

# **Review of Health Services for Children Looked After and Safeguarding in Harrow**

# Looked After Children and Safeguarding

## The role of health services in Harrow

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<b>CCGs included:</b>	Harrow CCG
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## Summary of the review

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This report records the findings of the review of health services in safeguarding and looked after children services in Harrow. It focuses on the experiences and outcomes for children within the geographical boundaries of the local authority area and reports on the performance of health providers serving the area including Clinical Commissioning Groups (CCGs) and Local Area Teams (LATs).

Where the findings relate to children and families in local authority areas other than Harrow, cross-boundary arrangements have been considered and commented on. Arrangements for the health-related needs and risks for children placed out of area are also included.

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## About the review

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The review was conducted under Section 48 of the Health and Social Care Act 2008 which permits CQC to review the provision of healthcare and the exercise of functions of NHS England and Clinical Commissioning Groups.

- The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.
- The focus was on the experiences of looked after children and children and their families who receive safeguarding services.
- We looked at:
  - the role of healthcare providers and commissioners.
  - the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
  - the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.
- We also checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, Working Together to Safeguard Children 2013.

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## How we carried out the review

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We used a range of methods to gather information both during and before the visit. This included document reviews, interviews, focus groups and visits. Where possible we met and spoke with children and young people. This approach provided us with evidence that could be checked and confirmed in several ways.

We tracked a number of individual cases where there had been safeguarding concerns about children. This included some cases where children were referred to social care and also some cases where children and families were not referred, but where they were assessed as needing early help and received it from health services. We also sampled a spread of other such cases.

Our tracking and sampling also followed the experiences of looked after children to explore the effectiveness of health services in promoting their well-being.

In total we took into account the experiences of 67 children and young people.

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## Context of the review

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Harrow is an outer London Borough where 25.2% of the population is under the age of twenty with 82.1% of school children coming from a black or minority ethnic group. Some 45% of pupils speak English as their first language. Gujarati, Tamil and Somali are the most recorded, commonly spoken community languages in the area. The health and well-being of children in Harrow is generally better than the England average. The infant mortality rate is worse and the child mortality rate is similar to the England average. The level of child poverty is similar to the England average with 21.2% of children aged under 16 years living in poverty. The rate of family homelessness is better than the England average. There are 16 children's centres that provided services to nearly 10,000 under-fives up to the end of 2011, including 4,000 under-fives from the areas which are in the most deprived 30% of the borough. These centres are the hub for most early years and early help services.

In comparison with the 2006-09 period, the rate of young people under 18 who are admitted to hospital as a result of self-harm remains broadly similar in the 2009-12 period. Overall rates of admission in the 2009-12 period are lower than the England average. The rate of A&E attendances for children under four years of age was significantly better than the England average.

In 2011/12, 0.6% of women giving birth in this area were aged under 18 years. This is similar to the regional average. This area has a lower percentage of births to teenage girls compared to the England average and a lower percentage compared to the European average of 1.2%.

Commissioning and planning of most health services for children are carried out by Harrow Clinical Commissioning Group (CCG). Acute hospital services and accident and emergency service for children are provided by Northwick Park, part of the North West London Hospital NHS Trust. The hospital also provides acute paediatrics; maternity and neo-natal unit services and the designated doctor for looked after children. Children and families access primary care services through one of 35 GP practices, walk in centres and the Urgent Care Centre at Northwick Park Hospital.

The Urgent Care Centre is commissioned by Harrow CCG and provided through a partnership. Ealing ICO are the main contractors for the service and employ the nurses and Greenbrook Healthcare are responsible for the UCC day to day management and employ the GPs. Governance for the service is shared across provider partners reporting to ICO clinical governance.

Community and universal services such as health visiting and school nursing, commissioned through public health, and the looked after children's nurse are delivered through Ealing Integrated Care Organisation which covers Ealing, Harrow and Brent.

Child and adolescent mental health services (CAMHS) are provided by Central and North West London NHS Foundation Trust (CNWL) mainly delivered in the community. The trust does have a child mental health in-patient service for children aged under 13 with complex emotional, behavioural and psychological difficulties located at the Collingham Child & Family Centre in the Kensington and Chelsea local authority area. The mother and baby inpatient unit is based at Park Royal Centre for Mental Health (local authority of Brent) along with the specialist perinatal community service that operates across Brent and Harrow.

Young people and adults who are misusing drugs and/or alcohol receive services from Compass, an independent sector provider.

The last inspection of health services for Harrow's children took place in May 2012 as a joint inspection, with Ofsted, of safeguarding and looked after children's services. Judgements at that inspection were that health's contribution to safeguarding was adequate and the Being Healthy delivery for looked-after children was inadequate.

Recommendations from that inspection and the subsequent actions taken are covered in this review.

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## The report

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This report follows the child's journey reflecting the experiences of children and young people or parents/carers to whom we spoke, or whose experiences we tracked or checked. A number of recommendations for improvement are made at the end of the report.

