Review of health services for Children Looked After and Safeguarding in Richmond upon Thames

Children Looked After and Safeguarding
The role of health services in Richmond upon Thames

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Provider services included:	Central London Community Healthcare NHS Trust Change, Grow, Live- Richmond Integrated Recovery Service Hounslow and Richmond Community Healthcare Trust Kingston Hospital NHS Foundation Trust South West London & St George's Mental Health NHS Trust
CCGs included:	Richmond upon Thames
NHS England area:	London Region
CQC region:	London Region
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Contents

Summary of the review

This report records the findings of the review of health services in safeguarding and looked after children services in Richmond upon Thames area. 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 Richmond upon Thames 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.

About the review

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 2018.
- Where we found areas for improvement in services provided by NHS but commissioned by the local authority then we will bring these issues to the attention of the local public health team in a separate letter.

How we carried out the review

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 87 children and young people.

Context of the review

The London Borough of Richmond upon Thames has a population, 227,032 (2017) of which approximately 45,000 children and young people are under the age of 18 years. This is 23% of the total population in the area. The borough is one of the least deprived boroughs in London and Richmond has one of the lowest percentage of children living in low income families out of all the London boroughs.

There is substantial variation in patterns of ethnicity among wards and educational institutions within the Borough. Children and young people from minority ethnic groups account for 19% of all children living in the area, compared with 21% in the country as a whole. The largest minority ethnic groups of children and young people in the area are the mixed group and Asian or Asian British.

The health and wellbeing of children in Richmond upon Thames is generally better compared with the England average and one of the safest and healthiest boroughs in London.

Commissioning and planning of most health services for children are carried out by Richmond upon Thames Clinical Commissioning Group and Richmond upon Thames Local Authority Public Health. Some lead safeguarding roles are undertaken across the both Richmond and Kingston CCG. It should also be noted six clinical commissioning groups (CCGs) in south west London (Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth) have established a 'Committees in Common' to make decisions as a collective in some areas of their work.

Acute Hospital services provided by Kingston Hospital NHS Foundation Trust (KHFT) were reviewed as part of the review process.

Community based services of health visiting, school nursing and sexual health services are commissioned by Richmond upon Thames Local Authority Public Health and provided by Central London Community Healthcare NHS Trust (CLCH).

Commissioning arrangements for looked-after children's health are the responsibility of Richmond CCG, the operational looked-after children's nurse, is provided by Hounslow and Richmond Healthcare Trust (HRCHT). The Designated Nurse and Designated Dr Looked After Children posts sit within Richmond CCG. The children and young people receiving looked after care will be referred to as Children Looked After (CLA) within the report, this aligns with local terminology.

Child and Adolescent Mental Health Services (CAMHs) and Adult Mental Health services are commissioned by Richmond upon Thames CCG and provided by South West London & St George's Mental Health NHS Trust (SWLStG).

Drug and Alcohol services for Richmond upon Thames residents are commissioned by Richmond upon Thames Local Authority Public Health and provided for adults by Change, Grow, Live as Richmond Integrated Recovery service. The young people's substance misuse service is also commissioned by Richmond upon Thames Local Authority Public Health and provided by Achieving for Children- Youth Resilience Team.

Richmond upon Thames have delegated their children's services statutory functions to Achieving for Children, a community interest company. The last inspection of services for children in need of help, child protection and looked after in Richmond upon Thames took place in September 2017 and was carried out by Ofsted. The overall effectiveness of the safeguarding services including for looked after children was judged as good. Ofsted undertook a focused visit in April 2019.

The local area has not been subject to a Joint Targeted Area Inspection or a Special Education Needs and Disability inspection.

The report

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.

What people told us

We spoke with young people who attended the CAMH service. They told us,

"I got help from CAHMs and I love coming. I can tell him how I feel."

"I was given clear instructions and got to write my own goals, they listened to us as a family and didn't judge."

Foster carers who told us

"Previously processes and consultations where not efficient. Now wiped the floor clean, fresh start, on the ball, so efficient."

"Prior to a change in health visitor 6 months ago, my health visitor was brilliant, amazing. Easy access to her if I had any questions."

"Health needs that are identified are followed up and you get calls about your appointment."

A foster carer told us the they attended the first medical for their foster child and was treated '*lovely*'. She found the whole experience comfortable, informative and professional and there was been good liaison from the LAC team and the professionals in the local authority she lived in.

The child's journey

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

1. Early help

1.1 Children and young people who attend Kingston Hospital NHS Foundation Trust (KHFT) emergency department (ED) access an appropriate environment to meet their needs. The paediatric ED waiting area provided a safe and welcoming environment and children and the accompanying adult could be observed by clinicians while they were in the waiting area. This allowed deteriorating conditions to be recognised and addressed. It also allowed observation of interactions if there were emerging concerns.

1.2 Care of children in ED was prioritised using a recognised clinical assessment tool. This identified the child who needed to be seen quickly and for intervention to be commenced. Children between 16 and 17 years old were given a choice as to whether they would like to be seen in the adult or paediatric department, supporting them to make choices about their care and recognising the individuality of the young person.

1.3 We saw consistent evidence that staff in paediatric ED were recording who accompanied when a child attended. The information contributed to the practitioner's overall assessment of the child's family and relationships and further allowed exploration of whether the person accompanying held parental responsibility. However, this positive area of record keeping was not supported by evidence of the 'voice of the child' being captured in records examined. This limited the practitioner's ability to see the situation from the child's eyes and that this information would strengthen multi agency, interdisciplinary liaison. ***(Recommendation 2.1)***

1.4 Children who attend the ED are not always benefitting from good information sharing between the ED and Central London Community Health Trust (CLCH) 0-19yrs service. The quality of information passed to the liaison health visitor from ED staff was seen to be variable and open to interpretation. We were told that the liaison health visitor either completed detailed information sharing form to health visitors and school nurses or telephones the relevant practitioner. However, neither of these approaches included recording actions on the child's ED records we saw. Therefore, the record is not complete, and, for example, it made it difficult when there were repeat attenders to the ED to understand what concerns were shared previously and whether a referral to a different service for early help maybe needed. ***(Recommendation 2.2)***

1.5 Think family and think child approaches are underdeveloped in the adult ED. We did not see consideration of caring responsibilities of the attendee or consideration of whether the person had significant contact with children, especially with reference to an adult with concerning behaviours who attends the department. The adult assessment template does not include triggers or prompts to help practitioners consider risk factors and we did not see any records that noted children's details. We were not assured a child in the care of an adult attendee could be identified as needing early help or considered as a safeguarding concern. ***(Recommendation 2.3)***

1.6 Midwifery assessment and documentation would be enhanced by greater exploration of the unborn child's father or mothers' partner. This information and analysis by the midwife would assist in risk assessments undertaken of the mother and unborn child. ***(Recommendation 2.4)***

1.7 Pregnant women under the age of 20 benefit from additional focus on their clinical and social needs. The Bridge Maternity Team offer care to young women aged 17 and 18 with identified risk factors. The approach is part of the KHFT Teenage Pregnancy Guidelines. A recent audit showed overall, compliance with the guidance was good. This approach assists in identifying early help that may benefit the young person during pregnancy and as a new parent.

