Report on the Outcome of the Integrated Inspection of Safeguarding and Looked After Children's Services in Buckinghamshire	
Date of Inspection	**29th November – 10th December 2010**
Date of final Report	**24th January 2010**
Commissioning PCT	**NHS Buckinghamshire (5QD)**
CQC Inspector name	**Lynne Lord**
Provider Services Included:	**Buckinghamshire Healthcare NHS Trust (RXQ)** **Oxfordshire and Buckinghamshire MH NHS FT (RNU)**
CQC region	**South East**
CQC Regional Director	**Roxy Boyce**

This report relates to the recent integrated inspection of safeguarding and services for looked after children which took place in the above Authority recently

It provides more detailed evidence and feedback on the findings from the Care Quality Commission's (CQC) component of the inspection, and links these to the outcomes requirements as set out in the Essential Standards for Quality and Safety.

Thank you for your contribution to the inspection and for accommodating the requests for interviews and focus groups with your staff and those of partner agencies at relatively short notice.

The team provided feedback to your local Director of Children's Services at the end of fieldwork and the joint inspection report to the authority is now published on the Ofsted website and can be accessed via this link: The joint inspection report .

Name of Authority - Buckinghamshire	
Safeguarding Inspection Outcome	**Aggregated inspection finding**
Overall effectiveness of the safeguarding services	Good
Capacity for improvement	Good
Looked After children Inspection Outcome	**Aggregated inspection finding**
Overall effectiveness of services for looked after children and young people	Good
Capacity for improvement of the council and its partners	Good

This report includes findings from the overall inspection report, and provides greater detail about what we found, mapped where relevant to the Essential Standards, in order that your organisation can consider and act upon the specific issues raised.

A copy of this report is being sent to your commissioning PCT, and CQC Regional Director. This report is also being copied to the Strategic Health Authority/Monitor as appropriate and CQC's head of national Inspections, who has overall responsibility for this inspection programme.

*In respect of the recommendations in the report, please complete an action plan detailing how they will be addressed and submit this to CQC and your SHA Chief Executive within **20 working days** of receipt of the final report.*

The Inspection Process

This inspection was conducted alongside the Ofsted-led programme of children's services inspections. These focus on safeguarding and the care of looked after children within a specific local authority. The two-week inspection process comprises a range of methods for gathering information – document reviews, interviews, focus groups (including where possible with children and young people) and visits – in order to develop a corroborated set of evidence which contributes to the overall framework for the integrated inspection.

CQC contributes to the inspection team and assesses the contribution of health services to safeguarding and the care of Looked after children relating to that authority. Our findings from the inspection contribute to the joint report published by Ofsted and also enrich the information we use to assess providers against the Essential Standards of Quality and Safety. This report sets out specifically the evidence we obtained in relation to these standards and extracts from the published report are included and identified.

CQC used a range of documentary evidence in advance of and during this inspection, and interviewed individuals and focus groups of selected staff and, where possible, children and young people, their parents and carers in order to provide a robust basis for the findings and recommendations.

This document sets out the findings in relation to the organisations listed above, but includes some areas which apply to one or more other NHS bodies where pertinent.

Context:

Within Buckinghamshire the commissioning and planning of national health services and primary care is undertaken by NHS Buckinghamshire (5QD). All community children's services, including health visiting, school nursing and all acute health services are now delivered by Buckinghamshire Hospitals NHS Trust (RXQ), since April 2010. The main locations of acute hospital services are at Stoke Mandeville Hospital, Aylesbury (RXQ02) and Wycombe Hospital, High Wycombe. (RXQ500) Child and Adolescent Mental Health

Services (CAMHS) are provided across the county by Oxford and Buckinghamshire Mental Health Foundation NHS Trust (RNU), through a joint commissioning contract and pooled budget arrangements with Buckinghamshire County Council for Tiers 2 and 3 and for Tier 4 (inpatients) through a contract with NHS Buckinghamshire. With a population of approximately 479,000, 26% (125,900) are children and young people. 345 of these children and young people are looked after, with 133 placed out of county

1 General – leadership and management

1.1 The contribution of health agencies to keeping children and young people safe is good. There is a strong safeguarding ethos, which is well embedded throughout the primary care trust (PCT), Acute and Child and Adolescent Mental Health (CAMHS) provider organisations. Leadership is strong from the designated and named lead professionals across healthcare services, including the Named GP. Consistent working relationships continue to strengthen the effective promotion of safeguarding.