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## What people told us

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We heard positive experiences of health support from some foster carers;

In caring for severely disabled children;

*"I couldn't have asked for better service and support. The speech and language therapist, occupational health and physiotherapist co-ordinated appointments so I just needed to attend one appointment. The paediatricians were fantastic "*

*"I have had the same health visitor for over 20 years and she has trained me as I needed help".*

*"My foster child was upset and noisy when we went to hospital and they fast-tracked us so he was seen quickly".*

However, foster carers also identified some gaps in support;

*"I didn't get any formal training on how to care for babies with drug dependency, although I have asked for training many times."*

*"I haven't had any health training this year. I have had training on health needs in the past and it has been very useful."*

*"The boys (unaccompanied asylum seekers) don't want to attend anything on sexual health and about contraception delivered by a female. A male nurse or professional to do this would be really great."*

We heard about how looked-after children and foster carers experienced annual health reviews:

*"The health visitor comes to my home to do the review, that's really helpful and much easier to organise". – a foster carer*

*“I don’t get a copy of the health review. I do get copies of health reports from consultants. My social worker makes sure I get these.” – a foster carer*

*“The health review happened once a year and the nurse came to my home. You had to do it rather than it being particularly useful.” – a care leaver*

*“I was never asked about where the review happened. It always happened at the foster placement. A neutral environment might have been helpful, a bit of flexibility.” – a care leaver*

*“I never got a copy of my health plan or any health history at my last review before I left care. The review just seemed the same as all the others.” – a care leaver*

*“I was always seen on my own, without my foster carer and I liked that”. – a care leaver*

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## The child’s journey

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This section records children’s experiences of health services in relation to safeguarding, child protection and being looked after.

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### 1. Early help

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1.1 In most cases, there is effective handover of new mothers and new borns between midwives and health visitors usually by telephone with paperwork faxed between the teams. While health visitors do not routinely undertake pre-birth home visits, these are subject to an assessment of risk and discussion between the health visitor and team leader if vulnerabilities have been identified. The new provision of perinatal mental health input into the midwifery service which is due to commence shortly, is a positive development.

1.2 The urgent care centre (UCC) has a robust system for initial clinical triage at registration and its co-location with the emergency department ensures that people are efficiently directed to the most appropriate service. However, systems for the identification of indicators of safeguarding risk at registration are not robust, relying on manual checks and identification of those on child protection plans. There is no system for flagging children who are looked after or identifying frequent attenders. In both UCC and paediatric emergency, there is no routine recording of who is accompanying the child although documentation used in the children's emergency department (CED) does contain areas to record this (recommendation 1.1). In the UCC, we observed appropriate responses to concerns that were identified while children and young people were attending the unit and good liaison with social care to share these issues. However, we did see evidence that the correct safeguarding protocols are not always followed and we referred a case back for management attention where the actions taken did not comply with agreed protocols and were not sufficient to ensure that the child was safe (recommendation 1.2).

1.3 In the paediatric emergency department (CED) at North West London Hospital NHS Trust's Northwick Park Hospital, a system has recently been introduced by which a safeguarding sticker is required to be applied to each child's case notes to support effective risk identification. Safeguarding leads and department managers told us this was not routinely being used by doctors, thus undermining the system's effectiveness. No cases we reviewed had the sticker applied. Remedial action was taken to address this while we were in the department and the task has now been appropriately reassigned to the nursing staff. Managers are confident that this will ensure good practice and that this procedure becomes routine.

1.4 In paediatric emergencies, we saw cases where risk assessment had been effective and appropriate actions had been taken to ensure the child was safe and well. However, we also saw several examples of cases where referrals to the multi-agency safeguarding hub (MASH) or community services had been made but which had not been actioned promptly by clinicians in the hospital and had been delayed, in some cases referrals being made the day following the child's presentation. Worryingly, we saw several case examples where no referral had been made where the need for further investigation or support should have been clear to clinicians. There is no review of all presentations of under 18s in either paediatric emergency or the UCC to ensure that all safeguarding issues have been identified and responded to appropriately, either prior to or shortly after discharge. Given our small sample and the number of cases we identified where safeguarding risks had not been responded to promptly, this is of concern. Managers and safeguarding leads within the trust and commissioners cannot be confident that all vulnerable children have been identified and appropriate actions taken to protect them in either UCC or the paediatric emergency department (recommendation 1.2). We referred a number of cases back for review to support wider learning about gaps in current arrangements.



1.5 The process to ensure that appropriate follow-up in community health services takes place is not robust. The paediatric liaison health visitor service at Northwick Park is covered by Brent and Harrow community health service equivalent to 1 WTE, although at the time of the review, a post holder for Brent had just been identified after a significant gap. The paediatric liaison health visitor for Harrow is assiduous in reviewing all cases referred to her and in ensuring appropriate follow up but the service is very stretched, covering both the paediatric emergency department and urgent care centre in three visits per week and with no effective cover for periods of leave. Capacity to provide a comprehensive paediatric liaison health visitor service that includes appropriate practitioner and service manager feedback to support continuous practice improvement within the current resource allocation is questionable (recommendation 3.1). Although there is some confusion about the criteria for referral to the service (we were given two different versions), it is unlikely that all appropriate cases are passed to the liaison health visitor and we saw examples where this was certainly the case (recommendations 1.2 and 1.3). There is currently no process in place to monitor this however. Also, there is no effective and aggregated reporting of the number or nature of cases and actions taken by the paediatric liaison health visitor to either North West London Hospital NHS Trust or Ealing Hospital Integrated Care Organisation to ensure effective safeguarding and continuous improvement across the whole system (recommendation 4.1).

1.6 In some cases we saw that arrangements for regular liaison between GPs, health visitors and community midwives were effective. This had supported the early identification of vulnerabilities within families and facilitated the provision of early help services through children's centres. Both practices we visited had arrangements for weekly/fortnightly meetings between GPs, health visitors and midwives to discuss cases of concern, and relevant notes were put on the practices' IT system where concerns were identified. GPs told us that they have improved communication and relationships with children's social care and acknowledgements to the receipt of safeguarding referrals is now routine. However, feedback on outcomes or if action has been taken by the multi-agency safeguarding hub (MASH), remains patchy (recommendation 5.1). GPs told us that communication and liaison from the safeguarding midwifery team was not embedded and that when they made referrals to 'Jade', the midwifery safeguarding team, there was a lack of communication from midwives about the outcomes of these referrals and how vulnerabilities would be supported. Effective liaison with primary care from the newly established maternity liaison meetings could address this concern and ensure all services engaged with mother and unborn child are fully informed about how concerns are being actioned and risks minimised (recommendation 6.1).