1.8 Processes are in place to ensure clinical and social history information is gathered from the GP for women who self-book their pregnancy. This supports a holistic approach being taken regarding a pregnant women's care. All bookings were received by the administration team who reviewed the information and then sent it to the community teams. If vulnerability was identified, then the referral was also sent to the specialist midwifery Bridge Team. For women not accessing antenatal care before 20 weeks, there was sensitive exploration of the reasons for late booking and potential safeguarding risks were considered. This recognises the unborn child's dependency on the mother to prioritise its needs.

1.9 Children in Richmond benefitted from the full implementation of the Healthy Child Programme aimed to ensure that every child under five years old gets the good start they need for a healthy life. The universal contacts were carried out in a variety of settings depending on child and family need. New birth, one year and two-year contacts were being offered and were supporting assessing for early help including safeguarding referrals, which were evidenced in the records.

There have been some recent changes to the antenatal contact which is now being offered as a group session if there are no known reasons to see the client alone, such as when safeguarding concerns have been identified. This is in its early stages, but feedback from clients has been positive and this will be reviewed as part of the service Central London Community Health (CLCH) transformation plan.

The health visiting service are effectively targeting more vulnerable clients antenatally to provide support at the earliest opportunity. The work is supported by effective notification from the Multi Agency Safeguarding Hub (MASH) team when they were made aware of concerns by way of referral.

For example, in one case examined we saw that the health visiting service became aware of the client following information sharing via the MASH after they had received an inter-agency referral form in relation to domestic abuse.

The health visiting service was able to arrange a home visit to complete an antenatal contact for a young pregnant first-time mother. Due to the age of the client, the health visitor and the school nurse worked together to see the client antenatally. The records were clear about the risks and plans going forward. Appropriate safeguarding alerts were placed on the clients records after the home visit. This meant the GP was also able to see the record and be aware that there are some vulnerabilities identified.

The practitioners had discussed the case during their one-to-one child protection supervision and the risks posed by the father of the unborn child were fully explored and clearly recorded in the client record.

The record demonstrated good liaison between midwifery services, health visiting and children's social care that described the safeguarding measures put in place and also the offer of public health services to the young parent and her baby.

1.10 Health visitors were liaising with GPs in most primary care settings and the arrangement is formalised by a partnership agreement between the disciplines. The process allowed for information to be reviewed prior to attending the meeting which assisted discussion and we were told outcomes from the discussions were recorded in the child's records. This is supporting interdisciplinary working and coordinated care for families. We also heard how health visitors have regular meetings with children's centres and consideration is ongoing to implement groups for families in these settings within the CLCH transformation plan.

1.11 Potential risks to children from males associated with mothers of young, potentially vulnerable children were not always fully assessed and documented by the health visiting service. This is an issue that CLCH is aware of following a recent audit. Work is underway to improve this area of practice and to identify how IT systems can support this work. In some records examined we saw that fathers name had been recorded and there was an appropriate link on the record. However, we were not assured that consistent practice is embedded within the service. ***(Recommendation 3.1)***

1.12 We saw comprehensive school health assessments in both primary and secondary schools facilitating the early identification of risk and vulnerability in children. The standardised assessment undertaken by the school nurse prompted asking older children questions regarding substance and alcohol use, relationships and FGM and signpost to other services. Capturing this information ensured that the school nurses were able to appropriately safeguard and support children and young people who are at risk of harm or abuse.

1.13 The accessibility of school nurses to families and young people has been enhanced by ‘drop-in clinics’ established in primary and secondary schools where children can seek advice from their school nurse. Attendance at the sessions is good at primary level and we heard anecdotal evidence that they were well regarded, although the impact of these sessions has not yet been evaluated. However, uptake for the service in secondary schools is not as strong. To combat this the service has complemented the offer to young people with topic led presentations at assemblies, including for example, exam anxiety. The school nurses report the ‘Mental Health First Aid’ training has also built on their confidence in this area of work. The work of the school nurse has assisted young people to consider how they manage their own emotional health at a time of additional stresses, such as during exam periods.

1.14 The local area has responded to national awareness on the presentation of Attention Deficit Hyperactivity Disorder (ADHD) in girls. We heard of a positive project to educate the wider partnership about the symptoms of ADHD in girls which often exhibit differently than in boys. CAMHs have worked with a small group of service users to produce a short training video for professionals, which we were told would be available from September 2019. It is hoped that it will facilitate the earlier identification of need, which will lead to earlier diagnosis and prevent more girls from attending ED in crisis.

1.15 Young people in Richmond can access a dedicated young person’s sexual health clinic provided once a week. The ‘Off the Record’ young person clinic for under 21yrs is co-located with a locally commissioned young people’s information and counselling service. This increases opportunistic access to either service by the young people attending the centre.

2. Children in need

2.1 Children and young people who attended the ED in emotional crisis were effectively supported by the CAMHs. A well-established joint approach between the ED staff and CAMHs ensured that the child's needs were met. The ED staff offered young people aged over 17yrs the choice of whether to wait in the mental health assessment unit or stay in the paediatric facilities, depending on the outcome of a risk assessment. The joint assessment by ED clinicians and CAMHs practitioners for children also meant they were not waiting unnecessarily in the ED. A child focused approach was carried through on transfer to the ward where young people were afforded appropriate care either by registered mental health nurses or health care assistants depending on their identified level of need.

2.2 We saw effective multi-disciplinary sharing of information when an expectant woman was accepted onto the Bridge midwifery team caseload. The risk assessment and care plan were shared with the woman's GP and health visitor. There was also liaison by the health visitor with the midwife after antenatal visits when the woman was known to have complex needs. We saw evidence of good escalation of risk between community midwives and the Bridge Team when new concerns came to light for women already identified as vulnerable. This approach promotes supportive and coordinated care for the women and the unborn child.

