

Review of health services for Children Looked After and Safeguarding in Bedford Borough

Children Looked After and Safeguarding

The role of health services in Bedford Borough

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Provider services included:	South Essex Partnership Trust Bedford Hospitals Trust East London NHS Foundation Trust CAN drug and alcohol services Brook sexual health services
CCGs included:	NHS Bedfordshire CCG
NHS England area:	Midlands and East Region
CQC region:	Central West
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Summary of the review

This report records the findings of the review of health services in safeguarding and looked after children services in Bedford. 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 Bedford, 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 2015.
- 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 93 children and young people.

Context of the review

Most of Bedford Borough residents, 97.1% (162,416 residents) are registered with GP practices that are part of the NHS Bedfordshire Clinical Commissioning Group (CCG). There are some Bedford Borough residents that are registered with GPs that are a part of further CCGs but these are much lower in number.

The current 2014 Child and Maternal Health Observatory (ChiMat) profile identifies that children and young people make up 25.2% of Bedford Borough population with 37.2% of school age children being from a minority ethnic group.

On the whole, the health and well-being of children in Bedford Borough is generally similar to the England average. The infant and child mortality rates are also similar to the England rates.

The rate of looked after children under age 18 per 10,000 children as at March 2013, was similar to the England average. The percentage of looked after children having up to date immunisations when compared to the England average was significantly higher.

ChiMat reports that in 2013, the overall percentage of all Bedford Borough children having MMR vaccinations and other immunisations such as diphtheria, tetanus and polio by aged two was significantly better when compared against the England average.

The indicator for the rate of A&E attendances for children under four years of age in 2011/12, was significantly better when compared to the England average rate. The rate of hospital admissions caused by injuries for children under 14 years of age was significantly better when compared to the England average. The rate of hospital admissions caused by injuries for young people between the age of 15 and 24 years was not significantly different when compared to the England average.

The rate of hospital admissions for mental health conditions and hospital admissions as a result of self-harm in 2012/13, were not significantly different when compared with the England average.

In 2011, the conception rate for under 18 year olds per 1000 females and the percentage of teenage mothers in 2012/13 was not significantly different to the England average.

In 2014, the DfE reported that Bedford Borough had 180 looked after children that had been continuously looked after for at least 12 months as at 31 March 2014, excluding those children in respite care. The DfE reported that 86.1% (155) of these children received their annual health assessments. This percentage is lower than the England average of 88.4%. The percentage of looked after children that had their teeth checked by a dentist in Bedford Borough was 88.9% (160), which is higher than the England average of 84.4%. As at 31 March 2014, there were 50 looked after children who were aged five or younger, the DfE reported that all of these looked after children had up to date development assessments.

A strengths and difficulties questionnaire (SDQ) was used to assess the emotional and behavioural health of looked after children within Bedford Borough. The average score per child in 2014 was 16.1. This DfE score is considered to be borderline cause for concern and is higher than the England average of 13.9. The average score over the last two years in Bedford Borough has increased slightly which suggests that the emotional health of looked after children maybe deteriorating.

Commissioning and planning of most health services for children are carried out by Bedfordshire Clinical Commissioning Group (CCG) Children's commissioners and Central Bedfordshire and Bedford Borough Local Authorities.

Commissioning arrangements for looked-after children's health are the responsibility of Bedfordshire CCG and the looked-after children's health team, designated roles and operational looked-after children's nurse/s, are provided by South Essex Partnership Trust (SEPT) Community Health Services in Bedfordshire.

Acute hospital services are provided by Bedford Hospital NHS Trust.

Health visitor services are commissioned by NHS England and provided by SEPT Community Health Services in Bedfordshire.

School nurse services are commissioned by Bedford Borough and provided by SEPT Community Health Services in Bedfordshire.

Contraception and sexual health services (CASH) are commissioned by Public Health and provided by Brook & Terence Higgins Trust.

Child and Adult substance misuse services are commissioned by Public Health and provided by CAN.

Child and Adolescent Mental Health Services (CAMHS) are provided by East London Foundation Trust

Specialist facilities are provided by NHS England

Adult mental health services are provided by East London Foundation Trust

The Bedford Borough integrated inspection of Safeguarding and Looked After Children's Services took place in January and February 2012 as a joint inspection with Ofsted. Recommendations from that inspection are covered in this review.

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 heard from children and young people in care:

“it would be nice to be able to talk to someone when you feel you need to, without having to go through your foster carer. To know there was somewhere you could go or someone to get in touch with right then”

In terms of health reviews, we heard that *“it can be hard to talk about difficult or embarrassing things in front of your foster carer or if you don’t know the person”*.

A young person in care told us that *“health things could be more colourful to make them more interesting to us”*.

Regarding review health assessments: *“I like that they are private and don’t get sent onto others”*

“everything that I say to her (LAC nurse) she goes away and discusses with someone, for example if I have a problem with NHS or the dentist she will go with me”

“if I have any problems with the doctors she will help and ring up, I’ve changed GP recently because I wasn’t happy, I want a doctor that I feel comfortable around, some just sit there like I’m being interviewed”

Carer’s told us:

“The quality of initial health assessments depends on who you get. If the child is already seeing a paediatrician they should be able to carry on for continuity as it’s very important to children in care who have so many people involved with them. I always ask to see the person who is already involved but it’s not automatic.”

“The paediatricians can be fantastic or else some don’t understand what it means to be in care.”

“the LAC nurses do a tremendous job, especially with the older children, trying all sorts of ways to encourage them to talk about issues.”

“The child development centre at Kempston and the speech therapist there, are both wonderful, phenomenal.”

“the speech therapist was great for one of the children, but we had to go through the usual route first, of group sessions in a big room. They didn’t understand how difficult that was with us and the birth parent there, and no confidentiality but although these were needs we identified in the health plan, we had to go down the general assessment route which isn’t suitable for LAC. We had already tried all the basics, the child needed more and it took nearly a year to get one to one sessions which were in the end fantastic.”

“The appointments for health reviews are made well in advance and they discuss things with you beforehand so it keeps it as short as possible for the child and they get all the information in place.”