1.7 Where children and young people need mental health support, there is a clear and timely process for triage and access to child and adolescent mental health (CAMHS) although access to the service through the emergency departments remains a challenge for older children. Practitioners in a number of services spoke of their frustration that they can no longer refer directly to CAMHS. The team actively signposts young people to alternative services where they do not meet CAMHS criteria and there is a good range of independent sector services offering lower level support. However, we heard that CAMHS found it difficult to find an appropriate interpreter for a child in the early days of his engagement with the service, making him reluctant to continue. There are reported gaps for young people with ASD or ADHD in service provision. We saw case examples of CAMHS staff identifying young people's need for early help and making the appropriate referrals to children's social care. Practitioners demonstrate good awareness of safeguarding protocols, have made prompt referrals and apply the team's non-attendance at appointment (DNA) policy appropriately.

1.8 Sexual health services (CASH) are available and accessible to young people through clinics and outreach services with a range of opening times and which are focused on areas of highest need. Since moving to public health commissioning, the service had recommenced chlamydia and gonorrhoea testing as part of the early help offer and this service is being well used by the borough's young people across all communities. The rate of positive tests per month support the need for this service within the borough. Capacity pressures within school nursing prohibit their delivery of any sexual health education programme but a school nurse is based with CASH and the service has close relationships with local schools and the pupil referral unit facilitating young people's awareness and access to sexual health services. In December 2013, CASH revised its risk assessment approach informed by national research and good practice; introducing separate risk assessment proforma for under and over 16s. Currently, the proforma do not include fields for the practitioner to record their observations of the young person's demeanour which would further strengthen the assessment of risk. The service is well used by young people from diverse communities including those where female genital mutilation is potentially an issue. However, the service's risk assessment does not currently explore the issue with service users and is potentially missing an opportunity to gather data potentially useful to Police and other agencies engaged in trying to tackle this locally and nationally. The service's information system is stand-alone which, while protecting individual privacy, does not facilitate effective safeguarding information sharing. The service does not receive notifications of children subject to child protection plans that other services get routinely, has no read only access to other IT systems which could facilitate child sexual exploitation (CSE) risk identification. CASH is not as well connected with wider safeguarding forums as it might be such as the multi-agency risk assessment conference (MARAC) or local multi-agency work on CSE. The service is small and engagement with wider work would put pressure on capacity, but should be explored in order that multi-agency working on these issues is most effective. Cases are discussed daily and where vulnerabilities are identified, these are discussed at monthly clinical governance meetings. The service has made no safeguarding referrals in the past 12 months. CQC will draw the local authority's attention to these issues.

1.9 We saw evidence of very positive outcomes for young people from the work of Compass substance misuse service. The transition pathway for young people with ongoing substance misuse problems into the adult support service is seamless and flexible reflecting the needs of the individual young person, as services are delivered by a single provider. The well-established provision of a specialist Compass worker in the youth offending service ensures good support to this cohort of young people. Although Compass provides training to referring agencies on use of the drug and alcohol screening tool, the service reports that this is not well used and the service was unable to cite examples of any referrals from paediatric departments at Northwick Park hospital which warrants further exploration to ensure hospital staff are clear on referral pathways and that young people needing support for these issues are referred promptly.

**Case example:** *A school referred a 13 year old girl for self-harm and substance misuse. Compass worked with her over a three year period, supporting her through continued drugs use, risky behaviour and self-harm. Eventually, her Compass worker successfully encouraged her to engage with CAMHS, went with her to secure the GP referral and accompanied her to her first few CAMHS appointments.*

*The young person's own evaluation of the impact of the support from Compass was that she was class A drugs and alcohol free, although still using cannabis recreationally. She had gained confidence, being able to express herself more safely and effectively and was undertaking a full-time internship with a local company.*

*The case has now been closed by Compass as the young person no longer requires the service. She is well engaged with CAMHS and continues to benefit from her social worker's support.*

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## 2. Children in Need

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2.1 A multi-agency maternity liaison meeting has recently been established where professionals from a range of services meet to discuss identified vulnerabilities of unborn children. Where a similar model of liaison meetings has been established in other trusts around the country, these meetings are highly effective in facilitating the early identification of vulnerabilities in families and in the effective provision of multi-agency early help support which safeguards children. It is positive, therefore that meetings of this type have now been introduced at Northwick Park Hospital. This has the potential to be a highly effective forum to ensure early help support is put in place for vulnerable families and that cases progress quickly into child protection where that is appropriate. The meetings are still at an early stage of development and further consideration of membership, recording, action tracking and information sharing is warranted to ensure the forum is fully effective (recommendation 6.3).

2.2 There is increasing use of the common assessment framework (CAF) among health providers as a means of referring cases to children's social care but this is still slow and not yet embedded across the partnership. We were told that responses to CAF referrals can be variable and more work across the partnership is warranted to ensure that all services likely to be essential components to the resultant support package to the vulnerable child or family, are fully engaged in the planning process (recommendation 10.6).

**Case examples:** *We saw two examples of GPs completing CAFs, one for a three year old child and one for a 6 year old child, where the GPs had identified concerns about domestic violence and potential neglect.*

*In both cases, further investigations took place and both families have been allocated on-going support from social care and other support services.*

2.3 School nurses and health visitors are effective in identifying concerns about children's health and emotional well-being, leading to some good multi-disciplinary communication and liaison and positive outcomes for children and we saw examples of this. A lack of capacity in the school nurse team undermines the ability of staff to cope with the demands of an escalating child protection workload, and severely limits their ability to undertake preventative and early help work. Health visitors routinely see mothers alone in order to explore any domestic violence or emotional health issues and adopt a range of imaginative strategies in order to ensure this is achieved.