2.3 It is positive that Women who experience perinatal mental health concerns are now able to access a National Institute of Health and Care Excellence (NICE) compliant perinatal mental health pathway that will support them and protect the unborn and new-born infant. A perinatal mental health pathway has recently been introduced, consisting of a psychiatrist, a psychologist and a nurse, the services are provided at neighbouring Trust sites. This team will support women up to a year post delivery. The Bridge Midwives were supporting these clinics and provided continuity and a coordinated approach to care, which included identifying when early support or safeguarding referrals were needed. However, at the time of our review it was too early to measure the impact of the service.

2.4 Although there were organisational expectations for practitioners in health visiting, midwifery and sexual health services to explore any emerging or existing domestic abuse in families, the provider Trusts for these services cannot be fully assured that this recommended good practice was routinely being carried out.

2.5 The Trust maternity electronic booking form prompts the midwife to ask the routine enquiry questions to explore existing or emerging domestic abuse as recommended in NICE guidance. However, this work is not assisted by women being routinely seen alone at booking or at any other appointment during the course of their pregnancy. This approach limits the opportunity for the midwife to explore any emerging risk of domestic abuse or other confidential information the woman may wish to share. The Trust was also not able to assure itself that routine enquiry into domestic abuse was always asked as there had been no audit on practice. We are aware that there were plans to change practice and a letter has been developed to advise women that they will be seen alone at some time during the 16-week appointment. However, at the time of our review this had not yet been implemented. ***(Recommendation 2.5)***

2.6 Within CLCH health visiting service there was inconsistency in record keeping on whether the routine enquiry regarding domestic abuse was asked, and the responses given being recorded. This meant that there was a lack of clarity about how effectively domestic abuse was explored by the health visitor. ***(Recommendation 3.2)***

2.7 The requirement of CLCH sexual health practitioners to undertake routine enquiry of domestic abuse for all attendees was also too variable. Although domestic abuse enquiry is part of the risk assessment tool it was not a mandatory field and was not consistently completed. It is positive CLCH had recognised the additional support sexual health practitioners may need and resourced a dedicated safeguarding lead for the service. However, the inconsistency in the recording of enquiry of domestic abuse is not offering the Trust additional assurance of the impact of frontline practitioners work in identifying and empowering individuals and families to manage their safety and change. ***(Recommendation 3.2)***

2.8 The identification and recording of domestic abuse in adult mental health service was not effective. We did not see the consistent completion of adult safeguarding forms when significant risks and vulnerabilities including domestic abuse had been identified and there was an absence of alerts used on electronic client record systems to notify practitioners of risk. This was a gap, given the vulnerability of children and young people when parental mental health co-existed with domestic abuse. ***(Recommendation 4.1)***

2.9 The Health providers we reviewed were appropriately involved in Multi-Agency Risk Assessment Conferences (MARAC) process to safeguard children. Kingston Hospital midwives had a system in place to ensure they were aware of women discussed at MARAC and a vulnerability flag was then placed on the Hospital system to alert practitioners of identified risk. The Richmond Integrated Recovery service for clients needing support with drug and alcohol issues participated in MARAC. In one case examined we saw how their information informed the discussion of a client their service was trying to engage with. We also saw in the 0-19yrs service, that when a client is discussed at MARAC, an appropriate amount of information was entered onto the case notes of that client. This meant that practitioners accessing the records were aware of the vulnerabilities of the family and the plan and could take this into account in their interactions with the family.

2.10 Sexual health service practitioners were not consistently recording their enquiry about Female Genital Mutilation (FGM). The risk assessment tool available to practitioners does not facilitate them to consider the wider impact of FGM alongside the type of FGM the women may have suffered. Identifying potential and existing cases of FGM can enable support and protection to vulnerable women and their female children. ***(Recommendation 3.3)***

2.11 Health visitors reported that when safeguarding concerns or referrals were made to the local authority Single Point of Access (SPA), they were confident they were made aware of those concerns via the inter-agency referral form that is shared with them from the MASH. We saw evidence of this happening in a number of the records we reviewed. This meant that clients who were more vulnerable or would benefit from early help could have prioritised health visitor contact.

2.12 School nurses demonstrated skill in identifying and responding to the holistic needs of children and young people they were working with. They showed tenacity in identifying and managing the health needs of children and young people. In one case examined we saw how the school nurse offered focused support to the child and their mother while waiting for specialist service to be provided. We also saw examples where the school nurse's role and their capacity to undertake the work was supporting individualised care being offered and provided to children and families.

2.13 Children who transition from health visiting services to school nurse services benefited from a well-established transfer process. For those children who have recognised health needs or where safeguarding concerns had been identified, there was a face-to-face handover and joint visits, including attendance at safeguarding meetings where required, by both the school nurse and health visitor. This ensured coordinated care, with children transferring into their new school environment with minimal disruption to their health care plans and families remaining supported.

We heard of an example of the school nurse work where a young person was referred to the school nurse by the school to discuss their emotional wellbeing and how this was affecting their diet. This led to the school nurse, with the young person's agreement, to working closely with them and their mother to support them while waiting for specialist appointments and also liaising closely with their GP. The school nurse also worked as an advocate, increasing the young person's own knowledge on a subject to ensure they accessed services promptly and the family had expert support.

2.14 Inspectors did not have assurance that the health needs of electively home-educated children were effectively met and overseen. Home educated children and young people who are not in education are not receiving the core offer from the school nursing service to support their health needs that included discussion of their emotional health and wellbeing as well as information on the recommended immunisation programme. Therefore, the cohort of young people home educated who often have underlying health or safeguarding needs cannot readily access school nurse for support, advice or intervention. ***(Recommendation 3.4)***

2.15 Currently, children and young people are not always receiving timely access to an appropriate CAMH service. While it is positive that the CAMHs single point of access (SPA) referral process included self-referral by children and young people, the CAMHs SPA was not meeting commissioning targets due to the higher level of demand on the service. However, we are aware that commissioners are knowledgeable of these issues and further that processes are in place to manage and prioritise the work to address service provision by South West London St Georges Mental Health Trust (SWLStG) with oversight by Richmond CCG.

2.16 The CAMHs SPA co-location with partner agencies has facilitated joint working with children social care practitioners in the MASH. We saw examples of where this had supported safeguarding discussions at the earliest opportunity and joint consideration of the most appropriate help available.