“The health visitors have been amazing and supportive with both the children and me. They were superb and I couldn’t fault them at all”

“The LAC nurses are very professional and always contact me by telephone to arrange the medicals and check on information. For example they will check when the last eye test was and if the children have seen a dentist, or when we last saw CAMHS”

“It took a long time to get a CAMHS service for the children, we waited two years. The children had very muddled heads and we couldn’t sort them- we are foster carers not specialists. When you have traumatised children you need help. If we’d got it earlier it might have been better for the children”

With regard to the current CAMHS service we heard “It’s brilliant. The children go fortnightly and are seen by separate therapists because they have different needs. I go to the support group and I can go every week, it’s fantastic”

“I get a great GP service, if the children need to be seen I can ring on a morning and be seen the same day. The GP knows I’m a carer and always asks how I am and how I’m coping”

Parents told us:

“my health visitor has been great, always there to give advice”

“my midwife is most amazing, she is very warm and never treats my questions as silly. She will work around me, for example because I have a lot of children she sees does home visits to save me having to go to the clinic”

“I definitely feel listened to, especially by the midwife, for example I had a lot of problems with my previous pregnancy and was worried, she listened and reassured me”

“Sometimes I wish they would liaise more with each other, a lot of health professionals don’t talk to each other and I end up saying things twice”

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 Midwifery booking in sessions are flexible and inclusive ensuring all women have access to appointments in a range of locations across the week and at weekends. This facilitates early access to health advice. There are good opportunities to see expectant women alone or at home. Cases sampled illustrated the benefits of home visiting in completing a thorough risk assessment, as it identified concerns which then enabled enhanced support to be offered at an early stage. However we are aware that home visits is not a departmental standard for all practitioners. (**Recommendation 2.1**)

1.2 A robust parent craft offer is in place to ensure everyone has access to parent education sessions. This includes a specialist programme for Yarls Wood Immigration Detention Centre. Following feedback that many pregnant women in Yarls Wood were unable to complete the full course of parent education due to placement moves, a "train the trainer" model has been established to allow staff in the centre to support women and their unborns more effectively. The maternity education team are also developing a collaborative 'Birth and Beyond' programme in conjunction with South Essex Partnership Trust (SEPT) health visiting services. Teenagers are able to access individualised parent education and the monthly ante-natal fathers group means all families can access advice and support on becoming a new parent.

1.3 Within maternity services we saw good compliance with recording of partner's details. Whilst midwifery practitioners told us that domestic violence (DV) is a routine enquiry, current paperwork does not easily support the confidential recording of this and we found limited evidence recorded in notes that questions about domestic violence had been asked. We are aware that there is some exploration of file coding to highlight DV questions, and the maternity service is well engaged with the local Multi Agency Risk Assessment Conference (MARAC) arrangements. (**Recommendation 2.2**)

1.4 Aside from key workers for teen pregnancies, arrangements for access to specialist midwifery for teenagers and women with mental health or substance misuse issues are limited. Apart from the safeguarding midwife, there is no availability of either specialist practitioners or clinics to ensure women are able to access the additional health support they need through enhanced visits. We heard how the newly established family nurse partnership is eagerly anticipated to effectively support vulnerable young parents in both the ante-natal and postnatal stage. (**Recommendation 2.3**)

1.5 Early identification of needs for expectant mothers is facilitated by comprehensive risk assessment with clear onward referral to the Multi- Agency Safeguarding Hub (MASH) as appropriate. However we saw some cases where risks were identified but women were not always followed up by midwives to ensure their health needs were being met. This was particularly in cases held outside of formal child protection measures. The lack of use of chronologies of significant events does not support midwives to identify drift in cases. In some cases we saw an over reliance that other disciplines were involved and therefore they would be managing risks, without effective checks to ensure this was the case. (**Recommendation 2.4**)

1.6 Person centred planning around vulnerabilities in maternity services is not fully established. This is a gap for families who do not meet higher level thresholds of support. Opportunities to involve the woman in planning for birth and for midwives on the delivery suite and postnatal wards to better support unborns are therefore being missed. (**Recommendation 2.5**)

1.7 In maternity services, we saw good awareness of female genital mutilation (FGM) alongside thorough risk assessment; including onward referrals to the MASH. All practitioners were clear when to refer to ensure women and children were offered support and safeguarded.

1.8 There are limited formal opportunities in maternity services to liaise with other disciplines such as adult mental health and substance misuse to ensure succinct joined up working. There are currently no arrangements for midwifery to attend GP practice safeguarding meetings in areas where they are happening, or to liaise with colleagues in social care as part of a safeguarding liaison forum. (**Recommendation 2.6**)

1.9 We have seen well developed service user involvement in maternity services with some tangible changes being made from both the maternity service liaison group and labour ward forum. Examples include the introduction of a “family in need” room for extended family to stay within the support structure of the hospital to help support new parents together in complex cases such as parents with mental health issues or ongoing medical needs. This is a positive development to ensure families who would benefit from additional help in the early days of parenting are well supported.

1.10 Regular links between midwifery and health visiting are robust and fully support cohesive transitions and smooth information exchange between services, thus ensuring children's and family needs are being met.

1.11 Following the impact of call to action on health visiting services, the imminent re-instigation of universal early support services will ensure children and families in Bedford will have access to a range of evidenced based interventions and programmes. This includes early help support groups such as "bumps, babes and beyond" with evening sessions to facilitate access for all parents and a postnatal depression support group including access to a dual trained health visitor/counsellor.

1.12 The additional capacity in the health visiting team has also positively impacted on increased levels of visiting and health visitor's ability to undertake maternal mood assessment on a more regular and routine basis. This ensures women with early signs of postnatal depression are offered support quickly.

1.13 At present, health visitor's offer targeted ante natal visits which have resulted in those families who require additional support being identified at the earliest opportunity. This will be further strengthened by the introduction of an enhanced healthy child programme to include universal antenatal visits by the end of 2015, thus allowing all families to access support and intervention at an early stage.

1.14 Good partnership working is in place between health visitors and children's centres which is underpinning cohesive support being offered to families with vulnerabilities. This includes integrated children's development reviews and monthly liaison meetings between health and children's centre staff. The purpose of this is to update all professionals involved with families who are accessing support, to ensure their needs are being met on an ongoing basis.

1.15 Health visitor's attendance and engagement with team around the child meetings (TAC) is good, and we saw some good joint working and liaison between disciplines on individual cases. Liaison arrangements with midwifery are now developing well, following initial issues with communication and notification of new bookings. This has now been resolved via the implementation of electronic notification from midwifery to health visiting to ensure that families can receive earlier support via a health visitor home visit.

1.16 Recent changes to staffing in the MASH, including the introduction of a co-located health visitor post, have resulted in positive outcomes. This includes ensuring all health professionals are fully informed of domestic violence incidents. Until recently, police notifications of domestic violence were not widely distributed and often a health practitioner's first awareness of domestic violence in a family was when a Multi-Agency Risk Assessment Conference (MARAC) enquiry was generated. The implementation of a health visitor post in the MASH now ensures all health teams are aware of low levels of domestic violence quickly and can offer appropriate advice and support to victims in a more timely way.

1.17 Health visiting and school nursing files reviewed demonstrate that attendances of children at local emergency departments are routinely copied and recorded in patient records. This means that both teams have the most up to date information on health activity within a family and can offer support and follow up as appropriate. However, non-attendances for planned care such as physiotherapy appointments are not highlighted, meaning there is a significant information gap for families who do not attend appointments. There is therefore limited ability to follow up and ascertain if children's ongoing health needs are being met.

(Recommendation 1.1)

1.18 Individual health visitors have recently been identified as a link for each GP practice, however, relationships are variable across the area. Some health visitors are attending GP practice meetings routinely in the practices where they exist, but others have less opportunity to meet on a regular basis. Where these links have been well secured and there is regular liaison, children are being safeguarded more effectively. Multi-disciplinary liaison meetings are not routine in all GP practices. This means there is a lack of opportunity for information exchange to ensure the needs of the child and family are met in a co-ordinated manner. In practices where this is taking place, vulnerable families are engaging with early help services.