2.4 We observed the MASH process operating well to ensure early notification of referrals across agencies, share information and secure appropriate action by relevant parties to promote early help as well as preventative / reactive work. Referrals to MASH from GPs have increased since the recruitment of a health professional to the team. The work of the MASH is ensuring effective and well informed decisions are being made about the level of service likely to deliver the best outcome. We heard about joint assessment work and joint visits leading to positive outcomes, for example; a referral to health services for both a child and its parents. In one case we noted initial delay in making the referral to MASH from the paediatric emergency department, but once the referral had been made, a prompt response by the MASH team led to good risk assessment, development of an effective safety plan and prompt referral of the family to appropriate services.

**Case example:** *referral to MASH of concerns about risks to an unborn baby with a sibling of less than 12 months old. The mother was reporting domestic violence. Case was discussed at daily MASH meeting. Section 47 enquiries were being made due to concern at level of violence reported plus mother is pregnant.*

*The MASH public health practitioner notified the relevant midwife to engage with mother and ensure mother is seen alone. Checks being made with GP and health visitors to obtain further information and alert services to S47 enquiries.*

*The mother is currently staying with family so she and infant and unborn baby are safe. An independent domestic violence advisor recruited to MASH and taking up post imminently is to help develop a safety plan.*

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### 3. Child Protection

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3.1 Following the joint SLAC inspection in 2012, the local pre-birth protocol was revised to address the pre-birth and multi-agency planning concerns that were highlighted at the time.

3.2 Where pre-birth concerns had been identified in our case sample however, we did not see routine, effective communication in all cases between midwifery and other involved services such as adult mental health and health visitors (recommendation 6.1). Key services involved in child protection cases are not routinely informed by midwives of the birth or discharge of babies into the community. In one case, the health visitor learnt of the birth of the baby from the paediatric liaison health visitor and the substance misuse worker was informed of the mother's discharge from hospital by the pharmacist. Also in this case, a discharge planning meeting was held, without full professional involvement, seven days prior to the actual discharge owing to the baby having an extended hospital stay. Despite the potential for circumstances to have changed significantly in the intervening time, there was no discussion about reconvening the discharge planning meeting to ensure that all agencies involved with this highly vulnerable mother and baby were fully cognisant of the safeguarding concerns and to ensure as effective a support plan as possible was in place (recommendation 6.2).

3.3 Health visitors are not routinely invited to pre-birth meetings, discharge planning meetings and have not been involved to date in the maternity liaison meetings. The early development of a positive and trusting relationship between the family and the health visitor is essential in safeguarding children (recommendation 6.2). Health visitors and school nurses are clearly prioritising child protection work and are dogged in their efforts to engage effectively in child protection arrangements. We saw an example where the persistence of the school nurse in raising her concerns about a lack of progress and potential drift in an extremely challenging case has had a positive impact, resulting in improved outcomes for the child.

**Case example:** *Concerns about a family with six children aged under nine years old in a chaotic and dirty home environment were raised by the health visitor, GP and school. Early intervention support over a period of months did not bring about any positive change. The health visitor continued to raise concerns at a professional meeting and an initial case conference was convened but the family moved to another area.*

*The health visitor liaised with colleagues in the new area and ensured that all concerns and records were transferred to the new health visitor team in order that the children continued to be protected.*

3.4 The adult mental health service demonstrates a positive response to pre-birth concerns with thorough risk assessment and joint working with other health services and social care to promote the safety of the unborn and the well-being of the mother. The service took the initiative in arranging professionals meetings to discuss protective strategies in one case we reviewed and demonstrated good interagency communication and planning with intensive support and monitoring of the parental mental health.

3.5 The adult substance misuse service delivered by Compass was not able to assure us that it has a robust *Think Family* model of practice in place and that child protection practice, risk assessment and practice management is effective. We identified significant concerns in relation to one case concerning a new born baby in the care of a mother on a methadone programme. The assigned worker lacked appropriate child protection knowledge and experience and was not sufficiently well supported by management to ensure good child protection practice. Immediate remedial action is being taken to ensure the worker's child protection practice is supported effectively and that the case is properly assigned and managed (recommendation 9.1).

3.6 The GPs we met demonstrated a clear understanding of and competence in child protection issues, well supported by clear flagging on their respective patient record systems. They demonstrated good practice in the identification of concerns, the completion of CAFs, making notifications and participating in child protection processes including attendance at child protection case conferences. In one case, although a family had moved out of the practice's catchment area, they were retained within the practice as the child was subject to a child protection plan and the GP recognised the value of maintaining the continuity of care.

3.7 Where children have high levels of health needs and are subject to child protection plans, we did see examples of good communication and joint working across health and social care; this involved GPs, health visitors social workers and both local and specialist out of area health providers and was effective in protecting children.

**Case example:** 6 month old male. There were significant concerns about the welfare of this baby with disabilities who was losing weight due to a lack of parental support. Effective multi-agency working and information sharing between GP, health visitor, midwifery, Great Ormond Street Hospital and children's social care ensured prompt action was taken to protect the child and the baby is now in care.

*As a result of neglect within the family the child's other siblings are now subject to child protection plans. Agencies continue to work closely with the family as the mother is now pregnant again.*

3.8 However, in most cases we have seen, there is a significant over reliance on formal child protection forums such as core groups and child protection conferences for inter-professional communication and contact. In some cases where there was a high level of risk, we did not see evidence of any routine discussion or sharing of information on key professionals' contact, observations and interventions with the parent and child; such as between the health visitor and adult substance misuse worker. No joint visits were considered or undertaken although these may have been valuable and there was no sharing of professional expertise to support the other in discharging their role in the child protection plan. For example, adult substance misuse and mental health workers could usefully share indicators of relapse with health visitors to facilitate their risk assessment when visiting the home. This does not happen and does not facilitate the early identification of rising risk which could prompt effective and early intervention (recommendations 7.1 and 9.2).

