

# **Review of health services for Children Looked After and Safeguarding in Luton**

# Children Looked After and Safeguarding

## The role of health services in Luton

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<b>CCGs included:</b>	NHS Luton 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 Luton. 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 Luton, 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.
- 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.

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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 56 children and young people.

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## Context of the review

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Luton is located in Bedfordshire some 30 miles north of London. Luton has a multi-cultural community with a population of approximately 208,000 residents, including over 59,000 children and young people aged 0–19 years (2013 estimates). Approximately 50% of its population might be from a minority ethnic background with approximately 30% being Asian or Asian British. The child and maternal health observatory (ChiMat) data states that children and young people make up 28.4% of Luton's population with 70% of school children being from a minority ethnic group (March 2014).

Commissioning and planning of most health services for children in the Luton area are carried out by NHS Luton clinical commissioning group (CCG). Acute hospital services are provided by Luton and Dunstable foundation NHS trust (LDFT) at the Luton and Dunstable hospital. The hospital provides intensive neonatal care, high dependency care and special care. The hospital also has a paediatric emergency department. LDFT services are commissioned by Luton CCG.

The looked after children health team is provided by Cambridgeshire Community Services NHS Trust (CCS) and are commissioned by Luton CCG.

Maternity services are provided by LDFT and are commissioned by Luton CCG.

Children's community health visiting and school nursing are provided by CCS with children's speech and language therapy and occupational therapy being provided by South Essex Partnership Trust. School nurses are commissioned by Luton borough council and health visitors are currently commissioned by NHS England.

Child and young people's alcohol services are provided by alcohol services for the community, commissioned by Luton borough council and the young person's shared care drug service is provided by CCS.

Child and adolescent mental health services (CAMHs) and adult mental health services are both provided by South Essex Partnership University Foundation NHS Trust (SEPT). Both services are commissioned by Luton CCG.

Adult drug and alcohol services are provided by a range of providers including ASC, SEPT and CCS. From 1<sup>st</sup> October 2014 all drug services will be provided by CCS and all alcohol services will be provided by ASC

Contraception and sexual health services are provided by Brook advisory services being commissioned by Luton borough council.

The last safeguarding and looked after children's services (SLAC) inspection took place in March 2012 as a joint inspection with the Office for Standards in Education (Ofsted). During the 2012 inspection the 'overall effectiveness of safeguarding services' was assessed as 'good' with the 'overall effectiveness of services for looked after children and young people' assessed as 'adequate'. The recommendations from the inspection of 2012 are covered within this report.

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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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Whilst at Luton and Dunstable hospital we spoke with the parent of a young person who was waiting for further advice following an x-ray. She told us:

*“We last came here about six years ago and we had to wait hours to be seen. It was horrible. Today, we only had to wait here (in the dedicated paediatric waiting area) for about 20 minutes and the service has been excellent. We have had every step explained to us too.”*

We then spoke with the young person who said: *“They’ve been really nice.”*

Both were then invited to a private area for consultation. On their return to the waiting area they told us that the young person would have to return to the hospital the following day for a procedure to be undertaken under general anaesthetic. The young person told us:

*“It’s OK, I’m not worried. They have told me why it needs to be done and what would happen and that made me feel better about it.”*

We spoke with the father of child who was waiting for assessment. He told us:

*“Her (the child’s) wound from surgery is not healing properly. We were asked to come along today so that we could be told what the plan is to put it right. I’m looking forward to hearing what they are going to do, but we have only been waiting for a few minutes and I think we will be seen pretty soon, it all seems quite efficient.”*

We spoke with the carer of a young person who told us, *“CAMHs have been really supportive to our whole family. I can’t fault them. When he (the child) had a set-back they came round and sat with us all which is just what he needed. It was just what we all needed really.”*

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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 Health visitors are routinely made aware of vulnerable antenatal mothers by midwives. Information is shared about this vulnerable group prior to the birth so that health visitors can proactively prepare. Health visitors generally reported good working relationships with GPs, with them being allocated to individual GP practices so as to act as a conduit for information sharing.

1.2 Interpreters are currently routinely used to ensure equal access to health visitor services, and a specialist clinic in one area of the town with an onsite Polish key worker is a positive offer. The 'hard to reach' health visitor post covering travelling communities, families in emergency accommodation and those resident in women's refuges, also ensures vulnerable families and children have access to additional support. However, the further development of keyworkers with special interest and training in locality health visitor teams would be useful in facilitating skill development in frontline practice and provide more specialist support to vulnerable families. (**Recommendation 3.1**)

1.3 Vulnerable pregnant women are targeted for an antenatal visit at 28 weeks. However, capacity issues mean this is not routine practice at present. Decisions on who will be offered an antenatal visit are taken by the individual practitioner, leading to the risk of inconsistency across the area. We are aware of the re-commissioning exercise currently underway in Luton and the drive to ensure increased staffing capacity is a central part of this process. (**Recommendation 3.2**)

1.4 Strong joint working with children's centres in Luton ensures all families have high levels of access to a range of early help and support options. We saw that during new birth visits by health visitors, all families are automatically registered at a children's centre and that they are supported to access activities there wherever possible, including intensive parenting programmes. We were also advised that health visitor clinics take place at children's centres to facilitate parent's access and engagement with wider community support services. This is seen as good practice.

1.5 The family nurse partnership programme (FNP) in Luton has been commissioned and is planned to commence in March 2015. This service will provide an important service to young families who require more intensive support including specially trained family nurses visiting young parents aged 19 or younger on a regular basis, from early in pregnancy until the child is aged two years.

1.6 Due to the success of the teenage pregnancy strategy and the falling numbers of teenage pregnancies, the midwifery teenage pregnancy team have expanded their remit to include 18 year olds who have recognised vulnerabilities. This capacity increase has developed a useful service for other vulnerable expectant mothers within that age group and this is seen a positive step.

1.7 Midwifery risk assessment is supported by the booking at home policy to allow midwives to assess the home environment and other social factors. Pregnant women are routinely offered the chance to be seen alone at an early stage in their pregnancy to discuss possible domestic violence issues. All pregnancies are now routinely booked in this way. If fathers of unborn children attend the booking- in appointment midwives will seek further opportunity to speak with women so that issues that might affect them can be discussed in private, such as possible domestic violence.

1.8 Early help services in targeted areas of Luton as part of the 'flying start' lottery funding bid clearly identify risk and protective factors and provide a range of social and additional health support for vulnerable families who would benefit from support. Although Luton was not successful in securing the full financial bid, we were advised that it is hoped this pilot work, which achieved positive outcomes, will continue to be used to inform extensions to current service provision such as 'bumps to babes,' and further inform future service development based on known local need. We observed good outcomes as a result of the work undertaken so far, along with comprehensive information gathering on local trends such as the potential isolation of certain groups in the community.

1.9 There is no dedicated paediatric reception area at Luton and Dunstable hospital accident and emergency unit (A&E). However, reception staff quickly signpost young people through to the dedicated paediatric waiting and assessment area keeping waiting times in the general reception area to a minimum. The dedicated paediatric waiting area is accessed by a pass card and is overseen by health professionals who work in close proximity to the area thus ensuring general oversight of potentially vulnerable young people.