(Recommendation 4.1)

1.19 The co-location of school nurses and health visitors in the "0-19 service" is helping to foster good working relationships between teams and provide holistic support to families. We saw many case examples of flexibility between services including, where appropriate, health visitors holding cases beyond a young person reaching school age. For some families, continuity of practitioner was considered beneficial to ensure continued engagement with early help services and positive outcomes. Such cases are regularly reviewed so that the health visitor will not hold the case for an inappropriate length of time and handover is completed with the child and families full co-operation.

1.20 School nurses in Bedford Borough now provide 'drop in' services at all but two schools where children and young people can discuss issues that may be troubling them. This is a positive way of intervening early to provide care and support, and is often prior to children and young people going to other services such as CAMHS when in crisis. CAMHS practitioners have provided training to school nurses in managing mental health problems at tier one and two. We were told by school nurses that this has been beneficial in their early intervention work to best support children and young people with emotional wellbeing needs.

1.21 There are no specialist school nurses to provide care and support specifically to the children of travelling families and immigrants to the country, especially those who might not be registered with a permanent GP. This is a missed opportunity for South Essex Partnership Trust (SEPT) to assure themselves that the services they provide are reaching those children and young people who may be difficult to access, and who might also not be in receipt of appropriate healthcare provision. This will be brought to the attention of Public Health England.

1.22 There was some confusion amongst school nurses we met with regarding their roles and responsibilities in relation to recognising and appropriately referring children at risk of sexual exploitation (CSE). Some staff members we spoke with were unsure how to appropriately recognise signs of CSE and likewise they were not aware of the local changes in arrangements from the sexual exploitation risk assessment conference (SERAC) to the CSE panel. Practitioners were not using the borough wide CSE central identification tool and some additional work on raising awareness and coaching on the scoring element of this should be considered. This will be brought to the attention of Public Health England.

1.23 Children who attend the emergency department (ED) at Bedford General Hospital are seen in suitable facilities and assessed by appropriately trained staff in a timely manner, with review by a senior member of staff where indicated. The paediatric liaison nurse check on all under 18 attendances is an effective safety net to provide an oversight on any cases that may require further support. It also ensures that the needs of children and young people are followed up after leaving the hospital.

1.24 Emergency department staff have access to a range of information to assist with effective decision making to help keep children and young people safe. Records reviewed contained a note of the child's previous attendances, the identity of the adult the child attended with, details of the child's parents, and a note of the child's GP and school. Any previous attendances by the child automatically resulted in a call for the child's previous notes to be checked prior to examination.

1.25 We saw paediatric case examples of good safeguarding risk assessment by clinicians and appropriate referral to health visitors to ensure prompt follow-up visits in the community. However documentation in ED is not NICE compliant and does not include supportive prompt questions on the paperwork to assess safeguarding risk. The current risk assessment process is over reliant on the knowledge, skill and professional curiosity of the clinician to fully risk assess children and young people. **(Recommendation 2.7)**

1.26 Clear processes are in place for ED practitioners to document and alert their concerns around children and family vulnerabilities. Where concerns were identified, such as from inconsistent accounts of injury or delays in presentation, an additional paper record known as "information sharing and consent form" was completed. This enabled staff to seek and document the consent of the adult with parental responsibility to gather and share information. In the examples we looked at, we saw that this supported staff in adding to their knowledge about a child's circumstances and informed their decision making where they had concerns. This ensured support and safeguards were put in place.

Staff on the paediatric ward took steps to offer early intervention beyond children's immediate medical needs when opportunities arose. In one case, this included a referral to a counsellor to support the new parents of a premature baby who were experiencing attachment issues due to levels of medical intervention. Support included parenting demonstration, baby care and talking therapy to allay fears and resulted in increased bonding between parents and baby.

1.27 Young people have good access to sexual health services and emergency contraception from Brook both via local pharmacies, school drop in and the “Central Hub”. A well-established outreach service is available for young people at highest risk including those in the local Immigration Detention Centre. The young people’s outreach nurse provides a very flexible service to many young people who otherwise would not attend clinics, including home visits to advise, test, treat or provide contraception.

1.28 Brook CASH services have good links with the termination of pregnancy service and hold a clinic on site, where they receive referrals from midwives to support young people and advise on avoiding subsequent pregnancies. This service model is believed to have contributed to the reductions in teenage pregnancy rates in Bedford borough. The service uses data to aid targeting and effectiveness of their services and has a clear understanding of demographic patterns in the Borough. This has allowed services to develop to better meet needs that are identified and to provide optimum support to young people requiring a contraception and sexual health service.

1.29 While there is awareness in the CASH service about child sexual exploitation (CSE) and female genital mutilation (FGM), this is not included in the list of vulnerabilities the service encompasses in its risk assessments. This is a gap. Risk assessment documentation within CASH could be strengthened to include CSE and FGM. The service acknowledges that there is scope to improve the assessment tool and extend the questions with the benefit of recent research findings. Brook are planning to roll out a more comprehensive risk assessment with additional questions. Use of the LCSB CSE assessment toolkit was not evident. Whilst staff are said to be aware of risk indicators, there was no readily accessible quick prompt list in evidence. This will be brought to the attention of Public Health England.

1.30 Brook CASH services also manage the local chlamydia screening programme and employ a results officer who is vigilant in reviewing screening information. This has resulted in some good identification of safeguarding concerns through the postal screening test system, such as a teenager who stated that her partner was over 50. In this case the worker alerted the CASH clinic so that this and the risk of CSE could be further explored at a follow up appointment.

1.31 Early identification of needs is facilitated by robust processes for “CAN” drug and alcohol staff in identifying new clients who might present a risk to children as a result of their substance misuse. Sampled cases highlighted rapid identification of specific risks to children with thorough risk assessment and analysis of parental/carer responsibilities and contact with children. This ensured that appropriate referrals were made and vulnerable children and young people received maximum support. The impact of substance misuse on clients’ children was clearly assessed via the parental capacity assessment, which resulted in specific actions to either refer onwards, or as an opportunity for early help as appropriate. Where the potential impact on the children was assessed as being of a low level (for example, the presence of other protective factors such as another parent who did not misuse drugs or alcohol), the service made referrals to other services including family therapy support groups where early help for all the family might be offered.

1.32 There is a lack of recognition of the important role of primary care in domestic violence arrangements. Understanding of MARAC is underdeveloped across primary care. GPs, along with other health disciplines, are not routinely receiving DV notifications, leading to missed opportunities for GPs to engage victims in appropriate support. Although DV is included in level 3 training, GPs we met with were unclear on local systems or how they fit into them. The impact of DV on children has not had sufficient local focus to ensure that practitioners are able to safeguard children in households experiencing DV. (**Recommendation 4.2**)

2. Children in need

2.1 Comprehensive Individualised birth plans are routinely in place for unborns on child in need (CIN) and child protection (CP) plans and are formulated by the maternity safeguarding team. Plans we saw were of an extremely high quality and used a standard format to support staff in identifying who needs to be informed about the delivery of the baby and any specific action to take place to ensure newborn's safety at all times.