1.2 Commissioning and performance management within health is good. A joint commissioning framework is well established, with a joint commissioning children's health lead in post. There are pooled budget arrangements for key priorities including CAMHS and for children's disability services. The service commissioning specifications clearly demonstrate effective contracting arrangements, which take full account of safeguarding children and young people, and are wrote by the Designated Nurse for Safeguarding.

1.3 Performance monitoring is managed by the Joint Commissioning Board, who effectively monitors the performance of the provider services against the priorities agreed within both the Joint Strategic Needs Assessment (JSNA) and the Children's and Young Peoples plan (CYPP). The Joint Commissioning Officer post is a joint funded post with the Local Authority (LA) and this enhances partnership working and communication across health and social services. A refresh of the JSNA is on going so that there are current plans in place to refocus the deliver improvements in priority areas, which include safeguarding

1.4 There is good partnership working across health and social care.
Healthcare professionals interviewed described effective and robust partnership work across agencies such as the PCT, Acute Trust, LA, Mental Health Trust, Housing and Voluntary sector, having a positive impact for CYP and families. Co-location of the safeguarding team and a number of health services including Health Visitors, School Nurses and Children's Disability Therapy teams, has been planned for early in the New Year and will further enhance communication and partnership working.

1.5 Learning from serious case reviews (SCR) is effectively actioned across health services. Policy and procedure guidance is appropriately reviewed were applicable, to reflect any recommendations made. Both the Designated Dr and Nurse, who sit on the LSCB, ensure the dissemination of action plans from any SCR and also provide feedback from health partners into the LSCB. Within the Acute Trust recommendations from SCR have been formatted into action plans for the Trust and these are regularly reviewed at the LSCB, Strategic and Serious Case Review Group subcommittee and an update given at the Healthcare Governance meetings held every 3 months.

1.6 Information sharing protocols are in place across the Mental Health, Acute Provider and the PCT and these are seen as a major improvement in reducing delays in initiating appropriate care pathways and interventions for CYP.

2 Outcome 1 Involving Users

2.1 There is appropriate user engagement and evaluation of the health services provided. Within sexual health regular user satisfaction surveys are undertaken and the comments section on the sexual health web site is very popular for obtaining user views. A review of the sexual health strategy is on going and has gone out for consultation amongst YP and youth groups. Engagement with YP is good and improving via the increased publicity about services offered. YP are encouraged to design posters and contribute to the updating of the website. Within sexual health services, venues for more discreet consultations were found in the universities, acting on comments from BME students.

2.2 For Looked after Children, in cases were the YP have more complex needs, involving self harm and substance misuse, the CAMHS outreach team have implemented a single interagency care plan and risk assessment. The care plan is implemented with input from the YP, parents and carers.

2.3 The Aiming High Programme for disabled children has provided some creative user engagement, from representation on the programme board to YP involved in assessing bids within tendering process. There are very high levels of positive feedback from users. There is a positive impact for CYP, providing a programme that is commissioning services partly designed by service users and increasing choice and opportunity for disabled children, young people and their families. This is making excellent progress in closing the gap for some of the most disadvantaged children and young people.

2.4 Health passports are in use, which document health information about CYP with disabilities. These assist in communicating the individual health needs and care plans of the CYP and are available to any healthcare or social care professional who is not familiar with the individual CYP. These were created with input from the CYP themselves and Parents and Carers.