1.10 All qualified nursing staff employed within paediatric A&E during day and night hours are paediatric care trained and qualified.

1.11 Reception staff at Luton and Dunstable hospital A&E are safeguarding trained in line with intercollegiate guidance. However, other than general corporate training they are not offered any further training regarding how to recognise other issues that might affect vulnerable young people attending the unit, such as domestic violence, female genital mutilation (FGM) and child sexual exploitation (CSE). We were advised that health staff are reliant on the 'life experience' of reception staff to recognise any such risks to young people and report them accordingly.

1.12 On arrival at A&E reception all children and young people's details are recorded in electronic format. It is during this process that any identified child protection concerns are automatically flagged to healthcare professionals, including multiple attendances to the unit.



1.13 We were advised by the A&E department lead for safeguarding that the threshold for admissions to paediatric wards via A&E at the Luton and Dunstable hospital is low and that, where appropriate, young people who might otherwise be directed to an adult ward who live with a learning or physical disability can be admitted to a paediatric bed for further assessment and treatment although this is not currently written into policy.

1.14 CAMHs workers were seen to provide appointments and family based models of intervention at flexible locations in order to facilitate better access for families of young people who could not attend CAMHs appointments at their office location. This pragmatic approach ensured young people are supported in an indirect way and that the parents were accessing appropriate regular support for both themselves and their children.

1.15 Care plans within CAMHs were seen to be of consistent high quality, with comprehensive detail and clear measurable outcomes so as to help practitioners provide care and support to vulnerable children and young people.

1.16 Staffing capacity in the community CAMHs mental health team is an issue and impacts on the work health professionals are able to undertake. However, the team are maintaining their 28 day target for initial assessments usually booking appointments in 14-21 days from receipt of referral. We are aware that an increase in staffing capacity is planned as part of the ongoing re-commissioning of services. (**Recommendation 2.1**)

1.17 Children, young people and families benefit from access to a wide range of early help options via the multi-agency liaison team (MALT) focusing on working with vulnerable young people and their families. Work includes open access for looked after children, a parent and infant psychotherapy service for under four year olds and an early intervention service into schools. Additionally, we were made aware of 28 schools that 'buy in' extra services from CAMHs.

1.18 In one case reviewed we saw, and then were advised by a healthcare professional that health visitors were no longer able to make direct referrals to the speech and language team (SALT) for assessment where it was believed the child concerned had delayed speech. We were further advised that families were instead encouraged to attend a SALT 'drop in' centre where they could be assessed. In the case discussed there was no information placed on the Systemone computer system to evidence that the child's family had taken them to the drop in service as directed.

We were further advised by the health worker that the drop in service was due to be reduced from five days per week to three, which she believed would further discourage vulnerable young people making use of the service due to the waiting times. There was also an identified risk that vulnerable young people who were not the subject of child protection measures, who persistently did not attend for assessment would not be recognised by health professionals as having not attended due to there not being a referral mechanism in place.

We have been since advised and have examined evidence which demonstrates that the issue lies with staff awareness of how to make appropriate referrals and that referrals can indeed be made directly to SALT. (**Recommendation 1.1**)

1.19 In health visiting, referrals to children's social care (CSC) regarding safeguarding concerns can now be made by secure email. This provides evidence of receipt to the health practitioner making the referral.

In one case we examined we saw how the health visitor had made a referral to children's social care for their consideration for child protection measures to be put in place. The detailed referral form was sent as an email attachment along with a copy of the latest common assessment framework form (CAF) for information. This was made clear in the covering email. There was a delay of over two weeks without any reply being heard from children's social care during which the health visitor made several attempts to 'chase' the referral. It was eventually discovered that the receiving person had not noticed the attached referral and had not read the covering email which had caused the referral submission and evaluation to be delayed. It was only due to the diligence and tenacity of the health visitor that the referral was appropriately reviewed, albeit late.

1.20 Young people accessing contraception and sexual health services (CASH) provided by Brook are generally safeguarded well. Practitioners working with young people under 18 years are required to complete a comprehensive assessment which considers lifestyle, previous sexual activity and other factors which might indicate vulnerabilities. We saw evidence of how the form was used to prompt sensitive discussion with vulnerable young people and resulted in appropriate referrals to other agencies including counselling services and substance misuse services. At initial assessment practitioners can now refer to a 'sexual behaviours traffic light tool' which clearly highlights risk that will promote appropriate action on the part of the practitioner to provide support and care.

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## 2. Children in need

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2.1 Initial clinical assessments at A&E were seen to be robust in that the proforma document used for the assessment makes it clear that practitioners must enquire as to significant family member details and even includes a section where a family tree can be included. This promotes recognition of the 'hidden child' within families.

2.2 We were advised during our attendance at A&E that all children and young people attending A&E under the age of 16 with self-harm, drug abuse or mental health issues will be routinely admitted to a paediatric ward to await further psychiatric health assessment. CAMHs provide a psychiatric consultant up to 11pm, but they are generally only available by telephone consultation after 11pm and at weekends and bank holidays. If a young person requires admission to a ward after 11pm on a Friday for example, they will generally not be seen until the following Monday although advice will be given so that young people are provided with appropriate care and support. We were further advised by Luton CCG that CAMHS provide on call telephone cover outside of the hours of 9-5, Monday to Friday.

2.3 We were advised by nursing staff that young people presenting with challenging behaviour can be difficult to manage on paediatric wards at Luton and Dunstable hospital. However, we were further advised by the CCG and examined documentation at CAMHs which satisfied us that there is funding for psychiatric trained nurses to provide care and support to vulnerable young people on paediatric wards pending formal CAMHs assessment from a 'bank' of suitably trained and experienced staff.

We were further advised by staff at A&E that it is not unusual for there to be two or more admissions of children and young people awaiting mental health assessment onto paediatric wards every weekend and that this places a strain not only on staff working on the unit but also other young people resident on the ward and visiting parents. Clarification and the raising of staff awareness as to the criteria for and availability of additional psychiatric nurse support would help to negate those pressures. (**Recommendation 2.1**)

2.4 When a young person is admitted to a paediatric ward via A&E and is further assessed as requiring tier four CAMHs interventions, those young people may remain on the general paediatric ward for as much as two weeks before a suitable bed can be found for them. This puts a great deal of strain on both staff, other patients and visiting families alike, as those young people can be very disruptive to the day-to-day running of the ward. We are aware of the pressures to provide appropriate placements for these highly vulnerable young people, especially as there is no such provision in the immediate Luton area. However, children and young people who require such intensive tier four support are not best cared for on a general paediatric ward, especially when they might be very disruptive in nature to other service users. (**Recommendation 2.2**)

2.5 Current CAMHs commissioning arrangements mean they are unable to undertake proactive and preventative work with high risk populations. In one case seen, a young person's needs escalated dramatically with significant dangerous behaviour emerging over time. We understand this has been identified as a gap and will be rectified as part of contract tender process. However, management oversight to ensure these group's needs are met is required. (**Recommendation 2.3**)

2.6 Capacity and resource issues within the tier 3 core CAMHs home treatment service is having a significant impact on the ability to provide high levels of treatment in the community setting. The home treatment team consists of one practitioner who cannot provide daily home visits and is not commissioned to provide weekend cover. These young people are therefore requiring inpatient admission, which may account for the rising numbers of inpatient admissions into acute care reported as a concern by the local Healthwatch group. (**Recommendation 2.4**)

2.7 Service user involvement is well established in CAMHs and innovative ways of raising mental health awareness in young people, and this includes flash mobs (where large groups of young people break into a seemingly spontaneous dance in public areas to promote health issues), drop in events and awareness sessions delivered to local groups which includes Woodcraft folk (an educational movement for children and young people). All of these initiatives are seen as positive aspects to this service.