3.9 While relationships between services are generally characterised as positive, school nurses and health visitors do experience difficulties in communication and liaison with other services on occasion, undermining progress in some cases. Communication between school nursing and CAMHS is not routine and CAMHS do not routinely send summaries of reports to school nursing or looked-after children's health which results in health reviews not being fully comprehensive with all relevant information being considered.



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## 4. Looked after Children

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4.1 In all cases of looked-after children which we sampled, there were delays in both initial and review health assessments being undertaken. In one case, the initial health assessment (IHA) was six months overdue. Assessments were of highly variable quality. We have seen some examples of good initial assessments and reviews, including one exemplar initial health assessment conducted by a registrar on a young asylum seeker. The assessment was conducted using an interpreter which facilitated the comprehensiveness of the assessment and supported the young person in speaking freely, enabling the voice of the child to be heard. The assessment was sensitive to the experiences of the child in their home country and how these were impacting on his health and wellbeing in the short and longer term. The resultant health plan was both comprehensive and measurable. Sadly, the subsequent health review by the GP did not mirror this quality although it did show evidence of following up some of the issues identified for this young man.

4.2 Asylum seekers are not all as well served and we saw another example where the recent IHA was handwritten and almost illegible, lacked any appreciation or analysis of the potential impact of the young person's experiences and referred to him by the wrong name for part of the assessment (recommendation 10.1).

4.3 Some asylum seekers are reluctant to attend information and advice sessions on sexual health issues delivered by female practitioners; sessions and clinics delivered by male practitioners to specifically meet the needs of this cohort are not being provided currently (recommendation 10.3).

**Case example:** *three year old child. Birth mother has history of mental health problems and the child was taken into care but did not have an initial health assessment for seven months. The IHA was undertaken by a paediatric consultant in another London Borough. The IHA was very brief and lacked relevant family health history. There were also gaps in key sections of the assessment such as the immunisation section not having been completed and several sections reading “no information available” although information would have been known by key professionals and could have been made available to the paediatrician.*

*The child’s review health assessment was undertaken by a health visitor nine months later and was of good quality although delayed. The review assessment was thorough and detailed. The health visitor appropriately identified a need for the child to be referred for support for emotional/behavioural needs although suggesting this was done when future plans for the child were clearer.*

*The assessment was quality assured by the safeguarding designated nurse who advised that referral not be delayed and this had been actioned so that, once the need was identified, the child received appropriate support.*

4.4 For all the looked-after children’s cases we examined, health reviews which were undertaken by health visitors were generally of good quality; detailed and thorough with close attention to drawing out the voice of the child and young people were given the opportunity to sign their own consent although this was inconsistent. However, most health plans we saw, were of poor quality with some of these having been completed by the looked-after children’s nurse. Most health plans were not SMART, with vague accountabilities and a lack of clear timescales making it difficult to ensure the child’s health needs were being properly addressed (recommendation 10.4).

4.5 We saw a case where the looked-after children’s nurse had undertaken the initial health assessment. On referring this case back to the designated doctor we have received assurance that this decision was taken on clinical grounds in line with an interagency local protocol whereby some young people looked after may benefit from initial health assessments completed by the looked-after children’s nurse. However, the rationale for this delegation was not set out at the time on the child’s looked-after child records. Generally, this is not ideal practice placing a potentially inappropriate burden of responsibility on the looked-after children’s nurse and running the risk for the child’s key health issues not to be fully assessed and should be avoided in the future.

4.6 Where health needs for looked-after children are identified, these are generally addressed. Health visitors are diligent in ensuring looked-after children are engaged with universal services and follow up outstanding issues. We also saw examples of prompt hospital treatments for asylum seekers and the foster carers we spoke to felt well supported by health and social care. One spoke positively about fast tracking at the hospital when a disabled child she cared for was very distressed by the hospital environment. We did see some case examples however, where there was a lack of follow-up and some drift, mainly due to a lack of specific accountabilities being identified in the health plans.

4.7 Foster carers spoke mostly positively about the training and advice they had received from the looked-after children's nurse and other health professionals in the past although no training had yet been offered in the current year. We heard that there had not been training on how to care for babies born effected by maternal drug dependency although this had been requested. Foster carers also told us that they were not given copies of the health review but did receive copies of health reports from consultants if the child had had to access specialist treatment.

**Case example:** *female aged 16 years who has been looked after since 2007. The health review was undertaken by the looked-after children's nurse at the civic centre which was the young person's choice as she had been reluctant to engage otherwise.*

*The review addressed issues around hygiene and weight and cessation of smoking but the resultant health plan which was developed did not set out clear and measurable timescales. It would be difficult to know when key issues had been successfully delivered or when things needed to be chased up, therefore. It was also difficult to identify who was responsible for doing what.*

4.8 Strengths and difficulties questionnaires (SDQs) are sent out by a CAMHS worker based in the local authority and are returned to CAMHS but are not utilised within the looked-after child's review to enable the young person to track their own emotional journey nor to inform the professional undertaking the review. We were told of plans to bring the SDQ process into the looked-after child health team remit in order that the SDQ would be sent out in advance of the young person's health review and utilised within the review.

4.9 Support to care leavers was identified as underdeveloped in the previous inspection and remains an area for development. Care leavers do not routinely receive any health history when they leave care but are given a copy of *Get Healthy, Feel Great*, a national publication rather than local age appropriate public health information specific to their own individual needs. Work has been done with the participation of young people to develop health passports for care leavers which will also include a feedback facility to help inform future service development. Although, these are potentially positive, they are not established and it is too early to determine their impact (recommendation 10.5).