2.5 It was widely reported across health groups that appropriate regard is given to CYP ethnic and cultural needs when undertaking any care or risk assessment. Key issues are identified and responded to. Access to interpreters is good. Interpreters are effectively utilised, with no issues of availability reported whenever required. Within the Speech and Language service a bilingual co worker is available and used frequently to speed up communication and eliminates the use of relatives as interpreters

3 Outcome 2 Consent

3.1 Within both the Acute and Mental Health providers there are appropriate policies and procedures in place that ensure consent is taken prior to any treatment of CYP. Consent is gained from Parents and Carers and is appropriately documented. Competency of YP is fully assessed within tier 2 and tier 3 sexual health services.

3.2 A consent form to undertake annual/six monthly Health Assessments/Medicals is in use, in accordance with the Department of Health's Guidance, by the Children in care health team. Consent is also obtained to the share the summary and health recommendations with Social Care and GP's.

4 Outcome 4 Care and welfare of people who use services

4.1 Within the Acute trust emergency care for CYP is provided in a safe and dedicated environment in the Paediatric Decisions Unit (PDU) at Stoke Mandeville Hospital. This is also used as observation and assessment unit for CYP up to 17-18 depending on assessed competency.

4.2 The Paediatric Liaison Health Visitor attends the PDU on a daily basis to review attendances from CYP 0-18yrs. Visits are also made across county to the Medical Emergency Centre at Wycombe and any clinical area where CYP may present. In patient admissions are also reviewed. This role is undertaken by one individual and cover for any absences is provided by the generic health visitors. It was reported there have been issues in the past were communication of information to other agencies has been delayed due to other work commitments of the HV. Also capacity is a concern as there is no admininistration support for this role. There is currently no electronic alert system to flag up CP or safeguarding issues; however a new IT system is be introduced in the New Year. .

4.3 Sexual health services for YP are good. The teenage pregnancy rate is currently 22.5 (National average 42.5) – 4th lowest in England and has fallen 15% since the1998 baseline. 2/3 of pregnancies in 15-17 year olds end in terminations.YP have good support following terminations and to date the rate of a second pregnancy is very low.

4.4 Outreach services at tier 2 are provided by external partners, commissioned by the PCT. They are in a number of venues including schools, colleges and the two universities and offer a "one stop" service for sexual health advice, condoms, Chlamydia screening and additional contraception advice. YP are also signposted to tier 3 services for long acting reversible contraception (LARC), such as implants. Test and treat services are being piloted at a number of pharmacists as uptake of Chlamydia testing is generally low. There is a good sexual health website that signpost to available services across the county. New mobile units have been provided in areas of high deprivation. This is resulting in good engagement from YP, as these can be in remote rural areas.

4.5 Tier 3 sexual health services are provided at clinics across the county from Aylesbury to Wycombe at 10 locations. YP can access any sexual health advice or services from contraception, Chlamydia screening, GUM, HIV and LARC. Sessions are held in YP clinics that offer better engagement opportunities and provide additional healthy lifestyle advice. The service works closely with a range of agencies such as youth support, DAT, YOT and Connexions supporting and/or signposting to additional help and advice. Drop in sessions are held in some secondary schools and the team work liaise with the health zone coordinator in some colleges and work is on going to provide on site Chlamydia screening in the New Year within the universities. There is a fast track service for LAC and the team work closely with the LAC health team, teenage pregnancy midwife and midwife for vulnerable families.

4.6 A major redesign of the CAMHS services and care pathways has been undertaken. Access is improving and is ensuring a more equitable service across the county. Waiting times are good with CYP assessed in less than or approx 4 weeks. There is a fast track service for LAC and CYP are seen within one week, commencing early intervention and treatments. Targeted mental health in schools (TAMHS) provision is provided in a number of schools, primary and secondary and 2 of the special schools. This is delivered by a Primary Mental Health worker, who works closely with the school nurses. Any health professional has access to guidance and advice via a consultation line during normal working hours. Out of hours the rapid response crisis service is available.

4.7 It is reported that when a YP has been admitted via A&E, the rapid response outreach service arrive within 90 mins to carry out assessments. Acute staff now feel more confident in caring for these YP and report better multi professional working. If the YP is known to CAMHS then every effort is made to ensure that the same care coordinator is contacted to ensure continuity of care.