2.8 Recent initiatives in CAMHs to 'up skill' children's centres workers has had a positive impact on the identification of needs in children affected by domestic violence, leading to more children under four years of age gaining access to specialist services.

2.9 Children's social care referrals made by CAMHs health professionals were seen to be of a consistently high quality, with clear articulation of risks. CAMHs workers often provided an additional supporting letter in along with the referral form as submitted to provide further clarity as to the reasons for their making referrals.

A young person was referred to CAMHs by a GP regarding obsessive compulsive disorder. It was immediately recognised by CAMHs professionals that sensitivity would be required in this instance due to the young person's cultural and religious background and associated family beliefs. Translators were used to assist the young person at the initial assessment due to language difficulties.

Following initial consultation further appointments were made, but the young person failed to attend on two occasions. With this in mind, and considering both the young person's vulnerabilities and that they were fearful of family reaction to their attendance at CAMHs should their family find out, the CAMHs practitioner made a referral to children's social care. The CAMHs practitioner also questioned the possibility of forced marriage as it was mentioned during initial consultation.

In addition to the children's social care referral, arrangements were made for a CAMHs practitioner to re-engage with the young person at their school via the school nurse team. Through ongoing liaison between CAMHs, children's social care and school nursing services the CAMHS worker flagged their concerns that the initial referring GP had not recognised potential safeguarding concerns therefore missing the opportunity to refer the young person to children's social care at an earlier stage.

We also saw that the CAMHs professional in this case had recorded both extensive safeguarding supervision in this case and action planning following supervision.

2.10 Health visitor maternal mood assessment is currently undertaken on needs assessed basis and where it is used it is not routinely followed up according to the guidance. However, we were advised by staff members we spoke with that in their view assessment is undertaken on an 'ad-hoc' basis and might not be followed up due to staff capacity issues. This leads to potential risk that Mothers with declining mental health and those who would benefit from additional support are not being identified beyond the new birth visit. (**Recommendation 3.3**)

2.11 There is inconsistent liaison and joint working between community midwifery and health visiting to share information and prioritise families who would benefit from an enhanced health visitor package. This lack of ability to comprehensively handover cases is an inherent risk to safeguarding children and families. Further consideration on the instigation of maternity liaison meetings is required alongside work to develop communication between midwifery and health visitor teams. (**Recommendation 4.1**)

2.12 When health visitors are requested to provide a health report for child protection conference, we saw that the reports contained a good level of information to help those attending conference make informed decisions regarding the level and type of support to be offered to vulnerable young people. Health visitors are well engaged with the common assessment framework (CAF) and prioritised attendance at team around the child and child in need meetings. However, notification of meetings can be problematic with little notification time to prepare appropriately for those meetings. Staff members did tell us that they are generally kept informed of the outcomes of child protection meetings and reviews but do sometimes have to 'chase' up the information.

2.13 Both health visitors and school nurses are generally working with large case loads. School nurses in particular told us they hold on average 50 child protection cases in addition to child in need cases. Practitioners also told us of their frustration in not being able to provide as much health promotion and early intervention work as they would like and that they are rather 'firefighting' cases that are brought to their attention as opposed to working in a proactive way.

2.14 School nurses also told us of their concerns at plans for them to provide a 'drop in' service to young people in secondary schools. Whilst they agreed that the service would be beneficial to young people, their main concerns were that, considering current staffing levels, how they would be able to provide a reliable and consistent service considering the amount of time that is currently spent preparing for and attending child protection conferences. We are aware of the current recruitment drive to provide further school nurse support in Luton and that the service is being commissioned in response to wanting to deliver more health promotion and be more 'engaged' with schools.

2.15 Notification of domestic violence incidents is under developed within health visiting and there is no mechanism for police to alert health visitors of incidents apart from via multi-agency risk assessment conferences (MARACs). These are regular local meetings where information about high risk domestic abuse victims (those at risk of murder or serious harm) is shared between local agencies. There is a lack of joined up working in relation to domestic violence which is detrimental to fully assessing risk and support needed by families. (**Recommendation 3.4**)

2.16 Specialist midwives hold caseloads of women in need of additional support such as teenage pregnancy and substance misuse. The prevalence of domestic violence in Luton means all community midwives are involved in care of women affected by it.

2.17 Arrangements for expectant mothers with mental health needs are under developed in Luton. The absence of a specialist midwife for mental health and of a consultant psychiatrist has in played a part in two recent cases where mothers complained as they did not feel supported with their mental health needs. (**Recommendation 5.1**)

2.18 Midwifery cases examined highlighted that there was a robust and detailed information sharing processes in place for domestic violence and substance misuse, including appropriate plans being put in place to ensure staff were aware of recognised risks. The use of the pre-birth assessment documentation based on CAF questions was completed consistently in all cases seen.

2.19 The vulnerable women obstetrics team offer twice weekly clinics with a consultant to ensure all aspects of care and safeguarding have been assessed and planned for. Plans examined were seen to be comprehensive and included clear action points for health professionals to refer to. In all cases seen action points had been followed up consistently.

2.20 The 'Think Family' approach is not well embedded in adult mental health and, in the majority of cases we examined, full assessment and analysis of risk to children had not been undertaken, managed or documented. (**Recommendation 2.5**)

In one case examined we saw that a high level of risk to children posed by the client was recognised and reported in clinical notes. The notes included reference to how the client was not to be allowed to have any contact with children. Clinical notes included reference to the client having expressed intent to seriously harm his own children and further risks identified to his being homeless. However, despite those references made in the clinical notes seen there was no risk assessment on file, and the fleeting references made to children were insufficient to ensure due consideration had been given to vulnerable children and young people who were potentially at risk.

2.21 In another case we examined in adult mental health services we saw how, despite there being serious mental health issues recorded, no reference was made to the client's access to children outside of his own family and limited information was provided regarding relationships with his own children. We saw that there was no risk assessment or associated action plan regarding his level of risk to potentially vulnerable young people.

2.22 Community psychiatric nurses in the adult mental health team routinely conduct home visits so that a complete assessment of home environments can be made which includes assessment of risk to children.

2.23 We saw that robust arrangements are in place for young people who transition from CAMHs to adult mental health services. Senior health leads from both services discuss all 17 year olds known to CAMHs, mapping out the most appropriate pathways and support mechanisms for individual young people to achieve best outcomes.