2.2 Despite very recent changes in provider, the pathway into a range of CAMHS services is well established with access times being closely monitored. We saw many case examples demonstrating that young people and their families/carers benefit from the therapeutic interventions offered.

2.3 Trust managers report that access to CAMHS assessments for young people attending ED with mental health needs has improved recently. CAMHS have an effective on-call system ensuring that there is access to CAMHS expertise in working hours, and further exploration of out of hour's provision is underway. Young people are admitted to the ward in line with guidance and allocated a 1:1 worker as part of their care plan. This ensures they remain safe whilst on the ward and awaiting further treatment or placement elsewhere. However, paediatric ward staff have not accessed any additional training on mental health to best support these young people. (**Recommendation 3.1**)

2.4 We did hear some concerns around waiting times for mental health intervention and the interface between the tier 2 emotional wellbeing "CHUMS" service and tier 3 CAMHS referral thresholds. This led to lengthier waits for intervention to begin whilst decisions were made on the most appropriate service to take on the case. As a result, children and young people were not being able to access the support they needed in a timely manner to ensure their needs were met without delay. In one case we sampled the children had been referred to CHUMS but after an 11 week delay for triage, the CHUMS team subsequently referred onward to CAMHS after concluding that the case was too complex for them and required CAMHS input. The delay in securing input for the children resulted in the family struggling to manage and the children's care being fragmented. (**Recommendation 3.2**)

2.5 Following referral to CAMHS, we saw that initial assessments undertaken by practitioners were comprehensive and clearly identified need and risk. This included actions for further interventions and who should provide these. However this information was not however then used to inform a person centred plan of care. This reduces practitioner's ability to effectively monitor and track progress in children's mental health or identify where there is lack of progress and the level of intervention needs to be reconsidered to best meet children's needs. (**Recommendation 3.3**)

2.6 CAMHS care plans we sampled were not SMART and did not clearly articulate that children and young people were actively involved in the planning of their own care. Care plans seen were not signed as accurate or agreed by the young person. We spoke with CAMHS professionals who told us that the paperwork used did not easily promote in-depth care planning. We saw that there was little space on the forms to include detailed goals, planned outcomes and how those goals might be reached. (**Recommendation 3.4**)

2.7 CAMHS are represented at the monthly Bedfordshire and Luton wide multi-agency CSE panel to ensure cross county and boundary information exchange. This aids effective management of risk to young people. Information shared at these meetings is then cascaded to individual health professionals who are working with children and young people considered at risk to provide enhanced support. However we saw no clear evidence of the CSE pathway and use of the LSCB tool to assess risk of CSE and intelligence monitoring. Staff told us that they use professional judgements to explore CSE dependent upon the individual case. This leads to the risk that that not all young people may be identified quickly for support and safety measures. (**Recommendation 3.5**)

2.8 There is clarity within the CAMHS service of how best to support young people who do not attend appointments. Practitioners were seen to follow up quickly in the first instance to ensure the young person's immediate wellbeing and then subsequent case planning to make further attempts at helping young people better engage with interventions.

2.9 Health visitors are proactive in finding ways to support families with complex needs to achieve best outcomes. In one case sampled, we saw a dedicated practitioner who sourced specific personality disorder training in order to help her support a mum with mental health difficulties to best effect and ensure the child's development was not negatively impacted.

2.10 Referrals to the MASH from the 0-19 team were clear and articulated risk clearly, with appropriate professional challenge when necessary. Strong working relationships were evidenced with colleagues in the local authority including joint visits undertaken with health visitor and TAC co-ordinators to further analyse risk when it was initially assessed as not meeting thresholds for support. One case sampled highlighted that additional support and focused targets were developed following one of these joint visits, which led to significantly improved outcomes for a family of children under a child in need plan.

2.11 The introduction of a health visitor into the MASH is a positive development in ensuring health needs and their impact are fully considered as part of the assessment process and in information gathering and exchange between health and social care. Areas of development around gaps in 0-19 services receiving DV notifications should now be resolved in order that families can be offered support at the earliest opportunity. We have heard of an improving picture since the health visitor became based there, with more optimism around feedback and communication. Health teams told us they value the opportunity to discuss health issues and concerns they have, with a health professional in the MASH.

2.12 We have seen strong examples of a range of tier 1 to 3 CAN substance misuse intervention which led to positive outcomes for children and young people. This included those affected by the substance misuse of adults, and those young people who misuse substances themselves. Collaborative work with other organisations such as CAMHs, including joint assessments, ensures that their work compliments and is co-ordinated with other health care providers. The use of child focused assessment methods, such as the hidden harm wheel, focuses on the needs and wishes of children and young people and assists staff in providing the most appropriate types of support. Within this service, we saw a strong focus on CSE as drug and alcohol is often used as a grooming tool.

2.13 The interface with adult mental health and CAMHS is robust with quarterly transitions meetings to prepare case transfers for those young people aged 17 who are likely to need on-going services from the adult team. This is a vital process in enabling young people to adjust to the different style of support offered by adult services in comparison to the Family Systems models that are generally offered by CAMHS. Joint assessments and co-working arrangements are in place which promotes a good understanding of both services for young people.

2.14 In adult mental health, Think Family principles are embedded within practice with practitioners assessing needs in the context of whole family thinking. Standard practice is to ascertain details of children who are in contact with the referred adult and practitioners understand the need to prioritise the safeguarding of children while working with the adult. Risk assessment documentation includes identifying children with whom the client has contact as well as those for whom they have parental responsibility.

2.15 Within adult mental health services, joint visits across disciplines are not routine practice and some teams reported that direct liaison with adult mental health could be strengthened further. This would ensure that relapse indicators and mental health wellbeing and contingency plans can be shared with other disciplines, with the client's permission, and that all professionals involved with the family would be able to identify emerging needs and provide support. (**Recommendation 3.6**)

2.16 Children are not routinely viewed as young carers and there is no separate specialised provision for them to be referred on to within Bedford. East London Foundation Trust are currently exploring options for developing a young carer provision.

2.17 GPs would benefit from more clarity about their role in recognising where there are escalating concerns within a family that aren't being addressed by existing safeguarding plans and ensuring that risks and plans are reviewed to secure better outcomes. Some GPs we met with saw this as the role of the health visitor or midwife, to follow up and escalate and didn't recognise their role or power to intervene and ask for risks to be reviewed or to make a referral. (**Recommendation 4.3**)

Case A highlighted the good practice between a GP in regular liaison with their community midwife, resulting in their intervention being instrumental in ensuring that a mother's mental health issues and risks to an unborn baby were properly understood.

Following pre-birth discussions with the community midwife, a referral was made to children's social care but it was proposed not to take further action to safeguard the unborn as no concerns had been raised by the mental health team in relation to the mother. The GP was concerned at this and contacted the community mental health team where it transpired the mental health worker was off and had been unable to present their view of the history and risks. Once these were put forward by the GP, a safeguarding plan was put in place and the mother received support. The child is now thriving, and formal plans have been stepped down as the family are well supported by a TAC approach.