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## Management

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This section records our findings about how well led the health services are in relation to safeguarding and looked after children.

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### 5.1 Leadership and management

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5.1.1 Partnership working has improved significantly over the past 18 months. The challenging findings of the 2012 joint Ofsted/CQC inspection have been heard by both health and social care, action taken and the progress is clear. Both the CCG and children's social care are committed to working together productively and have established a mutually respectful foundation with shared values and goals. Although there is further progress to be made, the partner agencies are able to engage in a mature dialogue to resolve strategic and operational challenges within a difficult financial climate. In response to the recent crisis in the looked-after children's health service, the sickness absence of the looked-after children's nurse and build-up of a large back-log of initial and review health assessments, there was a concerted joint response by partners in taking effective remedial action and ensuring that children's health needs were met. Performance in the service has improved although it remains an area of challenge.

5.1.2 There is appropriate and active membership by health agencies in the LSCB and its sub-groups. Appropriate frameworks are in place and the board is well engaged in strengthening its approach to holding providers to account for their safeguarding activity. The named GP provides powerful leadership which is improving the safeguarding practice of GPs across the borough and she represents this perspective on the LSCB very effectively. Designated and named safeguarding practitioners are accessible and frontline staff value their advice and practice support.

5.1.3 The CCG's designated nurse for safeguarding children and adults supports safeguarding children and adult training within the CCG, trains GP practice staff in safeguarding children and has developed a safeguarding adult policy. There is involvement with cases where there are transition issues, but also safeguarding adult cases. The CCG has invested in the safeguarding team to increase capacity, highlighted as an issue in the 2012 SLAC. A new CCG safeguarding named nurse role has been created to focus on transition issues. This is already leading to positive outcomes for young people, through joint assessments to establish an effective pathway for that young person. There is close work underway with education to position services well to address future education service changes.

5.1.4 The NHS England area team is at an early stage of development and the CCG remains committed to leading on the delivery of GP training to ensure improvement momentum is not lost. The area team has established the safeguarding forum for North West London and representatives from the CCG have attended.

5.1.5 The recent recruitment of a health professional to the MASH team has had a positive impact on the engagement of health colleagues; strengthening communication and the awareness of the role of MASH. Action being taken to resolve the IT issues and recruit another member of staff will optimise the effectiveness of the role. There are effective monitoring systems in place that have led to improved efficiency in the team although the impact of these has yet to be determined. We saw evidence of good information sharing and co-operation of health staff in the investigation of circumstances around a recent child death.

5.1.6 Although action is being taken to review the systems and processes in the looked-after children's health service to improve efficiency and effectiveness, progress in delivering an improved service overall since the 2012 inspection is disappointingly slow. There remain significant areas to be addressed to ensure timeliness and quality of assessments, appropriate recording on the information system, and adequate responses to strengths and difficulties questionnaires (SDQs). The long-term sickness absence of the looked-after children's nurse in 2013 highlighted a lack of capacity and contingency planning within the service, and there was poor continuity of service over this period. The looked-after children's nurse has an action plan that includes focusing on young people placed out of borough and monthly reporting to the designated safeguarding nurse. The process of notifications and communication is under review and the provision of an admin worker and new database system supports more effective oversight of timeliness and tasks.

5.1.7 However, it is unclear whether the current management arrangements of the service are sufficiently robust or that staff and managers responsible for delivering such a significant improvement agenda, have the appropriate skill set or capacity to deliver and sustain improvements (recommendation 10.1). The service has recently been moved into the portfolio of the named nurse in ICO community health services. This is putting significant pressure on a role which is not primarily management focused, with broad responsibilities across an already wide service area dealing with its own improvement agenda. Although the named nurse had introduced a number of systems and processes aimed at improving the service, including moving to electronic recording; these systems were not all being adopted and none were established. Quality assurance of health reviews has been strengthened by moving this responsibility from the looked-after children's nurse to the designated nurse for safeguarding and we saw examples where this was impacting on quality. This is not sustainable in the longer term however and a robust quality assurance framework has yet to be established by the provider (recommendations 10.1 and 10.4).

5.1.8 The CCG and Harrow Council are working together to strengthen services that address low level mental health needs in order to reduce demand for specialist mental health services, close gaps in the existing CAMHS service and reduce demand for Tier 4 placements. The partners are developing a new mental health integrated service specification and agreed pathway. With commissioners' support, CNWLT CAMHS is working to roll out and establish the increasing access to psychological therapies (IAPT) model for children's and young people across the borough.

5.1.9 Partner agencies in Harrow demonstrate their commitment and growing capacity to learn from external service scrutiny and the local learning lessons reviews. The latter being carried out under the LSCB learning and improvement framework. It is clear that the 2012 joint children's safeguarding inspection by Ofsted and CQC have been taken on board and that the recommendations of the report have provided the foundation for developments since. Both the chair of the LSCB and the designated doctor report that the rapid response in the child death overview panel (CDOP) process was reviewed as a result of the previous inspection and has been strengthened. Following local learning lessons reviews, the Ealing Hospital ICO has revised the family health assessment questionnaire to include the father's role and to record other family members residing in the household.

5.1.10 Plans are in place for the CCG to review existing safeguarding service level agreements for providers' safeguarding children teams and the job descriptions for named nurses, named midwives and named doctors to clarify provider responsibilities and agree outcome indicators to support improved monitoring.