2.24 In GP services limited working arrangements are in place for joined up working and information sharing in relation to the 0-5 year old population despite each practice having a link health visitor in place. For example, GP practice linked health visitors do not currently routinely attend GP practice meetings. And not all GP practices hold practice meetings. This is a missed opportunity for information sharing and exchange to help keep vulnerable children and young people safe. We were advised that this is due to current staffing levels and it is hoped that the ongoing recruitment drive and re-commissioning arrangements will rectify this.

2.25 In one GP practice we visited, we saw strong arrangements were in place to ensure concerns about children are identified and followed up, either by the referring GP or by requesting health visitor or school nurse follow-up. Weekly clinical meetings were held to discuss cases of concern and GPs at the practice routinely review information regarding young people who do not appear for appointed meetings and then highlight any safeguarding concerns as a result.

2.26 GP practices visited both had GP leads for safeguarding in place and we saw evidence of other GPs in the surgery accessing this person for support and advice on next steps if they had any safeguarding concerns

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### 3. Child protection

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3.1 Family and significant adult's details are not always clearly recorded on both paper and computer records as seen, although this varies according to areas we reviewed. In one health visitor case file examined we saw that two children had been made the subject of child protection measures due to witnessing a domestic violence incident between their mother and father. There were other recorded instances of domestic violence between the mother and her previous partner with whom she maintained contact because of older siblings. Despite having knowledge of this, both father details were not recorded on Systemone, nor had any recording been made of any attempt by the health visitor to obtain the father details. This was a theme also seen in documentation examined in adult drug and alcohol services.

Failure to record the details of absent parents, especially when there is a recorded history of domestic violence, is a recurrent feature at serious case reviews.

**(Recommendation 6.1)**

3.2 The quality of risk assessments is generally good across services in Luton. However, we saw that action plan development following on from the recognition of risk was often poor and where risk was identified to vulnerable young people, plans to reduce that recognised risk were not always robust. Information provided to health professionals about how best to negate identified risk was often limited and did not form part of a specific, measurable, achievable, or realistic and time scaled (SMART), person centred care plan. **(Recommendation 6.2)**

3.3 Health visitors prioritise attendance at child protection conferences, including those for unborn children. In one case tracked, we examined exemplary work around planning, co-ordination and liaison with midwifery and adult mental health, all instigated by the health visitor. This included joint visits and ongoing regular support to the Mother resulting in a step down from child protection to child in need and finally the family are now only accessing universal services. The health visitor's unique contribution led to very positive outcomes for this child and family.

3.4 There is more to do to ensure risks associated with paternal health and lifestyle choices that may have an impact on the unborn or new-born children are checked and recorded at booking in with midwifery services. We did see that partner details are recorded at booking in, but that questions are not asked regarding potential drug and alcohol use and medical histories which might impact on children in the family. **(Recommendation 7.1)**

3.5 Arrangements whereby midwives are based in GP cluster surgeries helps to facilitate co-working and opportunities for midwives to liaise regularly with GPs. However, this does not support communication with health visitors as they are located geographically to single GP practices. No maternity liaison meetings between midwifery and health visitors currently take place. **(Recommendation 6.3)**



3.6 In midwifery, the cause for concern form is used consistently to alert midwives and other health professionals of additional needs and vulnerabilities. Risk assessment using a question format based around the CAF ensures needs are comprehensively assessed and documented. Cause of concern forms lead to a health plan specific to the type of vulnerability identified so midwives are clear on their roles and responsibilities in providing appropriate care and support to potentially vulnerable expectant mothers.

3.7 Midwives provide high levels of support to vulnerable women both at the antenatal and perinatal stages of pregnancy. Planning in one case examined was seen to be comprehensive and clearly identified known risk and protective factors leading to analysis and next steps to ensure the woman concerned received effective support.

We examined one case where it was identified at an early stage of pregnancy that the expectant mother was living with mental health problems and depression. We saw that she was referred to and attended consultant clinics specifically targeting vulnerable women and that she was also provided with additional home visits prior to giving birth.

Midwives also provided the expectant mother with the opportunity to text message them when she was feeling vulnerable. This enabled midwives to respond to her current needs in the community by providing additional, responsive support as and when required.

3.8 Following learning from a serious case review a standard operating procedure is in place that dictates how all midwives must order full medical and GP notes for women as soon as she has notified of her pregnancy. This ensures detailed information gathering and analysis of information to allow for holistic care planning, which also supports pro-active safeguarding of unborn babies.

3.9 Positive joint working between the substance misuse midwife and shared care drug team ensures parents to be with substance misuse issues are supported by safe and efficient services. The arrangements for a co-run antenatal clinic at the substance misuse office allows parents to access midwifery and drug appointments together and thus facilitates positive engagement with services.

3.10 Within midwifery services attendance at initial child protection conference (ICPC) was not fully consistent in all cases seen within midwifery. Attendance at team around the child and child in need meetings was seen to be limited although we were not given a specific reason for this. (**Recommendation 7.2**)

3.11 There is more to do to support less experienced staff in their ability to escalate safeguarding concerns across services in Luton. An escalation policy is in place, but we heard this is used inconsistently and practitioners lack confidence in knowing when to escalate and in the potential outcome of this. Staff members reported to us that they often 'held onto' low risk concerns as they were unsure if escalation was required or if there would be an outcome as a result.

**(Recommendation 1.2)**

3.12 In A&E, one case reviewed demonstrated how multiple attendances to the department resulted in a referral being made to children's social care. We saw that the referral was detailed and included the reason for the referral being made and significant family member details, including siblings. This is important information which means that children's social care are better able to check their own records for relevant information that might inform their judgement on how best to provide care and support to vulnerable young people, including 'invisible' family members.

3.13 In complex cases with significant child protection concerns, adult mental health staff are fully engaged with the child in need and child protection process, attending meetings when possible. However, risk analysis and consideration for unborn babies requires further training, alongside joint working with the specialist mental health midwife. In one case examined we saw that the practitioner had recorded, 'No risk assessment needed for the child as it is unborn.'

**(Recommendation 2.6)**

3.14 CAMHS practitioners are fully engaged in the child protection and child in need referral and review process and we saw that they routinely prioritise attendance at associated meetings.

3.15 Some issues were expressed in midwifery around the timeliness of invites to attend meetings and practitioners expressed frustration with this.

3.16 A robust escalation policy is in place within CAMHS and we examined evidence of consistent and ongoing extensive communication and interagency liaison which leads to cases of concern being flagged at an early stage and therefore appropriately handled without the need to escalate further. The strong interface between CAMHS and social care supports the safeguarding of vulnerable young people and ensures their needs are re-assessed on an ongoing basis.

We examined the case of a child who had attended A&E following an incident of self-harm. The child quickly was assessed by CAMHs practitioners and considered safe to discharge home with community CAMHs interaction put in place as part of a care plan. We also saw that there was extensive liaison and joint assessment of the case between CAMHs and the hospital safeguarding lead nurse.

Risk assessment of the case was seen to be extensive and the child and family were referred to a specialist CAMHs parenting group. Through ongoing analysis of need a joint parenting assessment was requested with children's social services. CAMHs practitioners were also seen to provide reports to and attend child protection conferences regarding this case.