2.18 Records we reviewed in midwifery had clearly identified safeguarding markers, however general record keeping is an area of development. In many case notes we sampled, the entries were not fully reflective of the amount of activity being carried out in cases. (**Recommendation 2.9**)

2.19 The use of the information sharing form in midwifery as a running record of safeguarding events is useful to ensure all pertinent safeguarding information is easily located. However after the initial information share of vulnerabilities, this form is only updated for midwifery use, not for further liaison with other professionals. We saw good use of the form to alert others early of potential concerns but there is a gap in limited follow up and ongoing checks to ensure needs are not escalating. (**Recommendation 2.10**)

2.20 The 0-19 service case records reviewed were of a variable quality with some detailed information about intervention and liaison with other agencies. The lack of chronologies is not assisting practitioners to identify drift in cases. Many clinicians we met with highlighted how beneficial it had been to complete a chronology for our case tracking in alerting them to this. Their use would ensure drift in cases is more easily recognised and would allow practitioners to be more outcome focused, helping them to see when they have achieved success in cases or when to escalate concerns. (**Recommendation 1.7**)

2.21 CAN young people substance misuse paper copy records were not fit for purpose. We found that some assessment documentation was not completed or was missing. For instance, forms relating to a child's motivation and treatment goals were blank in every case as were sections designed to help workers assess a young person's capacity to consent. This meant that staff could not be sure that these key questions, particularly the issue of consent, had been addressed. The files were segregated into different categories and were not chronologised, therefore they were difficult to navigate and there was a risk that some important information might be overlooked. In one file we saw that there was no risk assessment documentation which meant that any worker taking over the case would be unsighted on what the risks to the child were.

3. Child protection

3.1 On a case by case basis we have seen some persistence to ensure risks to unborns are well managed, including joined up working between midwifery and other services within the formal child protection system. However these are not formalised pathways and there are opportunities to further strengthen this work particularly with AMH and ASM services and to develop more consistency in practice across the team.

3.2 Clear processes are in place to ensure midwives attend CP conferences and we saw good compliance with this. There is more scope to develop and monitor the quality of reports submitted to ensure maximum contribution to decision making processes and ownership of health needs and risk.

3.3 The emergency department at Bedford Hospital had clear alert systems that enabled staff to identify children about whom there might be concerns. For example, the records of a child who was subject of a CP plan were highlighted with a red triangle which alerted staff. This ensured that the child was seen by a consultant paediatrician or by the senior paediatric doctor on duty and that the relevant social worker was informed of the ED visit.

3.4 We saw timely referrals from ED to the safeguarding team when there were any child protection concerns. Comprehensive records were kept in the emergency department and the telephone referrals to the safeguarding team were appropriately noted in records. However, only one of the cases we looked at showed that a written MASH enquiry form had been completed in follow-up to a telephone referral. This is contrary to the trust's safeguarding policy and the procedures for emergency department staff. Whilst staff were confident that important information would not be missed during a telephone referral, there is an inherent risk that referral information or risk factors might not be conveyed accurately or might be misinterpreted. (**Recommendation 2.8**).

3.5 Referrals to the MASH from health visiting were detailed and articulated risk clearly. This was also seen in cases of professional challenge, with transparent articulation of practitioners concerns and strong analysis of the situation by practitioners to ensure the needs of the children were prioritised.

3.6 The 0-19 health visiting and school nursing team are encouraged to prioritise attendance at child protection conferences and review conferences where appropriate to do so. We saw that reports submitted to conferences were consistently shared with parents and suitably detailed. The use of a standardised analysis template assisted in informing practitioners regarding the child's protection status. Records examined in school nursing showed that minutes from case conferences were not always uploaded onto SystemOne although the school nurses who attended the conference did record the actions arising in the client notes. There is risk therefore that if the practitioner does not attend conference that valuable information will not be recorded to inform their decision making process.

3.7 The importance and relevance of Brook's potential contribution in safeguarding arrangements needs to be better understood by statutory agencies. Brook is not often contacted for information in relation to section 47 child protection enquiries. CASH services do not routinely receive information about young people with child in need or child protection plans and so are unable to be clear on their role in safeguarding these children. CASH practitioners we met with were unsure about their role in escalating or re-referring where a young person appears to remain at risk even though many services are involved. CASH staff are unable to contribute to monitoring of the plan and identify if they have information about the plans effectiveness and best ways to safeguard the young person. This will be brought to the attention of Public Health England.

3.8 CAN substance misuse service play an active role in the ongoing support work offered to families of children who are subject to a child protection plan. This included effective communication with other services and participation in core group work that was related to the client's recovery plan to ensure focus on the whole family needs.

3.9 We saw evidence of the clear expectation that adult mental health staff will be fully engaged with the formal CP process, including attendance at meetings, evidence of contribution or engagement within the case notes and filing of CP Plans on records. Records we saw evidenced clear linkage between these and the mental health service's care plan developed with the client to maintain a strong focus on the needs of the child.

3.10 Currently there is no specific service provision for perinatal mental health although we are aware of developmental discussions in this area. Referrals in respect of pregnant women with mental health concerns are usually made to primary care services via the GP. The referral service is via a single point of access and women who are identified as being pregnant via the triage system are fast tracked for assessment. East London Foundation Trust have a perinatal nurse specialist seconded into the safeguarding team and have plans to develop perinatal services based upon their experiences in other regions. This would have a positive impact on some of the cases we have seen this week. In one case we saw the mental health team were not made aware from the referral that the child and unborn was subject to a child protection plan. The mental health team were not involved until after the birth of the baby and discharge home. A more robust perinatal referral and assessment process could have ensured earlier help and assessment. (**Recommendation 3.7**)

3.11 East London Foundation Trust is driving forward plans to better engage with children's social care (CSC) to ensure better information sharing protocols are put in place. This should result in CAMH professionals being better informed of the outcomes of multi-agency child protection meetings. Records we examined demonstrated that health professionals are currently not always in possession of the decisions made at meetings at which they do not attend. Care plans and risk assessments are not being routinely informed by the decisions made at core meetings. This means that the most up-to-date information regarding a child or young person is not always available to health professionals providing care and support. As such, issues that might affect their decision making processes, especially in relation to safeguarding, might be missed. (**Recommendation 3.8**)

3.12 A comprehensive standard GP template for contribution to CP conferences is in place however we found limited awareness of this in practices we visited. GP contribution to CP conferences tends to be via a letter or written report rather than attendance. There has been no exploration of alternative ways, including the use of technology, in increasing GP participation in, and contribution to, child protection case conferences. (**Recommendation 4.3**)

3.13 A clear escalation policy is in place however, there is more to do to develop staff awareness across the economy on their role and the process of escalation on cases where there is professional dissent. (**Recommendation 5.1**)

4. Looked after children

4.1 Initial health assessments (IHA) are undertaken by appropriately qualified clinicians, and recent issues with timeliness of assessments are in the process of being resolved to ensure assessments are carried out within statutory timescales. Overall the quality of IHAs and review health assessments (RHA) sampled was variable, with some exemplary work carried out by the LAC nursing team, although this was mostly confined to children placed out of area.