5.1.11 Ealing ICO continues to be challenged in achieving its targets on recruitment and retention of community health staff. The resultant capacity pressures create risk to service delivery and the successful achievement of quality and performance outcome measures. Home checks on new-borns and attendance at child protection case conferences are prioritised appropriately but practitioners are under pressure and less able to participate in wider early help services. In June 2013, the service was 5 WTE health visitors under establishment. An external consultancy firm undertaking a recent review of the service projected a shortfall of 2.7 WTE although 2 years previously, the projection was to be zero against the Call to Action target in 2015. This issue is on the trust's risk register and subject to regular scrutiny through the trust board and the trust is working closely with stakeholders in developing and implementing an effective workforce strategy.

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## 5.2 Governance

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5.2.1 Harrow CCG is working closely with three neighbouring London boroughs; Ealing, Brent and Hillingdon in developing safeguarding arrangements that have cohesion across the borough boundaries and in benchmarking the effectiveness of these arrangements.

5.2.2 The LSCB recognises that greater scrutiny is required of the quality assurance frameworks around safeguarding arrangements currently put in place by the agencies identified in this report and their impact on safeguarding children. The LSCB has an established programme of case file audits as part of its approach to multi agency quality assurance. This case sampling approach will be used to target the effectiveness of the delivery of the improvements identified in this inspection and set out in any subsequent action plan.

5.2.3 A pattern of regular service audit is beginning to be established across the health community. However approaches to the day-to-day quality assurance and managerial oversight of operational safeguarding practice are weak across all the services we have visited (recommendations 1.3, 2.1, 6.4, 9.1, 10.1 and 11.1). This is particularly evident in midwifery and the substance misuse service. We have also seen little or no routine managerial scrutiny of case records to ensure that recording practice is of sufficient quality, representing an accurate reflection of the day to day practice of the worker. We saw examples of very poor recording practice in both midwifery and the substance misuse service. Records lacked comprehensiveness and order, making it difficult to track the child's journey or professional accountability to be properly monitored to assure the safety of the child. Workers acknowledged that they had omitted to record key actions or inter-professional liaison they had undertaken (recommendations 6.4 and 9.1).

5.2.4 Recording practice was also poor in the looked-after children's health service. We identified a number of cases where health assessment and review documentation was missing from the records and could not be located. It was also surprising that in a service where the current priority is to ensure all recording is entered onto the electronic system, new hard copy files were being developed for some children who had entered the looked-after child system within the last few months, thus undermining the new governance arrangements being put into place by the current service manager, who was unaware of this practice (recommendation 10.2).

5.2.5 While there may be some feedback to practitioners or safeguarding leads in the paediatric emergency department by the paediatric liaison health visitor when she identifies sub-optimal safeguarding practice, this is not routine and it is not clear how this informs training or clinician performance appraisal (recommendation 1.3). There is no systematic recording, collation and analysis of the service's activity. Outcomes and impact of the paediatric liaison health visitor service is not reported in Ealing Hospital ICO's safeguarding children's annual report 2012/13. No collation or analysis of paediatric liaison health visitor data is being reported through the NWHT clinical governance infrastructure either, to assure the hospital board that safeguarding practice in paediatric emergency is of a satisfactory standard and effective in protecting children. As a result of our review of sampled cases and in discussions with practitioners, it is not clear that staff across these services properly regard the current arrangements as a whole system approach and there are therefore inherent risks that children are not effectively protected (recommendation 4.1).



5.2.6 At the urgent care centre, the recently appointed clinical lead GP has made some improvements to systems to support staff in identifying and recording safeguarding issues, and in monitoring practice. However, the service has not undertaken comprehensive case auditing to determine the quality of safeguarding screening to assure commissioners that safeguarding risk assessment and actions are robust. Also there are not yet robust arrangements for the safeguarding supervision of staff as set out in *Working Together 2013* and quality assurance of practice (recommendation 2.1)

5.2.7 Clinical governance meetings have recently been introduced in the CASH service on a monthly basis to strengthen the service's governance arrangements. However, this has meant a reduction in clinical capacity. The service convenes multi-agency meetings three times per year outside of service hours to review performance and identify developments as a result of auditing the service.

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## 5.3 Training and Supervision

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5.3.1 The CCG has just completed a review of its training needs and a bespoke programme of safeguarding training for commissioners is to be developed in order to support the development of stronger governance of providers' safeguarding practice. This is a positive development to better equip commissioners and contract monitoring staff in discharging their quality assurance responsibilities.

5.3.2 Last year Ealing Hospital ICO reported 100% compliance for adults and children's safeguarding training with health visitor training overall at 89% for the year. The CCG recognised the significant improvement in the trust's delivery of training and expressed confidence in their trajectory against targets.

5.3.3 There are no specialist paediatric staff in UCC, and although access to advice and support from paediatric staff based in the hospital is reportedly good. There are no protocols in place to guide UCC on when to seek specialist advice. Group supervision is established in paediatric emergency and the named nurse is to have regular input into adult emergency department training and development days to raise awareness of hidden harm issues. Not all midwives have undertaken CAF training or training on Strengthening Families (recommendation 10.6).

5.3.4 There is significant scope to use feedback and reflective practice approaches more effectively to reinforce positive practice by clinicians and build professional confidence in identifying and responding to child safeguarding risks. For example, in one case we looked at where there had not been immediate referral by a paediatric emergency clinician, the practitioner reflected on the presentation overnight and made a referral to MASH the following day. This referral resulted in a good outcome for the child. Currently feedback is not given routinely to benefit and reinforce clinicians' actions and this is an opportunity lost to build confident and improving safeguarding practice.

5.3.5 Arrangements for GP training and access to safeguarding advice and support through the named GP are sound although there are no formal arrangements for safeguarding supervision or monitoring of the quality of practice within surgeries (recommendation 11.1). GPs spoke very positively of the quality of the training they receive and its relevance to their daily practice.