CAMHs practitioners in this instance had highlighted the need for combined, multi-agency holistic assessments to establish the reason for the child's mental health presentation and then work together to provide appropriate care and support to both the child and their family

3.17 CAMHs cases seen highlighted extensive support and communication with schools and GPs to ensure children and young people's needs were being met in a co-ordinated and holistic manner. This ensures that all agencies involved were fully informed of ongoing needs and plans of action. CAMHs workers consistently instigated multi-disciplinary and multi-agency meetings and these arrangements lead to good quality information sharing and thus contribute to positive outcomes for children and young people.

3.18 CAMHs practitioners we met with are committed to ensuring young people's mental health needs are met, despite the challenges of working with service users who were sometimes difficult to effectively engage with. Flexibility around the did not appear (DNA) policy and the use of assertive follow up with young people and other agencies involved before closing a case also supports this model. This ensures young people can access the services they require and receive continuity of care long term.

3.19 CASH practitioners are not routinely informed of the outcomes of referrals made to children's social care. Further, they are not routinely invited to attend child protection conferences nor are they advised if a child or young person is made subject of protection measures. In discussion with service managers we were advised that this is in some part due to Brook (the service provider) not promoting the important role that they currently undertake. This is currently under review within Brook.

3.20 No specific arrangements are in place for lead GPs to access additional group support such as a safeguarding seminar or forum, although there has been discussion about using protected learning time slots for practices to do this, rather than introduce an additional forum. We were later advised that protected learning time and peer groups are utilised for safeguarding training and discussion.

3.21 We saw no evidence of GP attendance at child protection conferences in any of the cases reviewed. Where written reports were provided by GPs, we saw that they were on an ad-hoc basis with variability in the style, quantity and quality of information contained within those reports. (**Recommendation 8.1**)

3.22 GPs do however actively await information from child protection conferences, and in one case seen, the GP challenged the information the mother had provided to the conference around her compliance with drug rehabilitation programme. This was clearly documented in the notes examined and the GP had actively followed up with the conference chair to have the minutes amended accordingly. This is seen as good practice.

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## 4. Looked after children

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4.1 We were advised during the review that the 'health passport' health information document for care leavers is at an advanced pilot stage but is not yet routinely provided to young people on leaving care. Although health information is provided to young people on leaving care, it is currently generally in the form of a letter and not a more personal and informal 'passport'. This was a recommendation following the safeguarding for looked after children (SLAC) inspection of 2012. However, where health passports have been used by looked after children (LAC) services we saw that they contained good quality detail in a format that was easily understood by both the young people who owned the document and by health professionals who might require access to it.

We were advised later that the health passport is in routine use but this was not evidenced in all cases as reviewed.

4.2 We heard how the designated doctor for safeguarding in Luton took the pilot version of the health passport to a LAC children's panel for their views on the style and type of information contained within the document. Following this, changes were made to the document according to the views expressed by the children's panel. Where changes were not considered appropriate, such as in relation to the way that important medical detail was presented, this was fed back to the group by the doctor explaining why the requested changes should not be made. This shows good communication and liaison with young people who use services in Luton.

4.3 There are no clear specialist service pathways for LAC to access CASH, substance misuse or teenage pregnancy support. Currently, LAC are signposted to access generic service provision which might not take into account or pay attention to the particular needs of this vulnerable group of young people. (**Recommendation 9.1**)

4.4 The recent increase in capacity in the LAC team has had a positive impact on the timeliness and choices of location for children and young people to access review health assessment appointments. It has also increased the ability for review health assessments for children aged over five to be completed exclusively by LAC nurses. In cases seen, there was a significantly positive difference in terms of quality in those completed by LAC team rather than school nurses or health visitors as per previous arrangements.

4.5 Despite the absence of a LAC health needs analysis, new service developments are underway to improve the service to care leavers, including the introduction of drop in sessions to hostels where many care leavers are placed and also in a youth centre. One follow-up contact in the year immediately after leaving care is also now undertaken. This is a positive development to ensure care leavers ongoing health needs are met.

4.6 Under the new model, health visitors will complete all review health assessments (RHA) in the under-five population. However, the current parameters of this are unclear and there is the potential that a different health visitor will therefore undertake the review health assessment from one year to the next even though the aim of the health visitor service is to provide consistency of a health visitor to under-fives irrespective of locality or residence. This lack of continuity can be detrimental to cohesive health planning.

Cambridgeshire Community Services NHS Trust (CCS) anticipates an increase in health visitor staffing will allow a caseload approach rather than corporate team management approach, but arrangements are not currently in place to support this. (**Recommendation 1.6**)

4.7 Some initial health assessments (IHA) and review health assessments (RHA's) as seen were episodic in nature and not outcome focused. Plans on most were not SMART and lacked clear desirable goals. There is significant risk that children and young people's health needs are not being met appropriately. However, we were advised that since July 2014 arrangements have been in place for the LAC lead nurse to quality assess all health visitor review health assessments. It is hoped that this process will lead to a more consistent quality in the health assessment process. We were further advised that the designated doctor quality assures all IHA's.

4.8 Most IHA's and RHA's are now completed in a timely fashion following a period of timescale breaches. CCS have employed innovative and flexible approaches to ensure the backlog RHA's were completed and this has informed future service specification to prevent similar delays. We are aware that Luton CCG requested an action plan from CCS to evidence how health professionals will manage those review health assessments one year on and this has been submitted with progress on those actions routinely reported.

4.9 There is effective use of local documentation for IHAs and RHAs rather than the use of British Association for Adoption and Fostering (BAAF) forms. In all cases seen, the child's voice was clearly heard and the narrative free text within the forms was highly detailed and comprehensive. However, in most cases, this information had not been transferred appropriately to the health plan to inform actions and onward referrals. In one case seen the practitioner undertaking the initial health assessment was clearly aware of the young person's needs but chose to task an individual via Systemone rather than place their concerns and needs of the young person on an individualised health plan. We could not therefore be assured that any follow up action was undertaken in this instance. (**Recommendation 6.2**)

4.10 Information contained on care plans examined (particularly within RHAs) did not make use of additional detail that was highlighted by other professionals working with young people. In some cases, there was a lack of clarity shown by the health professional in what information they could or should document and action, even when the young person was extremely vulnerable. In one case we examined we saw how the health professional was aware of a concern raised by a social worker and key worker around the misuse of drugs. This was backed up by an attendance at A&E regarding their drug use. However, the health professional documented that the young person did not disclose any concerning issues to them and as such reference to the issue was not raised in any associated health plan. (**Recommendation 6.4**)

4.11 Under the service remodel, children and young people are now being given choices on where and when their RHA takes place. This is seen as good practice as children and young people are more likely therefore to engage positively in their review health assessments when given such choices. However, we did not examine any evidence aside from a care leavers 'exit rating survey' that demonstrated young people being actively involved in service development or service user involvement work. This is seen as a missed opportunity. (**Recommendation 6.5**)

4.12 The LAC health team do not actively support young people to access health appointments despite the high risk that many of these young people will not engage with generic services. This leads to the potential that LAC do not have their health needs met. The LAC team mainly functions as a co-ordination service, which is in part due to capacity issues and we are aware of Luton CCGs attempts to ensure improved staffing levels as part of the re-commissioning process. (**Recommendation 1.3**)

4.13 We saw limited evidence of health professionals showing influence or using escalation to highlight safeguarding concerns, particularly around children's social service requests for information, providing consent or regarding the completion of strength and difficulties questionnaires (SDQ's). In some cases seen, there was no-one advocating for young people's health needs, leading to those young people's disillusionment with health services and the RHA process. We saw one young person comment, "I'll go to the assessment but I'll not get anything out of it." We were later advised that the LAC service escalates non-receipt of SDQ's.