4.2 Some assessments we sampled did not highlight a good sense of the child as an individual or clearly articulate the voice of the child, however the reported information from accompanying adults was comprehensively recorded. It was clear that all practitioners gave time to the young people to ensure a thorough assessment, however some staff are missing the opportunity to ensure children's views are heard and to show their level of engagement by what is being recorded and documented on the assessment form. (**Recommendation 1.2**)

4.3 Health plans completed by the LAC nurse were SMART, however this was not the case for those carried out by other health practitioners. In these cases, recommendations were not specifically time limited and plans were task focussed with an over reliance upon others to complete actions. There was limited follow up of agreed actions to track progress or transparency in accountability. In one case where strength/difficulty questionnaires had been completed the outcome plan stated "therapy to be initiated" with a timeframe of "ASAP". In another case there was reference to the young person being sexually active but no outcome/follow up or other detail to demonstrate further consideration in relation to the exploration for potential child sexual exploitation (CSE). (**Recommendation 1.3**)

4.4 On those assessments undertaken by the LAC nurses, we saw comprehensive transfer of targets and checks on previous actions from one plan to the next, to ensure follow up of actions were monitored. However on those undertaken by the "0-19 team" (universal health team), plans had no mechanism for follow-up, leading to an over emphasis on other professionals or carers to request more health input in the future. There is currently no rolling programme of training for 0-19 practitioners to ensure best quality is achieved. (**Recommendation 1.4**)

4.5 The BAAF form part A has been replaced by a bespoke LAC health referral form which provides greater detail of the child's reason for becoming looked after and ensures as much information as possible is made available in relation to basic details and family circumstances. The form is also used to seek updated information for all health reviews. In all cases sampled we saw good examples of the completed documentation on the files and reference made to previous medical assessments and outcome being pulled through to the current assessment. There is space to record that the issue of consent has been discussed with those children and young people who are deemed Fraser competent, however we saw no evidence of the child/young person's signature or equivalent. No evidence was seen of parents being present at the health assessments. This is a missed opportunity to seek or confirm consent and also to gather essential family and birth history.

4.6 Young people placed out of the area have some choices about where they have their RHA and the looked-after child nurses are able to offer flexibility about location and time of day including evenings and Saturdays to suit the needs and wishes of the young person. However those RHA's undertaken in the borough are not able to be conducted as flexibly and young people fed back to us that they would like more choice in this.

4.7 The LAC Young People's Nurse role is dedicated to young people age 15 and over, and focuses on developing supportive relationships with them as they approach their final health review. Young people on leaving care are currently given a personalised health summary but the service is exploring how to strengthen this offer through the use of a health passport. We understand that the looked-after child nurse is consulting with the CIC council on this to ensure young people's views are sought when initiating improvements.

4.8 The care leaver's offer is developing and there are many potential opportunities, particularly as the service is now commissioned to 21. However it is not currently flexible in order to meet the range of young people's needs. Cases sampled highlighted that there were no plans to review a young person's needs unless requested by children's social care. There is an over reliance upon another professional to trigger the service to address health need. There is more to do to make best use of this role and the opportunities it provides. (**Recommendation 1.5**)

4.9 A specialist CAMHS service for LAC is in place and we saw and heard of good outcomes from this on an individual basis. This includes access to a number of groups including a group for foster carers, closed talking groups for adolescent girls aged 14-15 years and an art therapy group for younger children age 8-10 years. However there is a disconnect between LAC CAMHS and the LAC health nurses team, as there is no routine submission of progress briefings or reports to inform young people's review health assessments. This is a gap. There is a significant risk that the RHA's and subsequent health plans are therefore not fully representative of a child's emotional and wellbeing needs. (**Recommendation 3.9**)

4.10 There is good use of needs analysis within the LAC CAMHS team to ensure both children and young people and their carers have access to effective support. The provision of CAMHS looked after children's groups alongside foster carers and kinship groups offer carers time to reflect and meet with others who are often dealing with similar types of behaviours from children. The Kinship carers group was established following identification that this group of carers had specific challenges in relation to caring for children within their family or those who become subject of special guardianship orders. Often they are grandparents who are not only caring for children with complex needs but also managing contact with the child's parents. The groups are evaluated and outcome findings indicate that placements are sustained for children. This secures continuity and better relationships with carers who are helped to understand and contextualise behaviours of children that they are caring for.

A's placement was in jeopardy. The carer had been struggling to cope with the complex needs of two children and a decision had been made to end the placement and find an alternative. The LAC CAMHS team challenged the local authority decision to move the children and highlighted the need to maintain the same placement for the children. Individual therapeutic work was undertaken with the child and sibling and at the same time the foster carer attended the foster carer group. The outcome showed that the placement stabilised, the challenging behaviours of the children subsided and the school reported a noticeable improvement in A's ability to make friends in school which had previously been problematic.

4.11 We heard that GP's receive a written request for contribution to IHA's however we did not see any evidence of this, nor contribution from the GP. GPs we met with were unfamiliar with the paperwork for both IHAs and RHAs, although in all cases this had been scanned and uploaded. They recognised that they would benefit from a greater understanding of looked after children arrangements and their roles. LAC health leads are potentially an unrecognised asset for GPs. We are aware that plans are under development for LAC leads to increase GP involvement via the GP LAC champions keyworker scheme in each practice and this is welcomed.

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 Strong safeguarding leadership, advice and guidance in Bedford is provided by the designated nurse. She is a highly visible and accessible presence who is well valued and maintains an active role in driving forward both strategic and operational developments. Aside from this, capacity issues in the named GP role mean GPs lack leadership on child safeguarding. Despite the development of initiatives such as the GP template for CP conference contribution by the named GP, there is slow progress in disseminating this and ensuring effective and consistent primary care safeguarding arrangements. (**Recommendation 4.4**)

5.1.2 Good working relationships between the CCG and LA support an openness and transparency in discussion about achieving best outcomes for children and young people. In addition the pan Bedfordshire approach in some health areas such as FGM and CSE is a useful mechanism to look at cross county themes to inform strategic direction for commissioning and ensure needs are being met.

