorates for example, surgery, medicine or anaesthetics.
80. The BHRT has a well developed audit plan to ensure that clinical practice to safeguard children is fully complaint with trust policy and national guidance. There is evidence to show that findings from audit are integrated into future training programmes to ensure continuous improvement in practice. Recent audits have explored the impact of safeguarding children training, the quality of multi agency referral forms and record keeping in Accident and Emergency. Follow up audits have all shown improvement in practice.

81. Governance on safeguarding activity within NELFT is through the strategic safeguarding group which is chaired by the strategic lead for safeguarding children and adults. There is an integrated safeguarding group at which all named professionals throughout the organisation attend which co-ordinates the work of all borough wide operational safeguarding groups. Key performance indicators on safeguarding activity are measured and reported on; these include safeguarding training and the new policy is delayed because of the transfer in of Redbridge community services. There are key performance indicators on supervision; again the policy has been written and there is ongoing work with IT to refine identification and reporting of supervision practice. Safeguarding is a standing item on each individual’s supervision and on monthly team meetings. In addition the cycle of business at a directorate level has safeguarding as a standing item. This is in addition to the monthly MHS wide safeguarding meeting. The LSCB is attended by the Operational Director with the link to B&D and has overall accountability to deliver safeguarding in B&D.

Outcome 21 Records

82. The recording in health visitor and school nursing records seen as part of the inspection is too variable. Insufficient care is taken in recording ethnicity and other family information. Entries are not sufficiently child focussed and often do not contain any analysis or indication of risk. Health Care Practitioners are now using electronic records, in which case the skill mix team member’s entry is validated by the Specialist Practitioner if the community nursery nurse (CNN) has not completed the competency assessment framework to ensure appropriate oversight and management of the casework.
Recommendations

Within 3 months (from report)

NHS North East London and City to review the arrangements for supporting primary care in meeting their responsibilities in safeguarding children and child protection. Review the roles, responsibilities and resourcing of the named and designated safeguarding professionals, including designated professionals for Looked After Children across Barking and Dagenham to ensure they reflect the guidance in ‘Working Together To Safeguard Children’, 2010 and the Intercollegiate Guidance 2010. (Ofsted, July 2012)

NHS North East London and City, NELFT and Barking Havering and Redbridge University Hospitals NHS Trust to review the care pathway for supporting young people who attend accident and emergency department with self harm to ensure it meets NICE guidance. (Ofsted, July 2012)

BHRT and NELFT to review the membership and terms of reference of their safeguarding committees to ensure that they represents the whole business of the trusts to ensure that good safeguarding practice is embedded in all departments and teams.

Within 6 months

Review the provision of sex and relationship education and contraception and sexual health services across the partnership to provide a more integrated approach. (Ofsted, July 2012)

Review the working relationships with adult mental health services and the probation service to ensure that both agencies understand their responsibility in safeguarding children. (Ofsted, July 2012).

NELFT Introduce a mechanism of continuous cycle of improvement to improve the quality of analysis and recording in health visiting and school nursing records.

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.