4.14 There is a significant gap in information sharing and exchange between GPs and the LAC team which undermines holistic planning and management of young people's needs. We were advised that GPs are routinely contacted for IHA and RHA information, but in the documentation we examined we did not see any evidence of this information being provided. (**Recommendation 6.6**)

4.15 In one case we reviewed we examined evidence which demonstrated a lack of understanding in the role of the LAC nurses in providing ongoing support for the young person concerned. The health visitor had listed the LAC nurse as actioning support in obtaining sexual health services despite the LAC nurse having no involvement with the young person. The case would suggest there may need to be a review of the understanding of individual roles and responsibilities of LAC across all health disciplines. (**Recommendation 6.7**)

One case we tracked clearly illustrated historical isolated working practices across health disciplines and also the lack of collaborative working between agencies. The young person was recognised as being extremely vulnerable, but health and social services were fragmented in their approach to care provision for her and there was an over reliance by individual practitioners that other professionals and/or agencies were actioning concerns rather than a co-ordinated approach being taken to ensure this young person was safe and well supported. The young person's failure to attend for appointments across services was not routinely followed up and likewise other professionals tasked as part of the child protection process were not always made aware of the significance of failures to attend for appointments.

We were not assured that recent service developments have tackled these issues going forward to date.

4.16 Commissioners are aware of the capacity issues in the LAC team and have agreed funding to increase the capacity permanently by recruiting an additional full time LAC nurse. This should have a longer term positive impact on the LAC team offer and consistency in quality of review health assessments.

4.17 The multi-agency liaison team (MALT) training offer is strong, with systematic training via an accredited open-college network counselling skills training provision in place for foster carers. This is a positive approach to help prevent placement breakdown for the LAC adolescent population. This in turn contributes to stability and improved outcomes for LAC.

4.18 On most cases seen, young people were signing as consenting to both the initial health and review health assessments. As long as young people are aware of the implications of providing consent for multi-agency professionals to share information about them, this helps to engage the young person in their assessment and for them to start to take responsibility for their own health. However, consent was not routinely reviewed when young people's circumstances or support packages changed. In CASH we were advised that consent from young people is routinely provided verbally but even then case workers are not always signing documentation to evidence this.

4.19 Young people do not have a forum to input or report on their emotional wellbeing as part of strengths and difficulties questionnaire (SDQ) process. SDQ's are not used routinely to inform the health assessment process. This leads to risk that young people's needs are not fully being met and that determination in emotional wellbeing will not be identified. However, in CAMHS the implementation of the SDQ pathway has had a positive impact on the amount of training, coaching and education staff members can provide to social workers to assist their completion of SDQ's. (**Recommendation 6.8**)

4.20 CAMHS practitioner's report an increase in the numbers of social workers requesting more information and support following these recent training sessions and it is anticipated there will be a positive impact on the numbers of SDQ's completed. Children's needs will therefore be more robustly identified than previously. This work to ensure social care staff have a clear understanding of mental health issues is commendable.

4.21 We examined how in one case workers with LAC experience within CAMHS showed awareness of the complex needs of a young person and employed a flexible approach to facilitate engagement with CAMHS, including providing appointments with a consistent staff member. Staff travelled to the young person's placement outside of Luton and arranged appointments around his training commitments to encourage him to attend CAMHS on a long term basis. This is seen as good practice in supporting vulnerable young people.

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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 It is recognised that Luton CCG is working closely with partner agencies, including local and across border police, regarding recognised safeguarding concerns posed to children and young people living in Luton due to issues seen as specific to the area. This is seen as pro-active work to help safeguard those young people, including where risks might be posed by the activities of other family members or associates.



5.1.2 Luton CCG, although not directly the commissioning body for health visitors, are monitoring the planned recruitment of a further 30 health visitors to reach a total of 70 whole-time-equivalent staff members planned to be in place by March 2015 in line with call to action workforce targets. They are further aware of the training and support requirements of such an influx of staff and are likewise monitoring provider arrangements in this area. This is seen as good practice.

5.1.3 We examined evidence that demonstrated how Luton CCG put in place effective safeguarding children strategies on initial notification of serious case reviews taking place. This demonstrated pro-active work to safeguard vulnerable young people even before official investigations took place.

5.1.4 Luton CCG report good and effective working relationships with other agencies involved in the protection of vulnerable children and young people. Luton is considered a small area and geographically teams work in close proximity of each other which promotes good working relationships. However, the effectiveness of inter-agency working was not consistent across all areas of care provision in Luton in both documentation seen and on discussion with health practitioners. Little evidence was seen as to the monitoring and quality assurance of effective inter-agency working. (**Recommendation 1.4**)

5.1.5 The CCS named nurse for safeguarding children routinely undertakes operational duties alongside strategic work due to current staff shortages. This places obvious pressure on effective quality assurance of her current workload, but the recent successful recruitment of a whole time lead specialist nurse for safeguarding children and child deaths is seen as a positive move to reduce those pressures.

5.1.6 The school nurse team lead will now be attending the sexual exploitation risk assessment conference (SERAC) meetings as a panel member. To date there has been no health representation at the panel and it is hoped that she will be able to feedback CSE concerns to the school nurse team as they currently receive no information from the panel despite making CSE referrals to it.

5.1.7 The corporate caseload management model is not conducive to information exchange, particularly between health services and GPs. The implementation of link meetings between health visitors and GPs is designed to bridge this gap. However, we saw limited evidence of consistent health visitor attendance at these meetings due to ongoing capacity issues. A formalised offer to GP's regarding these meetings is currently being discussed and current plans to increase health visitor numbers will help to address this issue.

5.1.8 The lack of a robust DNA policy negatively impacts on the health visitor's ability to ensure children's safety and that families support needs are being met in a timely way. Currently, individual health visitors make decisions on when or how to follow up children and young people's failure to attend for appointments. Assertive follow up following DNA's requires more management oversight and audit to ensure best outcomes and to ensure consistent information exchange with other disciplines e.g. GPs. (**Recommendation 3.5**)

5.1.9 All cause for concern forms used in midwifery services are reviewed by the safeguarding maternity team to ensure any issues have been analysed and actions taken, with appropriate plans being put in place to protect mothers and unborn children. This includes concerns around substance misuse, children's social care involvement and drug and alcohol use. Plans are then placed in hospital notes and are forwarded to the health visitor team.

5.1.10 Midwifery services are responsive to changing needs and local patterns, and the rising numbers of vulnerable women needing observation clinics led to action being taken to increase the number of clinic slots available. This resulted in waiting times dropping from 14 weeks to four weeks.