5.1.3 The roll out of SystmOne in all GP practices has provided opportunities for information sharing to ensure children are supported in a co-ordinated way. However we found its functionality was not being used to best effect to support consistent safeguarding practice. Aside from tasking, GPs were not always aware of important information on records and the availability of safeguarding templates. This means that the GP may not be not fully informed of any risk or vulnerability when in consultation with their patient. (**Recommendation 4.5**)

5.1.4 There is not yet consistency of use of alert flagging within primary care and community health arrangements on SystmOne to ensure that practitioners are alerted where additional risks have been identified for children or their families. The flagging system in place does not fully enable GP practices to identify the cohorts of children in the practice who are looked-after, on child protection or child in need (CIN) plans. Some GPs we met with were unclear what CIN means or what should happen as a result of a CIN plan. (**Recommendation 4.6**)

5.1.5 The pilot underway for developing the MASH is aiding collaboration and cohesive working to achieve best outcomes for children and young people. This includes the role of the designated nurse in resolving challenges between health and social care and the co-located health visitor to assist with assessment and analysis of health risk. The health visitor also monitors the quality of referrals coming into the MASH from SEPT health teams and can address quality issues with individual practitioners. Cases sampled highlighted equal inter agency working, and decision making included a health overview and analysis of threshold. This was particularly beneficial for families where there was no further CSC involvement, as the health analysis ascertained the role of universal services in supporting families for example with domestic violence or low maternal mood who did not meet CSC thresholds, but would benefit from extra support.

5.1.6 Further work is needed to clarify and embed new initiatives to ensure staff are confident and competent in their use, for example, this was a common theme on initiatives such as the use of the LSCB cross provider CSE identification tool, and the GP contribution template for CP conference. The ongoing joint strategic review of CSE processes aims to provide clarity on assurance, provide recommendations to move services forward and to be definitive on governance structures. Whilst a clear strategy is in place for CSE, there is more work to do on the detail of this and sharing this with frontline practitioners, to ensure they are fully informed of the resources and pathways available to them to better support young people at risk. (**Recommendation 5.2**)

5.1.7 Recent learning taken from an SCR out of the Bedford Borough area led to an audit of cases to ascertain how much information was received from child protection meetings to inform health care plans and risk assessments in the borough. This continues as 'work in progress' to better engage with CSC and share information accordingly.

5.1.8 Within 0-19 services, the Benson service planning tool is used to indicate where to effectively place staff members to provide effective service provision to children and young people. This takes into account child protection and child in need numbers according to individual areas and schools, to give a figure as to the number of staff required to deliver the healthy child programme. This has proved effective when planning staff placement in Bedford Borough and has provided better and more timely services to children and young people, as resources are now allocated to areas of highest need.

5.1.9 The achievement of System1 as the IT system across all Bedford GP practices is welcomed. School nurses reported better working relationships with GPs now and highlighted the benefits for example, of being able to message GPs directly from System1 to request information. This is assisting with providing co-ordinated support to families at an earlier stage.

5.2 Governance

5.2.1 Contract specification and monitoring is robust, ensuring appropriate levels of scrutiny and accountability. Governance and monitoring of provider activity by the CCG and training compliance is well developed. Examples of this include the recent changes in services for children who are looked after outside the area. Contract monitoring meetings identified issues with the timeliness of RHA's for these children and led to commissioning changes to develop a specific out of area service, leading to improved outcomes for children placed out of area.

5.2.2 In order to ensure services learn from serious incidents and that practice is subject to continuous improvement, learning events and updated training has been developed, and we were able to see the impact of this across some services we visited. The CCG healthwide forum held bimonthly with all providers checks evidence of SCR learning. This ensures providers have to show evidence of embedded learning at an accountability forum. Luton health leads also attend this to ensure robust cross boundary arrangements.

5.2.3 The LAC team have a proactive approach which is often a catalyst to further develop thinking and practice from a service provision focus to an outcome focus. We saw good operational oversight of outstanding issues such as young people who miss or refuse health assessments. The introduction of the "exceptions" meeting with CSC colleagues to discuss ongoing needs for specific young people, ensures any outstanding issues are monitored and followed up quickly to ensure their needs are being met and to prevent drift.

5.2.4 LAC Quality assurance processes are underdeveloped. An in house quality assurance tool has been developed and we saw benefits in its use for assessments completed by other health providers outside the area. However it is currently being used within Bedford borough to identify gaps in the assessments only and is therefore not driving up practice on internal assessments within South Essex Partnership Trust (SEPT). (**Recommendation 1.6**)

5.2.5 Reporting arrangements in LAC are robust and we saw a strong commitment to establish and embed systematic monitoring and evaluation in relation to outcomes. This includes quarterly schedule reports for the CCG, key performance indicators and a LAC focus in the annual safeguarding report to SEPT. The quarterly LAC health improvement group provides a forum for key groups involved with looked after children to actively engage with service improvements to help drive forward outcomes for children and young people. This includes representatives from Paediatrics, Public Health England, CCG, CAMHs, Youth offending team, CAN, young people health champions, CASH service and the Local Authority.

5.2.6 The CAMH service user participation officer role actively engages CAMH service users in the development of services, obtaining feedback from them and their families and to promote CAMH services around Bedford Borough. Children and young people are encouraged to attend meetings where they can discuss issues relating to them and others that are important to them. It is an opportunity for those young people to improve confidence and self-esteem which is a positive aside to health professionals seeking feedback on the services that they provide. Provision is also made for carers and families to attend coffee mornings to discuss issues and ideas that they might have.

5.2.7 Bedford Hospitals Trust (BHT) employ a dedicated paediatric liaison nurse to quality check all paediatric cases that emanate from ED. This ensures that all follow-up action was taken and opportunities for early help were maximised. For instance, children who were identified as potentially benefitting from early intervention or other support were identified and telephone referrals made to other health providers such as the health visiting or school nurse service. The paediatric liaison nurse also acted as a safety net to ensure that information about any children of concern or who were subject of a CP plan was passed on appropriately.

5.2.8 The named nurse and named doctor at BHT carry out periodic peer reviews on sampled cases in ED to determine whether all actions had been taken appropriately to safeguarding the children concerned and in accordance with local procedures and established good practice. Learning was shared with the relevant clinicians directly, with the leadership team through risk management briefings, and cascaded to the staff team during ward meetings.

5.2.9 BHT have well-established governance processes for safeguarding that enabled the senior team to have oversight of safeguarding activity in the ED and the paediatric ward. For example, there was a rolling programme of audit that considered the performance in key areas, such as follow-up for children who did not attend outpatient's appointments and the completion of pro-forma data in the emergency department records. We saw a variety of management oversight methods to ensure that the children's ED and the paediatric ward operated safely. These included daily site meetings that considered safe staffing levels and skill mix; twice weekly conference calls with the CCG and other health partners to consider resourcing more globally; early management review meetings to consider significant events, such as capacity in the paediatric ward or individual cases and the previously reported paediatric liaison nurse which was a key role in providing a safety net for individual safeguarding cases.

5.2.10 Brook has appropriate governance arrangements in place for oversight and learning from cases where safeguarding issues are identified. Managers within Brook retain copies of referrals to CSC or other agencies, and all safeguarding issues are reported into Brook's senior management team for monitoring and evaluation.

5.2.11 CAN substance misuse services case management oversight ensures that all decisions are in the best interests of children. For example, all decisions made about referral onwards, whether as a child protection matter, child in need or opportunity for early help, were signed off by the case worker's line manager. In the case of CP referrals, the completion of an incident record meant that these decisions were reviewed by a more senior manager and all active cases with a safeguarding children element were reviewed at monthly managerial safeguarding meetings to monitor progress and ensure that there no outstanding activity was left incomplete. This also created the environment in which any cases could be escalated where circumstances might have changed and risk heightened to ensure children's and young people's safety.