2.17 We did not see genograms available within the CAMHs children's care record to aid clinicians understanding of complex family compositions and relationships. We were told information from them would be captured in the record but not routinely uploaded. Whilst assessments examined did consistently capture direct family members details, exploration of risk to wider family members and siblings was not as strong. The availability of the original genogram would support all information being available in one record and allow any practitioner working with the family to, for example, reflect on the impact of the child's mental health on other family members. ***(Recommendation 4.2)***

2.18 CAMHs practitioners have an effective Trust wide clinical disengagement or 'was not bought' policy. Within CAMHs, children who are not brought to appointments by parents or carers are followed up rigorously and not discharged from the service unless it is appropriate and safe to do so. This ensures that children and young people who disengage from treatment or who are not bought to appointments, benefit from robust multi-agency discussion and response. We saw evidence in records examined of practitioners making persistent attempts to re-engage with young people and joint working with multi-agency partners to support them with their ongoing mental health needs.

In CAMHs, in one case examined we saw thoughtful child centred care of a young person with a complex history including ADHD and emotional dysregulation. This had led to an episode of inpatient care in which at times had been emotionally challenging for them. After discharge, the young person was keen to understand in detail how their care had been managed and the effects of the medication and why it had been prescribed as they did not have a strong recollection of all the care provided to them.

The young person's psychiatrist discussed their care and spent time explaining the purpose of the prescribed medications with them. This ensured that the young person understood the intention of their care purpose and had the opportunity to reflect and ask questions to help them understand and aims of their treatment and denotes a child centred practice.

2.19 In adult mental health services consideration of the child within the family is not fully embedded in front line practitioner practice. Whilst some assessments reviewed were detailed and holistic, there was insufficient exploration of the unborn or children who may be dependants of or associated with the service user. Chronologies and genograms were not used routinely in the service to facilitate practitioners understanding of complex family compositions, history and risk. Children who may live or have contact with adults living with significant mental health issues may not be in receipt of the help that they need to ensure they are safe and supported. ***(Recommendation 4.3*** *and* ***4.4)***

2.20 Adult mental health practitioners are not consistently recording within the care record if a service user has dependent children or contact with other children. An electronic children's safeguarding form should be completed to highlight if there are children linked to the service user as part of the adult assessment and the information would then be available on the record. The SWLStG Trust had identified an issue with compliance and are now monitoring that a child safeguarding form is completed as part of every assessment of adult clients. However, the Trust cannot be assured that all safeguarding concerns for children living with adults with mental health issues are identified and acted on. ***(Recommendation 4.5)***

2.21 The Richmond Early Intervention Team within the adult mental health service were providing highly personalised support to children and young people of adult service users who experienced first episodes of psychosis. Children and young people were supported to identify relapse indicators to enable them to identify when their parent or carers mental health was deteriorating. This was supporting young people who may be adversely impacted by their parent's mental health condition, to have time and space to discuss their feelings, fears and concerns and raise awareness of any safeguarding need.

2.22 The safeguarding of Young people accessing the 'Off the Record' sexual health service in Richmond would be improved by the consistent completion and analysis of the risk assessment tool within the care record. Although an assessment of vulnerabilities and risk of abuse and exploitation is expected to be undertaken at each attendance for all young people under 16 years, the completion of such assessment was inconsistent. This increases the risk of young people who may be vulnerable to, for example, child sexual exploitation not having their needs identified. We were advised CLCH staff participate in the multi-agency meetings that discuss young people with increased vulnerability including CSE, which can support sharing of information for those young people already identified at risk of CSE. ***(Recommendation 3.5)***. *This has been brought to the attention of Richmond Local Authority Public Health.*

2.23 The majority of services in Richmond are considering and recording the 'voice' of the unborn and child within the care records. We have seen good examples of practice in care records, midwifes were able to demonstrate the 'voice' of the unborn in records examined and we saw an example that sensitively reflected the needs of the unborn within a case conference report. A CAMHs practitioner offered good evidence of a young person's wishes and feelings being thoughtfully recognised. The voice of the child was also well recorded in the 0-19yr service. Listening, reflecting and documenting the child's view is crucial to practitioners understanding of the lived experience of the child.

2.24 Adult mental health and Richmond Integrated Recovery service recording of the child's perspective in the care record should be strengthened. The voice of children and young people was not consistently incorporated into the parental records. We did not see recorded evidence of discussion with parent on their understanding of the child's perspective of the parent's alcohol, substance misuse or mental health and this was a missed opportunity to consider the child's physical and emotional wellbeing within the family unit. ***(Recommendation 4.6*** *and* ***6.1)***. *This has been brought to the attention of Richmond Local Authority Public Health.*

2.25 Young people transitioning to adult substance misuses services receive coordinated care planning prior to their 18th birthday. We saw evidence of where both services had worked with the young person in preparation for the transfer. The services had holistic care plans in place which address vulnerability and risk of young people. The draft transition policy with a standardised template will give structure to the process and allow monitoring of the joint approach to care when it is formally implemented.

3. Child protection

3.1 We saw MASH health visitors and CAMHs SPA representative were integral to the joint decision making undertaken at MASH referral meetings. We heard there was an open culture to challenge on case decisions made within the MASH. We saw a proactive approach to discussing cases by health practitioners and their professional view being valued by multi-agency partners.

3.2 We found MASH health visitors to be diligent in seeking out the father's details for children referred to MASH. However, there was inconsistency in ensuring the information was routinely added to the child's care record during the process. CLCH had recognised there was a deficit in ensuring all fathers' details are recorded, this was noted in a previous CQC inspection, there is ongoing work by CLCH to address the issue. The recording of the father's details within the MASH process would assist in ensuring a comprehensive record of a child's family and relationships is created to support family focused care. ***(Recommendation 3.1)***

3.3 All services seen during our review showed commitment to their staff attending case conferences and other statutory safeguarding meetings. The majority of services monitored attendance to offer assurance that staff were able to prioritise this area of work. The Signs of Safety approach to referrals and case conference report format was well established in the local area. Senior management within the local authority spoke positively of the commitment by health practitioners to the use of the Signs of Safety template in the reports they submit. This has promoted a consistent approach across the local area in recognising strengths within families and areas of risk when planning their care.

3.4 We found children's referrals to MASH were of a good quality. Overall referrals by practitioners articulated risks and what action needed to be considered to inform the decision-making process. We also saw reports for child protection conferences which offered detailed insight of the unborn child and other children and young people, with a good analysis of risk. This allows focused discussion with family and the practitioners at conference on what needs to change meet the needs of the child.

3.5 Richmond Integrated Recovery service do not routinely prepare a report for case conference of their involvement with the service user if the practitioner is to attend that meeting. This reduces the practitioner's opportunity to reflect and consider the Signs of Safety approach prior to conference and formally share their professional view with the parent. It also means that should circumstances change and the practitioner is unable to attend the meeting then that conference might not be in receipt of relevant information on which to make a decision. ***(Recommendation 6.2)***. *This has been brought to the attention of Richmond Local Authority Public Health.*

3.6 Vulnerable children attending ED were identified by the use of appropriate and consistent flagging system on the electronic records when attending the service. This included the use of the national Child Protection Information System (CP-IS). We saw this being effectively used to inform care and in one record examined we saw that the child had a child protection plan and had subsequently become looked after. The record clearly identified who needed to be informed of the attendance. This supports assessment of risk, alerts the clinician to any concerns and supports onward care.