5.1.11 Learning from reviewed cases has resulted in a change to community team protocols within midwifery to ensure consistent follow up in cases and reduce risk. Visits required are now logged in a team diary and must be allocated and checked off every day by team, rather than by individual case holders.

5.1.12 In adult mental health, thorough risk assessment and management oversight is hampered by the team not having a database of service users who have children or contact with children, or those where children are on a child protection or child in need plan. Adult mental health used to keep a record of known children but this was discontinued some years ago. (**Recommendation 2.8**)

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## 5.2 Governance

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5.2.1 There is no formal policy or pathway in place for staff to follow in relation to female genital mutilation (FGM) and CSE. Currently, staff raise concerns via routine safeguarding procedures. It was recognised by the CCG and Luton local safeguarding children board (LSCB) that FGM appears to be an infrequent occurrence in Luton and as such reliance is placed on providers to make staff members aware of the issue. However, Luton CCG do not currently quality assess or audit the effectiveness of those processes. There is a risk to children and young people where, by their being no formal pathway in place for staff to refer to in relation to FGM and CSE, that occurrences or the risk of FGM and CSE taking place might be missed or not recognised and effective and early safeguarding actions put in place to protect young people. (**Recommendation 1.5**)

5.2.2 The use of a multi-agency safeguarding hub has been discussed at LSCB but as yet it is considered inappropriate for implementation in the Luton area. As part of the ongoing review of commissioning arrangements a referral pathway to the safeguarding hub 'no wrong door' is also being considered. This would make it possible for anyone to make a referral into the safeguarding hub, not just health professionals.

5.2.3 All children and young people who present at A&E are routinely notified to the 0 – 19 team of school nurses and health visitors. There is currently no quality assurance or filtering of the information before it is sent, this being routinely undertaken by the receiving practitioner which takes time out of their general working day. Due to the quantity of notifications necessary we were also advised that there were often inconsistencies in the timeliness of notifications being received in the absence of a paediatric liaison health visitor role. This can impede health visitor ability to make a timely response and action concerns. (**Recommendation 7.3**)

5.2.4 Following a recent successful recruitment drive, midwifery is now operating at full capacity with one midwife to 29 mothers' ratio. This is a positive development since September 2013 when the hospital inspection undertaken at the time saw a ratio of 1:33 which was outside of good practice guidelines. However, skill mix continues to be an issue and there is currently a higher proportion of less experienced midwives in the team.

5.2.5 Luton CCG and LSCB have, throughout the procurement process, been aware of the potential risks posed to vulnerable children and young people if transition to a different provider becomes necessary. We heard how the focus on potential service provision to children and young people was on the quality of those services proposed and how best vulnerable people would be safeguarded. Where the recognised risk was seen to be from transition from one service provider to another a transition governance structure was put in place to ensure potentially vulnerable people are suitably protected from risk.

5.2.6 We spoke with staff members who all told us that they had been kept up-to-date on change progress and that in the interim it was 'business as usual'. They were all keen to provide appropriate care and support to children and young people throughout the procurement process.

5.2.7 The adult mental health service is working between electronic and paper records and the transfer between systems has highlighted risk in relation to incomplete information being uploaded. In cases examined safeguarding information was either not transferred or was incomplete. This is an area that will require urgent action to reduce risk. (**Recommendation 2.7**)

5.2.8 Quality assurance for the review health assessment process is under developed, leading to inconsistency in the detail and quality of information recorded. A new 'East of England' quality assurance framework tool has been implemented to address this. However, as it has only recently been implemented and it is therefore difficult to fully assess its impact.

5.2.9 Recent changes to the Systemone computer system have given CCS the ability to audit and profile LAC caseload. This will provide them with the means to undertake formal evaluation of service needs and outcomes. At the time of our review we were not aware of this having been implemented or undertaken as yet.

5.2.10 In LAC services we saw that commissioners have implemented more stringent monitoring of provider activity since the last SLAC inspection of 2012 and the introduction of the monthly LAC health group has driven forward developments in the LAC service model and contributed to quality and consistency.

5.2.11 A business case has been put forward for an increase in LAC staffing to provide a leaving care service to young people in preparation for them leaving care. CCS as a provider has made attempts to recruit into the post but as yet have been unsuccessful. When filled, this post will provide a useful service to those young people preparing to move away from the more supportive LAC environment.

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## 5.3 Training and supervision

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5.3.1 Safeguarding supervision within paediatric A&E is provided on an ad-hoc basis and is not structured. There is no requirement on staff to attend for routine supervision unless directed to by a senior member of staff or at their own wish. Whilst as-and-when required safeguarding supervision is recognised as useful there is an inherent risk that cases might be missed which should otherwise have raised cause for concern, such as when staff members fail to recognise a safeguarding risk that regular structured supervision might have recognised. (**Recommendation 7.4**)

5.3.2 Health professionals are increasingly being called to give evidence in court at child protection hearings. We spoke with one health visitor who told us that she had recently attended court to give evidence and was cross examined by the defence team whilst doing so. We were told she had not received any training to give evidence in court and further that due to low staffing levels she had to attend alone and unsupported.

We were told by the named nurse for safeguarding children that planning is underway to provide appropriate training to staff in relation to giving evidence in court. (**Recommendation 6.9**)

5.3.3 Group safeguarding supervision has recently been implemented for health visitors and school nurses alike. Multi-disciplinary meetings take place every six to eight weeks and staff members are encouraged to bring cases for peer discussion and problem solving. Some staff members we spoke with saw this as a positive way to help protect vulnerable young people. However, some practitioners told us they have concerns about the viability of this with the planned addition of many new staff in the team later this year. Staff members also told us that they feel supervision on lower level cases of concern (e.g. low level neglect) would be beneficial to them.

5.3.4 Midwives have access to a high level of support and supervision for safeguarding due to the visible presence of the safeguarding maternity team and the on-call named midwife. We saw evidence of the team supporting midwives in cases and attending discharge planning meetings to ensure new born children's needs are met.

5.3.5 LAC health practitioners are provided with 'in house' level three safeguarding training which is multi-disciplinary and not multi-agency and thus is not in line with the latest intercollegiate guidance 2013. This was also seen within paediatric A&E. (**Recommendation 6.10**)

5.3.6 In adult mental health we saw that level three safeguarding training is multi-agency based and SEPT monitor all training as provided and attended by staff members on a weekly basis. This is good practice.

Within adult mental health safeguarding supervision arrangements for children are not robust with the emphasis in supervision being oriented toward adult with little consideration given to 'the hidden child'. (**Recommendation 2.9**)

5.3.7 LAC health practitioners have access to regular, structured safeguarding supervision from the named nurse for safeguarding which is undertaken in group sessions.

5.3.8 Within CAMHs, we were advised that named nurses complete audits of the types of safeguarding supervision requested by staff members and so identify themes and trends emerging for practitioners in local areas. We have since been advised that safeguarding supervision is available in clinical supervision, weekly case discussion team monthly meetings and senior management group meetings.

5.3.9 CASH practitioners are trained to safeguarding level two. This is not in line with intercollegiate guidance 2013 for practitioners who have direct contact with vulnerable young people. Likewise, safeguarding supervision is not structured and currently takes place as part of routine clinical supervision.