5.3 Training and supervision

5.3.1 Whilst all providers we visited had clear expectations for training and supervision, current arrangement and compliance is not meeting intercollegiate guidelines, particularly at level 3. Much of the training is delivered on an in house basis and despite multi agency content, is not delivered to a multi-agency audience. We recognise the challenges in accessing LSCB training however many staff we spoke with had not embedded training into practice at a level commensurate with their roles and responsibilities. (**Recommendation 5.3**)

5.3.2 In ED we found evidence of a learning and continual audit culture. Systems are in place for reviewing findings from serious case reviews and disseminating learning to the staff team through safeguarding newsletters, in-house training and ward meetings. This enabled staff to have access to up-to-date knowledge on protecting children.

5.3.3 GP engagement and contribution to safeguarding is developing with good progress in level 3 training uptake. However the current capacity of the named GP across Bedford, Bedfordshire and Luton is significantly impacting on safeguarding practice being consistently embedded across the patch. GPs we met with cited good support and information sharing from the designated nurse and highlighted the value of the MASH and additional training opportunities such as that delivered at the Saturday symposium sessions. In one practice, we saw the impact of the symposium FGM training leading to a direct pick up of a possible FGM case, which the practitioner reported to us may have been missed if the training had not recently taken place.

5.3.4 GPs are complying with minimum requirements for level 3 training although some cases sampled highlighted gaps in awareness of their role and pathways for example DV and CSE. This indicates that further training is needed to ensure they are sufficiently conversant with local and national themes and new developments. Whilst GPs in practices we visited have increased awareness of CSE, they are not yet well familiar with risk assessment tools to help them identify young people who are at increased risk, and to understand what prevention and early help support is available for this vulnerable group of young people.

5.3.5 All midwives have rapid access to ad hoc safeguarding advice and support which is well valued. However, formal group supervision arrangements with consistent attendance are not fully in place with the opportunity for practitioners to reflect on their cases. We saw limited evidence of safeguarding supervision or action plans being recorded in notes. Capacity of the safeguarding team within midwifery is impeding progress in improving safeguarding practice, and governance.
(Recommendation 2.11)

5.3.6 We saw good opportunities for the 0-19 team to access case discussion and reflective supervision. Team managers meet with all staff 1:1 monthly and review any vulnerable cases leading to good operation oversight of vulnerable families. Formal safeguarding supervision is robust and the model has been developed following learning from a SCR. This includes the named nurse seeing case notes prior to the supervision session and will request practitioners to bring certain cases for discussion. The use of a safeguarding template on SystemOne ensures all supervision actions are uploaded onto records. Safeguarding supervision takes place during four scheduled sessions per year and full participation is considered mandatory for all qualified nursing staff members. However there is an over reliance on clinicians to recognise the cases to bring for supervision discussions and we saw some evidence of cases where an overview discussion had not been sought , particularly with parents who are difficult to engage which is a risk.

5.3.7 The graded preceptorship that exists in health visiting provides good support for practitioners developing their skills and knowledge in safeguarding. The co-working of cases and reflective practice learning, allows opportunities for staff to build their confidence and best support families with vulnerabilities.

5.3.8 Staff in CAN services are supported in their decisions by an effective 1:1 supervision system where the progress of each of their cases is reviewed regularly by their line manager. This ensures that interventions are always appropriate. A supervision template is used with safeguarding as a standing agenda item and all active child protection cases are prioritised for discussion.

Recommendations

1. NHS Bedfordshire CCG and SEPT Community Health Services should ensure that:

- 1.1 Processes are developed to ensure the 0-19 team are aware of non-attendances for planned appointments
- 1.2 The voice of the child is developed in initial and review health assessments
- 1.3 Health plans for children who are looked after are SMART
- 1.4 Practitioners in the 0-19 team have access to ongoing training to develop their competence in and the quality of review health assessments
- 1.5 The care leaver offer is developed to ensure better access to services
- 1.6 The quality assurance process for LAC health assessments is further developed for children in local placements
- 1.7 The 0-19 team routinely use chronologies as part of their case recording

2. NHS Bedfordshire CCG and Bedford NHS Hospitals Trust should ensure

- 2.1 That home visits in pregnancy are established as an aid to risk assessment
- 2.2 That recording/coding of domestic violence is evidenced on all records
- 2.3 That arrangements for specialist midwifery access are reviewed to take account of vulnerabilities at all levels and ensure appropriate support is available
- 2.4 That the use of chronologies is an expectation in order to aid midwives in identifying cases with drift
- 2.5 That the use of individual birth plans is established in cases below child in need and child protection threshold
- 2.6 That liaison arrangements between adult mental health, substance misuse and GP's are developed
- 2.7 That ED paperwork is re-designed to include safeguarding prompts

- 2.8 That referrals to the MASH from ED are followed up in writing in line with trust policy
- 2.9 That record keeping in maternity services is fully reflective of levels of activity
- 2.10 That the use of the information sharing form in maternity services is developed to incorporate ongoing liaison with services
- 2.11 That formal supervision arrangements in maternity services are developed in line with reviewed capacity of safeguarding team

3. NHS Bedfordshire CCG and East London Foundation trust should ensure:

- 3.1 That mental health training for the paediatric ward is developed
- 3.2 That clarity on thresholds between the CHUMS and CAMHs service and the interface between the services is reviewed and monitored
- 3.3 That person centred care planning is established in CAMHS
- 3.4 That CAMHs paperwork is redesigned to include more opportunities to record consent and client's wishes
- 3.5 That the LSCB CSE identification tool is used consistently in all teams to improve risk assessment and analysis
- 3.6 That relapse indicators are shared between other teams
- 3.7 That a perinatal mental health pathway is established with some urgency
- 3.8 That CAMHS ensure they have received CIN and CP plans and uploaded these onto client records.
- 3.9 That communication between CAMHs and LAC team is established to ensure that progress reports will be available to further inform review health assessments.

4. NHS Bedfordshire CCG in conjunction with NHS England should ensure:

- 4.1 that GP practice safeguarding meetings are established with a consistency in approach across the borough
- 4.2 that GPs gain a wider understanding of local domestic violence arrangements

- 4.3 That GPs are aware of and use the child protection conference template.
 - 4.4 The capacity of the named GP is reviewed
 - 4.5 that across Bedford Borough, Systm1 functionality is used effectively to support consistent safeguarding practice.
 - 4.6 that the use of consistent alert flagging on Systm1 is developed across all GP practices
- 5. NHS Bedfordshire CCG in partnership with Bedford NHS Hospitals Trust, South Essex Partnership Trust and East London Foundation trust should ensure**
- 5.1 that all staff are fully aware of the agreed escalation process in cases of professional dissent
 - 5.2 that dissemination processes for new initiatives are developed to ensure frontline practitioners awareness
 - 5.3 That level 3 safeguarding training is compliant with inter collegiate guidance.

Next steps

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