3.7 Community and Hospital midwives do not have 24hr access to all information relevant to the pregnant women and unborn child when safeguarding concerns have been identified. Safeguarding information, including risk assessments or child protection paperwork, were held separately in an individual patient folder in a protected area of the IT system which only the Bridge Midwives and Named Midwife could access, and therefore this limited availability of the information to staff. Although community and Hospital midwives can access care plans for the woman and the unborn baby which were held on a separate part of the system, the Hospital notes reviewed did not reference ongoing safeguarding activity which could potentially direct and alert the midwife to the existence of more detailed safeguarding information. This is not supporting coordinated care and places barriers in sharing information effectively. ***(Recommendation 2.6)***

3.8 Richmond Integrated Recovery adult substance misuse service showed a strong commitment to partnership working. For example, we saw a high level of discussion and sharing of information with children's social care and midwifery services where a safeguarding concern had been identified. Richmond Integrated Recovery service were persistent in their attempts to engage clients when safeguarding issues or child protection concerns had been identified, recognising the impact of adult behaviours on children in their care.

We saw a positive example of joint working for a young woman whose vulnerability and lifestyle led to child protection procedures for her unborn being put in place. The young woman was identified as needing the specialist midwifery team care and referrals were made appropriately to children's social care. The records examined indicated a good level of communication between midwifery and health visitor services in managing her care.

Services involved with the young women and her partner shared information at MARAC meetings which considered all risks and enabled a plan for her and the unborn's safety to be put in place. We also saw how the adult substance misuse service were persistent and accommodating of the father in trying to engage him with their service. Although the client chose not to engage, many opportunities were offered, and children's social care were kept updated.

The case illustrated the complexity of care and support needed by vulnerable families at times and how good information sharing is essential to safeguarding effectively.

4. Looked after children

4.1 We saw good commitment by the CCG to working with the local authority to improve outcomes for CLA. The designated professionals and specialist staff fulfil their specialist roles, working across Trusts and with partner agencies to meet statutory requirements. Both parties are committed to their corporate parenting responsibilities of improving outcomes for CLA in Richmond.

4.2 In Richmond CLA do not always benefit from the timely completion of initial health assessments (IHA). There is ongoing work to address the issues that are leading to delays. The designated nurse for CLA has raised the poor performance at appropriate strategic meetings and it is on the CCG risk register. Data shows that health providers are responsive and timely in undertaking the health assessment once a request has been received from the local authority and locally set key performance indicators have been met. The CCG has now proposed that the local authority and health jointly undertake a root cause analysis on a number of health assessments recognised as being outside of timescales, and this work commenced in June 2019. This will allow real time scrutiny of process problems and jointly look to resolve the identified issue.

4.3 The Hounslow and Richmond Healthcare Trust (HRCHT) provider service have a robust process is in place for undertaking CLA health assessments. Children under-five years of age requiring statutory assessment were seen by the Named Doctor for CLA every 6 months, with the option of children placed out of area returning to Richmond for their assessments. RHAs for children age 5-19 were undertaken annually by the Looked After Children's Specialist Nurse. We heard positive feedback from foster carers regarding the high standard of service that children, and foster carers themselves are provided by the CLA team. The service maintains an overview of the health and wellbeing of children looked after and monitor any changes effectively.

4.4 Health assessments for children looked after undertaken by Richmond CLA team were of a good standard. They were holistic, assessing health problems and changes in activities of daily living which went on to inform focused health care plans. Where appropriate, they were also inclusive of the parent's or carers views. The voice of the child or young person was seen to be present and we also heard from foster carers that their perspective regarding the children in their care were listened to by practitioners.

We were told about and saw in records examined that there are effective working relationships between the CLA team and therapies such as speech and language services and physiotherapy.

In one case example reviewed we saw how a child's delay in gross motor skills identified at the looked after children's health review was effectively managed. The clinician referred the case to physiotherapy services and the child was seen promptly because of their recognised additional vulnerability. The foster carer was clear about the physiotherapy plan and this enabled them to deliver the care needed. We saw that from the records the child started walking within a few weeks of physiotherapy starting.

Prioritisation of CLA allows for needs that may not have previously been assessed to be addressed more quickly and improve outcomes for this vulnerable group of children.

4.5 The specialist CLA nurse does not always have sight of a child Education Health Care plan (EHCP) prior to undertaking the RHA. An EHCP is a legal document that describes a child or young person's special educational, health and social care needs outlining the outcomes they would like to achieve related to their special need. This is a missed opportunity to consider the interface between the two assessments and whether the care can be coordinated any further to meet the child's needs and help negate the need for the child to tell their story again to different health practitioners. ***(Recommendation 5.1)***

4.6 Health assessments we examined of children looked after living out of area (more than 20miles outside of Richmond) were of a satisfactory standard. They were reviewed by the Designated Nurse for CLA using a standardised template. Approximately 20% of Richmond CLA are placed out of area and this could lead to challenges ensuring their health needs were assessed by a suitably qualified practitioner and undertaken in a timely way. There was an effective process of monitoring, challenging and reporting by exception on any late completion of health assessments by the area in which the child was placed. The CCG is striving to fulfil their responsible commissioner role by ensuring a consistent standard of care for CLA placed out of area.

4.7 Health assessments for unaccompanied asylum-seeking children (UASC) were focused on their particular health needs over and above other CLA. The number of records seen for UASC were small, but it was clear the clinician took account of the young person's journey and was sensitive to their experiences and needs whilst seeking asylum. This was reflected in referrals that were seen to be made to children's social care after the assessment had been completed. This is important, as UASC have often had traumatic experiences and suffered exploitive situations which makes them additionally vulnerable.

4.8 Quality assurance process for the majority of health assessments undertaken within area is weak and this is a deficit, despite many of the assessments examined during our review being of a good standard. The CLA team recognise this and it is a priority area of work once the CLA named nurse is recruited. Currently, other than a small number of IHAs that are subject to quality assurance, there is little opportunity for assessing variations in the assessments undertaken and this limits improvement and learning. ***(Recommendations 5.2)***

4.9 The HRCHT were able to demonstrate through service user feedback that foster carers provided positive feedback on the service offer from the CLA team, with particular reference to the engagement with the CLA Named Doctor, this was reinforced by foster carers we spoke with during our review.