5.3.10 Across all health service provision, records we examined contained limited recorded detail of safeguarding supervision and actions to take forward following supervision. It was difficult therefore to evidence if individual cases had been discussed at supervision, especially cases where child protection measures were in place. (**Recommendation 6.11**)

5.3.11 South Essex Partnership Trust staff have access to ongoing training and new research on safeguarding issues, from both an adult and child perspective. Whilst this is not mandatory, demand for attendance currently exceeds supply. CAMHS level 3 training is multi-agency therefore those staff are trained in compliance with intercollegiate guidance.

5.3.12 Access to supervision and signposting to information referral processes for GPs was seen to be open and accessible from the named GP.

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# Recommendations

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## **1. Luton CCG should:**

- 1.1 Ensure staff are aware about how and when to make referrals to specialist services and further that systems are in place to record non-attendance once an appointment has been made.
- 1.2 Review the current safeguarding escalation policy and ensure it is fully understood by staff so that they have clear guidelines to both refer and adhere to when assessing risk.
- 1.3 Assure themselves that as a part of the re-commissioning process due consideration is given to LAC staff being able to proactively support young people in engaging with generic services.
- 1.4 Implement quality assurance measures across all relevant areas of care provision in Luton so that the CCG can assure themselves as to the quality of inter-agency working to protect vulnerable children and young people.
- 1.5 Implement a formal, auditable policy and pathway for staff members to refer to in relation to FGM and CSE.
- 1.6 Implement clear guidance and parameters to health visitors to ensure continuity and consistency when undertaking LAC review health assessments.

## **2. Luton CCG and South Essex Partnership Trust should:**

- 2.1 Ensure all staff members are made aware of, and have clear pathway access to, bank psychiatric staff when admissions are made to paediatric wards pending formal assessment by CAMHs.
- 2.2 Ensure adequate consideration is given to the provision of suitable mental health placements for children and young people requiring hospital admission so that placement on general paediatric wards is kept to a minimum.
- 2.3 Ensure adequate time is made for CAMHs workers to engage proactively with high risk members of the community as part of an already identified gap in service provision.
- 2.4 Ensure appropriate staffing levels and support is provided in the community setting to ensure hospital admissions for cases where lower tier CAMHs intervention might be suitable, do not routinely take place.

- 2.5 Ensure pathways and processes are in place for adult mental health practitioners to follow to ensure appropriate assessment and analysis of risks to children is undertaken, managed and documented.
- 2.6 Review training processes and staff awareness in adult mental health to recognise and document potential risk to the unborn child.
- 2.7 Strengthen current systems to ensure all relevant safeguarding information is transferred from paper records and electronic and assure themselves that in cases where information has already been transferred that it has been accurate and not missing in detail.
- 2.8 Consider the re-implementation of a database of children at risk in adult mental health cases to allow for more thorough risk assessment and managerial oversight of recognised risk.
- 2.9 Strengthen safeguarding supervision arrangements for adult mental health staff to take into account children living with, or accessible by, adult clients.

**3. NHS England and Cambridgeshire Community Services NHS Trust should:**

- 3.1 Review current specialist support provision within health visitor teams as a part of the current re-commissioning process to ensure staff awareness of domestic violence and teenage parenthood that mirrors service provision in midwifery services.
- 3.2 Ensure target antenatal visits at 28 weeks are routinely undertaken in relation to vulnerable pregnant women and that appropriate quality assurance measures are put in place so that inconsistencies in the timings of such visits does not occur.
- 3.3 Assure themselves that systems are in place and that staff have capacity to routinely undertake maternal mood assessments and that they are followed up where risk of declining mental health is identified.
- 3.4 Systems should be put in place to ensure multi-disciplinary and multi-agency information sharing regarding incidents of domestic violence which may impact on vulnerable young people are routinely shared. This is particularly important considering the current absence of a MASH.
- 3.5 ICCS to implement an auditable DNA policy and pathway for staff to follow as opposed to relying on individual staff members to make decisions as to follow up action following non-attendance.

**4. Cambridgeshire Community Services NHS Trust and Luton and Dunstable University Hospital should:**

- 4.1 Ensure systems are put in place to ensure joint working and information sharing is made routine practice between health visitors and midwives so that families who might benefit from an enhanced health visitor package are identified at an early stage.

**5. Luton and Dunstable University Hospital should:**

- 5.1 Ensure appropriate and timely specialist midwifery support services are offered and provided to expectant mothers living with mental health difficulties.

**6. Luton CCG and NHS England should:**

- 6.1 Ensure systems are in place to establish significant family member details are, where possible, obtained and recorded clearly in patient/client records across all services.
- 6.2 Ensure action plan development following the risk assessment process is coordinated and developed across all services in Luton to provide care plans that are both SMART and individually person centred.
- 6.3 Ensure communication and information sharing pathways are established and maintained between health visiting and midwifery services
- 6.4 Have arrangements in place which enable them to assure themselves that staff members are made clearly aware of how to access and make use of information provided by multi-agency and multi-disciplinary teams across all services to inform decision making processes.
- 6.5 Review the effectiveness of service user involvement strategies and surveys to ensure they are actively hearing the voice of young people and involving them when developing service provision.
- 6.6 Ensure a clear pathway is in place for LAC staff and GPs to adhere so that requests to provide information to inform IHA's and RHA's are routinely made and answered.
- 6.7 Strengthen staff awareness of individual roles and responsibilities regarding the care of looked after children across all health disciplines in Luton.
- 6.8 Ensure pathways already in place are consistently adhered to so that information contained within SDQ's is routinely used to inform the health assessment process.



- 6.9 Ensure appropriate training and support is provided to health professionals who are increasingly being called to give evidence at court in child protection hearings.
- 6.10 Audit safeguarding training across all commissioned providers to assure themselves that training provision is in line with the latest intercollegiate guidance.
- 6.11 Ensure appropriate recording in client case notes of supervision discussion and resulting actions in individual cases.

**7. Luton CCG and Luton and Dunstable Hospital should:**

- 7.1 Ensure recognition of risks associated with paternal health and lifestyle choices are assessed at the booking in stage with midwifery services and that appropriate action is taken where risks are identified.
- 7.2 Ensure provision is made to allow for the attendance at child protection meetings of relevant midwifery health professionals and that quality assurance processes be put in place to monitor attendance.
- 7.3 Review the current system of A&E notifications to health visitors and school nurses to ensure adequate filtering is undertaken of information sent following attendance at the unit of young people aged 0 – 19 and that this information is shared in a timely manner.
- 7.4 Strengthen safeguarding supervision arrangements within paediatric A&E to ensure regular, structured supervision takes place and is recorded within patient notes, action plans and care plans.

**8. NHS England and GPs should:**

- 8.1 Strengthen oversight and the quality of information provided by GPs to Inform child protection meetings. This is an area already recognised by commissioners as requiring improvement.

**9. Luton CCG and Cambridgeshire Community Services NHS Trust should:**

- 9.1 Ensure clear pathways are provided for staff members to follow when referring LAC children for specialist service provision.

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## Next steps

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An action plan addressing the recommendations above is required from NHS Luton 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.