5.3.6 While CAMHS psychiatrists benefit from team meeting discussions and ad hoc advice from safeguarding leads within the service, this is not underpinned by routine formal safeguarding supervision in line with statutory and intercollegiate guidance (recommendation 8.1). In adult mental health however, safeguarding supervision is well established. The safeguarding children's nurse advisor has set up well attended quarterly group supervision which encompasses themes, including how MASH operates, while also giving practitioners good opportunity for reflective practice learning.

5.3.7 In June 2013, Ealing Hospital ICO commissioned specialist safeguarding supervision training to train more safeguarding supervisors. Safeguarding supervision has continued to progress within the ICO over the last 12 months. All the health visitors and school nurses we spoke to were having regular supervision from either the named nurse or child safeguarding advisor and valued the support and reflective practice opportunity it gives them. Where cases are discussed in safeguarding supervision sessions, this is routinely being recorded on the child's case notes. However, on the trust's work plan it is noted that safeguarding supervision arrangements are not consistent across all its frontline areas. As an action the trust reported that a safeguarding supervision policy is to be fully implemented in all frontline areas by March 2014.

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## Recommendations

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- 1 Harrow CCG, North West London Hospital NHS Trust , Ealing Integrated Care Organisation and Greenbrook Healthcare should ensure;**
  - 1.1 that there are effective systems in place at the urgent care centre and children’s emergency department in order that safeguarding risk indicators and number of attendances can be identified for all children under 18 years attending for treatment.
  - 1.2 that all attendances for treatment by children and young people under 18 are reviewed by a suitably skilled health practitioner with safeguarding skills to ensure that all safeguarding concerns are properly identified and promptly acted upon.
  - 1.3 that there is effective quality assurance and managerial oversight of operational safeguarding practice, effective use of reflective practice and that sub-optimal practice is addressed promptly.
  
- 2 Harrow CCG, Ealing Integrated Care Organisation and Greenbrook Healthcare should ensure;**
  - 2.1 that the Urgent Care Centre service is compliant with agreed safeguarding protocols, statutory guidance as set out in *Working Together 2013* and demonstrate effective child safeguarding practice.
  
- 3 Harrow CCG and Ealing Integrated Care Organisation should ensure;**
  - 3.1 that a review of the paediatric liaison health visitor service capacity is undertaken and that activity monitoring arrangements for the service are robust.
  
- 4 Harrow CCG, North West London Hospital NHS Trust and Ealing Integrated Care Organisation in partnership with the LSCB should ensure;**
  - 4.1 effective and aggregated reporting of child safeguarding activity to the appropriate boards to ensure effective governance and continuous improvement across the whole system.

**5 Harrow CCG should ensure;**

- 5.1 that health agencies which make referrals to the multi-agency safeguarding hub are informed of the outcomes of the referrals whenever possible.

**6 Harrow CCG and North West London Hospital NHS Trust should ensure;**

- 6.1 that there is effective information sharing and on-going liaison by the midwifery service with partner agencies about new-born and un-born children where there are identified vulnerabilities or safeguarding concerns.
- 6.2 that maternity discharge planning meetings include all relevant professionals and where discharge is delayed, the need to reconvene is considered where there are identified vulnerabilities or safeguarding issues.
- 6.3 that the maternity liaison meetings membership, recording, action tracking and information sharing is comprehensive and effective in safeguarding children and vulnerable families.
- 6.4 that there is effective quality assurance and managerial oversight of operational safeguarding practice and case recording in the midwifery service.
- 6.5 that referral pathways for young people who attend CED and have identified drug or alcohol misuse issues are clearly understood and screening tools are used appropriately.

**7 Harrow CCG, Central and North West London NHS Foundation Trust and Ealing Integrated Care Organisation should ensure that;**

- 7.1 there is effective liaison and sharing of expertise with other health professionals in child protection cases including the undertaking of joint visits as appropriate.

**8 Harrow CCG and Central and North West London NHS Foundation Trust should ensure that;**

- 8.1 psychiatrists in the child and adolescent mental health service are supported to discharge their safeguarding responsibilities through the provision of effective safeguarding supervision arrangements in line with *Working Together 2013*.

**9 Compass drugs and alcohol service should ensure that;**

- 9.1 there is a robust *Think Family* model of practice in place and that child protection practice, risk assessment, case recording and practice management is effective.
- 9.2 there is effective liaison and sharing of expertise with other health professionals in child protection cases including the undertaking of joint visits as appropriate.

**10 Harrow CCG, North West London Hospital NHS Trust and Ealing Integrated Care Organisation should ensure;**

- 10.1 that the management of the health service for looked-after children is robust and delivering a quality assured service demonstrating continuous improvement.
- 10.2 that records of healthcare for looked after children are up to date, comprehensive and of good quality, reflective of the voice of the child and subject to routine and regularly quality assurance.
- 10.3 the diversity and cultural needs of all looked-after children are addressed effectively.
- 10.4 that health assessments for looked after children are timely and comprehensive leading to quality assured health plans which are specific with clear timescales and accountabilities.
- 10.5 that care leavers are well supported including the provision of their health history and age appropriate public health information.
- 10.6 that all frontline practitioners are fully trained and engaged with CAF and Strengthening Families arrangements in working with vulnerable families and children

**11 NHS England supported by Harrow CCG should ensure;**

- 11.1 that GPs have opportunities for safeguarding supervision and the quality assurance of safeguarding practice is developed within primary care practices.

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## Next Steps

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An action plan addressing the recommendations above is required from Harrow CCG within **20 working days** of receipt of this report.

Please submit your action plan to CQC through [childrens-services-inspection@cqc.org.uk](mailto:childrens-services-inspection@cqc.org.uk) The plan will be considered by the inspection team and progress will be followed up through CQC's regional compliance team.