The Designated Nurse for LAC has facilitated a project for children looked after to equip them with the skills to work as mental health champions within the local area. This was informed by listening and working with the views shared by children in care.

The young people of the Children in Care Council [a statutory council established in every local authority to help children in care improve the services available to them] identified that they would like to improve their understanding of mental health and offer a 'drop in' sessions for their peers. They felt their peers would be likely to listen to them as they had had similar experiences, but they didn't feel they had sufficient knowledge to help.

The Designated CLA Nurse organised a children and adolescent psychiatrist and psychotherapist to deliver a six-week course and facilitated the Young Health Champion qualification. The aim of the project was to promote the health and wellbeing of children in care. The course, resulting in a qualification for the young people was coordinated by the CLA nurse and delivered over weekends and evenings. The local area now has eight young people who have been given the skills, knowledge and confidence to act as peer mentors, increasing awareness of healthy lifestyles and encouraging involvement in activities to promote good health.

4.10 Children looked after benefitted from access to art and systemic therapists for their emotional health and wellbeing when there is a recognised need. The health professionals in the CLA team make recommendations to the social worker within the child's IHA/RHA Health Care Plan for a referral to the therapists. The CLA Nurse is co-located with the CLA social care team on two days of the week and this is enabling timely, direct discussions with social workers and therapists about the referred child to support this area of work.

4.11 We did not see a strong focus on joint work and coordination in relation to the emotional health and wellbeing for CLA, for example, we did not hear of CLA benefiting from access to a CAMHs professional linked to the CLA team or CLA being prioritised within the referral system to CAMHs. Leaders have recognised the need to strengthen mental health services for young people who are looked after including those transitioning to adult services and accessing mental health services. ***(Recommendation 5.3)***

4.12 GP engagement in the care of children looked after was inconsistent. Training had been delivered to primary care on the role they can play and the CLA named doctor has produced a covering letter that goes to GP's prior to a child's health assessment. Although following the launch of the letter there was a small improvement in response and quality it was not felt this has been sustained although this was not formally measured or audited. Currently the health assessments may not be informed by the most up to date health information held in primary care. ***(Recommendation 1.1*** *and* ***5.4)***

4.13 We saw limited examples of where the CLA service has used children and young people to shape services. For example, the re-design of the health passport did not involve children and young people and looked after children are not on interview panels for new team members. This is a missed opportunity to engage CLA in shaping the service.

Management

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

5.1 Leadership and management

5.1.1 The CCG are working with partner agencies to improve outcomes for children in Richmond children. We saw appropriate challenge of partner agencies to address issues, for example the approach being taken to address delays in completion of initial health assessments, and well-coordinated approaches to safeguard children such as the local multi-agency Risky Behaviour Service Review in response to concerns raised about young people's smoking, sexual health and drug and alcohol use in Richmond.

5.1.2 The designated professionals worked effectively to support statutory requirements and undertake their safeguarding board responsibilities. They were actively involved in local safeguarding board committees and corporate parenting boards. Joint agency initiatives and workplans indicated well developed relationships between agencies to secure good safeguarding outcomes for children in Richmond. The independent chair of the Richmond and Kingston Safeguarding Children Board (LSCB) spoke highly of the commitment and effectiveness of the senior leaders in the CCG and provider organisations that was supporting the work of the LSCB.

5.1.3 The CCG has worked with statutory partners to establish the framework for a Local Safeguarding Children's Partnership which will replace the current LSCB arrangement. Final arrangements and implementation were imminent at the time of the review and these will be in place within the legislative timescale. Partners will continue to focus on improving outcomes for children in areas prioritised by the current LSCB.

5.1.4 Repeated recruitment to interim posts has limited the CLA services ability to develop and evidence itself as a consistent driving force for improvement. We met dedicated staff who were focused on improving outcomes for CLA and we saw two keys posts had moved from interim to permanent position. Further work is needed by the CLA team to support quality assurance processes and auditing to allow tracking of service improvement. ***(Recommendation 5.5)***

5.1.5 There have been challenges in capacity within the designated nurse role. The ability to fully exercise the strategic designated functions of the role although managed have impacted service development. This is now being addressed by the CCG with recruitment into a named LAC nurse which was being progressed at the time of the review.

5.1.6 The CCG recognised that further work is needed to fully involve primary care in the safeguarding children agenda. Multi agency audits have recognised the increased role GP's could play in safeguarding for example reports for case conferences. The Named GP vacancy has been a deficit, the CCG have worked hard to try and recruit, they are hopeful that a GP will be in place soon to champion the development of child protection and safeguarding across Richmond. ***(Recommendation 1.2)***

5.1.7 We found good support and guidance provided to services and frontline staff by provider safeguarding teams, designated doctors, designated nurse. Committees were in place in provider services and the CCG to act as forums for discussion and challenge and overall these were well attended.

5.1.8 The designated nurse for safeguarding has offered expert advice to ensure safeguarding is integral to CCG commissioned services and this has included an advisory role to Public Health commissioned service specifications. There is recognition further refinement is needed on the small less child focused provider services and this forms part of a work plan. A strategic approach to safeguarding has assisted in setting service standards that can be monitored and drive improvement.

5.1.9 There has been good commitment by the CCG and provider organisation to health's involvement in the MASH. The CCG, CLCH and SWLStG managers recognised that the provision of health expertise in the MASH has supported effective multi-agency working to safeguard children. The quarterly SPA MASH Strategic Board, which the CLCH named nurse attends has used data to assist in identifying trends and themes from referrals to MASH. We also heard of work that is looking at the presenting issues within families referred to MASH, it is anticipated this will lead to more focused work by partner agencies and better outcomes for families.

5.1.10 The KHFT has taken steps to manage challenges in staffing levels in paediatric emergency department (ED). It was reported the shortage that mirrors the national picture and has been exacerbated by a disproportionate increase in numbers of people attending KHFT ED in recent years. The plan to manage any shortfalls in paediatric staff was seen and the robust monitoring arrangements of staffing levels by the Trust and the CCG was noted within reports.

5.1.11 We did not hear of a strong take up of the LSCB proposal for neglect champions in the health services we visited. CLCH named nurse is the champion for 0-19yr service and she was promoted the use of the LSCB neglect tool which has identified ways for practitioners to use language and words to identify neglect. It was not possible report on the impact of the neglect champions and strategy within health services we reviewed.

5.1.12 Agencies in the local area have been responsive to learning from two recent suicides in the borough. CAMHs have been integral to the development of the multi-agency Suicide Community Action Plan (currently draft) for responding to potential or actual suicide cluster or contagion that may occur in Richmond. The plan sets out a clear multi-agency response that can be initiated in the event of cluster suicides to reduce further deaths by suicide. This is a locally driven, proactive response to manage concerns for young people's mental health wellbeing.

5.1.13 We did not see extensive use of, or completion of a standardised CSE risk assessment tool to identify risk and incidence of child sexual exploitation, for example in the acute setting and sexual health services. We do recognise work has been undertaken strategically through the newly developed Vulnerable Children & Adolescent Strategy, and the establishment of the multi-agency panel 'MARVE' to tackle all forms of criminal child exploitation. However, currently in some key services further work needed for organisational assurance that exploration and recognition of exploitation is embedded in practice. ***(Recommendation 2.7** and **3.6)***

5.2 Governance

5.2.1 There is an effective governance arrangement to ensure the Richmond CCG board were informed of safeguarding activity across the local area, the Integrated Quality Governance Committee safeguarding reports were comprehensive. The bi-monthly Safeguarding Health Liaison Meeting chaired by the designated nurse and attended by local authority, provider and CCG safeguarding leads was a positive initiative offering the opportunity to share learning and discuss cases that may challenge effective partnership working.

5.2.2 The MASH HV were able to access the local authority MASH IT system record for referrals this supported information sharing and assisting case management. This allow decisions to be made collectively, in the best interest of children and young people.

5.2.3 Safeguarding governance arrangements were satisfactory within KHFT, there is a reporting mechanism from the Trust children's safeguarding committee to the Trust board. The safeguarding committee is well attended by internal and external partners which demonstrates an openness and willingness of the Trust to share and discuss its safeguarding practice. However, we did not see a strong culture of safeguarding audits to support the discussions and assurance process. ***(Recommendation 2.8)***

5.2.4 We heard of a well-attended multi-agency and multi-disciplinary meeting hosted by The Bridge team midwives, held monthly was allowing discussion on how to care for women who needed a high level of support including protecting the unborn child. Processes supported dissemination of the information to community midwives.

5.2.5 A small number of care records seen did not contain uploaded minutes from statutory safeguarding meetings, and this shortfall was most noticeable in adult mental health. This restricted practitioner's ability to ensure that actions which have been deemed as necessary to keep service users and children safe from harm have been fulfilled. ***(Recommendation 4.7)***

5.2.6 Health practitioners do not routinely retain a copy of safeguarding referrals in the child's record, which were completed via a local authority online portal, this issue was noted in nearly all settings we visited. This leads to the child's record being incomplete, and it does not assist the practitioner in ongoing assessment of concerns if a further referral is needed. Managers and the designated nurse where responsive to this finding and to resolving the issue. ***(Recommendation 1.3, 2.9, 3.7, 4.8*** *and* ***6.3)***

5.2.7 We noted only CAMHS services had a quality assurance processes for practitioner's reports, CLCH had recently introduced internal scrutiny with reports being shared with the safeguarding team. However, this was not in place for adult mental health or Richmond Integrated Recovery Service. Internal processes are an opportunity for managers to monitor the quality of reports submitted, identify trends and training needs. ***(Recommendation 4.9)***. *This has been brought to the attention of Richmond Local Authority Public Health.*

5.2.8 The use of alerts and flags were not effective in adult mental health service electronic patient system. The system to alert practitioners of when there were safeguarding concerns or children associated with adult service users, were not being used consistently. This meant it was not immediately clear to practitioners when there were safeguarding concerns or risks to children. ***(Recommendation 4.10)***

5.2.9 KFHT midwifery managers and internal IT department were quick to respond a shortfall in the electronic patient record alert system identified while inspectors where on site. Alerts indicating a women's vulnerability put in place during pregnancy were automatically removed and transferred onto the baby's record following delivery. This ceased to alert midwives or other practitioners within the Hospital to the vulnerabilities and increased need the woman may have. Immediate action was taken by the Trust to remedy the issue.

5.2.10 Links between Richmond Integrated Recovery service and children's social care service had strengthened over the past 12 months. Members of social cares assessment and referral team attend the services monthly safeguarding meeting. Both services had a manager as a point of contact to escalate concerns through and consider client case management. Records demonstrated a good level of joint working to safeguard children of carers known to the service.

5.3 Training and supervision

5.3.1 Commissioners of services and provider organisations had systems in place to monitor safeguarding training and generally, we found a good level of compliance with the Safeguarding Children and Young People: Roles and competencies for healthcare staff intercollegiate guidance. We were told some services were still adjusting to the changes in requirements of the updated intercollegiate guidance. For the provider organisations where levels have fallen to below that agreed with the CCG and Public Health commissioners, plans were in place to monitor improvement and trajectories had been set.

5.3.2 The SWLStG Trust had worked collectively across the local area to ensure CAMHs practitioners had received training on suicidal contagion in young people. The SWLStG CAMHs team delivered training across the five south west London Boroughs. This approach supported ensuring staff were knowledgeable in suicide management of young people and a consistent approach across the five boroughs of the issue.

5.3.3 The Designated CLA Nurse has led a piece of work with the Children in Care Council regarding a mental health project. The work involved training young people, so they could run a mental health drop in for young CLA people. The initiative led to a local area award. This is an excellent way of enabling service users, with training, to support other young people.

5.3.4 We were told by GPs that they utilise the support and advice of the Designated Nurse for safeguarding. Learning from serious incidents and case reviews were disseminated to GPs via the CCG learning forums. The designated professionals have continued to coordinate and undertaken three monthly workshops on local topical safeguarding issues for primary care in the absence of the Named GP. Gp's we spoke too reported these had informed their practice.

5.3.5 We saw examples of a mature approach to sharing safeguarding knowledge within the local area. Richmond Integrated Recovery substance misuse service have delivered basic substance misuse training to the local authority Strengthening Families teams within the Borough and in turn they have delivered domestic abuse training focussed on perpetrators. The designated professionals regularly deliver bespoke training through the LSCB such as FGM and Safe Sleeping for Babies. This supports developing a well-trained workforce across Richmond.

5.3.6 Not all adult mental health practitioners had received the adequate level of safeguarding children training, commensurate with the Safeguarding Children and Young People: Roles and competencies for healthcare staff intercollegiate guidance. This inhibits their ability to recognise and respond to children and young people's risks and vulnerabilities. The Trust has recognised the gap and we were told there are plans in place to ensure that practitioners receive and benefit from appropriate and effective safeguarding training. ***(Recommendation 4.11)***

5.3.7 The adult mental health practitioners have not received training on domestic abuse and this is a gap, we did not see strong emphasis on exploring domestic abuse within records we reviewed. Some service users will be at an increased risk of coercive and abusive behaviours during periods of mental ill health and staff may not be equipped with the skills to recognise the issue. ***(Recommendation 4.12)***

5.3.8 The KHFT did not have a consistent offer of child safeguarding supervision for their staff. In ED and paediatrics, were it was available it was on an ad hoc basis, therefore clinicians and nurses did not have protected time to regularly reflect and consider the management of child protection and safeguarding cases. This does not align with the Trust supervision policy which included recording of one to one supervision in case records and the audit of safeguarding supervision. ***(Recommendation 2.10)***

5.3.9 Currently the specialist midwives in the Bridge team receive an excellent model of supervision, but this was not available to the rest of the Trust's community and Hospital midwives. We understand that ad-hoc advice and guidance was available to these staff groups, however, this did not offer the valuable opportunity to reflect and learn from their individual practice. ***(Recommendation 2.11)***

5.3.10 Safeguarding supervision was consistently provided for the Richmond 0-19 service by CLCH. The model was well developed and included the safeguarding teams use of a suite of tools to support supervision. For example, visual aids to identify the severity of an untidy or cluttered home. We saw one to one supervision recorded in all the client record we reviewed that reflected the signs of safety model used.

5.3.11 CAMHs practitioners benefited from regular one to one clinical and safeguarding supervisions. This CAMHs service manager maintained a live, 'rag' rated data base which provided effective oversight of clinicians who had not accessed supervision. Actions from previous supervision sessions were routinely discussed, which reduced the propensity for case drift and maintained the focus on improving outcomes for children.

Recommendations

1. Richmond Clinical Commissioning Group should ensure:

1.1 CLA health assessments are strengthened by ensuring that GPs are well engaged and share relevant information about children they care for.

1.2 The Named GP role identifies and develops areas of work that will assist the engagement of GP in local safeguarding processes.

1.3 GP's are assisted to ensure a copy of referrals made to the MASH are available within children and young people's electronic care record.

2. Kingston Hospital NHS Foundation Trust should ensure:

2.1 The ED care record better records the 'child's voice' and a process is established to give assurance through governance arrangements.

2.2 Effective liaison and sharing of information is undertaken with other health professionals and including recording actions taken in ED as a consequence of the attendance.

2.3 Adult ED records prompt the recording of the adult attendee's parental or caring responsibilities to assist in assessing need and risk.

2.4 Midwifery documentation supports the practitioner to gather sufficient information to assist risk assessment for the pregnant women and unborn child.

2.5 Expectant women are offered a private discussion as recommended in NICE guidance during their episode of care to assist exploring the risk of domestic abuse and answers to routine enquiry are recorded and subject to managerial oversight.

2.6 Children at risk of CSE are effectively identified by frontline staff and there is assurance through management oversight and monitoring of this important practice.

2.7 The safeguarding children quality assurance processes and audits evidence the improvement and impact on the service on children and families.

2.8 A copy of referrals made to the MASH are available within children and young people's electronic care record.

2.9 A model of safeguarding children supervision is introduced for ED and for paediatric practitioners and adherence is monitored through assurance through governance arrangements.

2.10 A model of safeguarding children supervision is introduced for all midwifery staff and adherence is monitored through assurance through governance arrangements.

3. Central London Community Healthcare NHS Trust should ensure:

3.1 Children and young people's electronic care record reflects significant males associated with the family and governance arrangements evidence compliance with this requirement.

3.2 People at risk of domestic abuse are identified through the use of routine enquiry and that answers given are recorded and subjected to routine managerial oversight.

3.3 The risk of FGM is appropriately explored and recorded for women attending the sexual health service and that managers are assured of this by way of appropriate oversight and audit.

3.4 All home educated children and families are aware of the school nurse offer and have the opportunity benefit from Healthy Child Programme provided by school nurses.

3.5 Young people under 16yrs are safeguarded through the completion of a comprehensive risk assessment when attending the sexual health service.

3.6 Children at risk of CSE are effectively identified by frontline staff and there is assurance through management oversight and monitoring of this important practice.

3.7 A copy of referrals made to the MASH are available within children and young people's electronic care record.

4. South West London & St George's Mental Health NHS Trust should ensure:

4.1 People at risk of domestic abuse are identified through the use of routine enquiry and that answers given are recorded and subjected to routine managerial oversight.

4.2 Genograms are available to CAMHs practitioners to use within the child's main care record where complex family structures or relationships are indicated.

4.3 That adult mental health practitioners are skilled in assessing and considering safeguarding risks to the unborn or children and use provided tools when undertaking assessment and this is subject to managerial oversight.

4.4 Genograms inform assessment of risk and are available to adult mental health practitioners within the service users main care record.

4.5 Children are consistently identified within the care record of the adult service user and management has assurance safeguarding forms are completed and available on the system.

4.6 The child's lived experience is evidenced within the adult care record through work with the service user and/or the child.

4.7 That all documents related to the adult service user are available within the care record system.

4.8 A copy of referrals made to the MASH are available within children and young people's electronic care record.

4.9 Safeguarding reports from the adult mental health service to children's social care are quality assured to support organisational learning and a consistent standard.

4.10 Safeguarding alerts in adult mental health are consistently used within care records and a process is established to give assurance through governance arrangements.

4.11 All staff in adult mental health service are compliant with the intercollegiate safeguarding guidance for their roles and responsibilities.

4.12 Staff in adult mental health are appropriately trained on domestic abuse and their understanding and exploration of domestic abuse is embedded in practice.

5. Hounslow and Richmond Healthcare Trust should ensure:

5.1 CLA with Special Educational Needs and/or Disability, experience a 'tell it once approach' during health assessments by ensuring relevant information is available to support the discussion and assessment.

5.2 CLA Health assessments are subject to a quality assurance process that informs practice.

5.3 Arrangements for all children to have timely access to CAMHS services are strengthened, including priority access for CLA and to continue to improve transition arrangements for those looked after young people moving to adult services.

5.4 CLA health assessments are strengthened by ensuring that GPs are well engaged and share relevant information about children they care for.

5.5 Quality assurance and service improvement plans for CLA are strengthened to clearly evidence impact and measure progress.

6. Change, Grow, Live- Richmond Integrated Recovery Service should ensure:

6.1 The child's lived experience is evidenced within the adult care record through work with the service user and/or the child.

6.2 Reports are provided to all child protection case conferences irrespective of attendance.

6.3 A copy of referrals made to the MASH are available within children and young people's electronic care record.

Next steps

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

Please submit your action plan to CQC through 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.