4.8 The Specialist adolescent unit provides the utilisation of 3 beds. This was originally 2 but often fluctuated to 4-6. Due to the re-designed care pathway, the length of average stay has decreased from 70-90 days to 28-30 days. 44% of admissions were young people with eating disorders – these admissions have reduced to 18% seen as a result of an improved pathway across the integrated CAMHS service

4.9 Transition arrangements from CAMHS are begun when the YP is around 17, where it is evident that continued care and treatment will be required. Appropriate transition protocols are in place and there is good communication with adult mental health services, provided by the same Mental Health Trust. The care programme approach (CPA) documents safeguarding issues and ensures early links with adult services. A smoother transition is now ensured, as at first there was some difficulty with high thresholds into adult services.

4.10 There is a well established safeguarding team within OBMH. CAMHS staff are aware of the named professionals and who to contact if guidance is needed.

4.11 There is a well established children's disability therapy team. This includes community nurses, physiotherapists, occupational therapy and speech and language therapy services. There is good partnership working across agencies such as housing, social services and the adaptation service when providing more suitable accommodation for CYP both within mainstream schools and within the home. There is good provision for short breaks that are well evaluated by CYP. An external agency - The McIntyre Trust support placements for CYP with profound disabilities and this is jointly funded by education. Further funding is also obtained via the "Aiming High" project and this supports additional short break placements and more creative activities open to these CYP. Action for Children has been awarded a contract worth over £11million to run the county-wide Residential Short Break Services for Disabled Children, for the next five years. The new service will incorporate services currently provided by the LA and health.

4.12 The team report good communication with the social care children with disabilities team. Referrals into any therapy service are made in a timely manner and are clear and concise. Joint care pathways are agreed between social services and health and have lead to a better understanding of roles and responsibilities and earlier interventions for CYP.

4.13 Speech and language therapy services are very accessible through schools for statemented children and young people and through drop-in sessions across the county for under 5's. There have been waiting lists for assessments. In order to improve accessibility and outcomes the service is currently being jointly re-tendered with the County Council

4.14 Occupational therapists have input into educational support plans in mainstream schools for statemented children and young people with over 400 children being supported through their Statement of special educational need funded by education. There are considerable waiting times for assessments and interventions and the service is about to be jointly re-tendered with the County Council in the new year to improve accessibility and outcomes for children and young people

4.15 The number of completed annual health assessments for looked after children is good. The Children in Care Health Report in September 2010, showed that 89 % (204) of LAC had completed annual assessments.89% (204) had their teeth checked by a dentist. Completed immunisation programme was reported as 85 %(195). Assessments have steadily increased each quarter to date to over 90%. This is above national average figures. The majority of assessments are completed within the 28 day statutory time scale,

4.16 There is a comprehensive data base recording the demography and all health information of each child in care. It is updated daily by either health professionals or admin support. It ensures good understanding of the flow of any CYP and gives more confidence in tracking LAC at any one time. Staff are able to immediately identify out of authority LAC which allows them to pursue appropriate health professionals in gaining information.

4.17 There is a fast track access for LAC, with only one week waiting time for assessment into CAMHS. This earlier intervention and more integrated care pathways have resulted; it is reported, in a decreased level of dependency within the mental health services. Case tracking provided evidence of a high level of intervention with an individual LAC by CAMHS, with unorganised contact made on a regular basis when engagement had been difficult. Referrals for LAC with disabilities are prioritised on individual needs by the Children with disabilities team and no delays in accessing services have been reported from the LAC health team.

5 Outcome 6 Co-operating with others

5.1 Sexual health services, both at tier 2 and 3 have good links with Connexions and the RU Safe team ensuring that YP receive timely interventions and are signposted to appropriate agencies.
The services work closely with foster carers and care leavers provide guidance on talking with YP about sexuality and sexual health to try to avoid crisis situations.
Multi agency training is provided for a range of groups to promote healthier lifestyles and raise awareness in sexual health. This has included facilitating training for GP's in the taking of sexual history from YP and this is leading to better engagement of YP with GP's.

5.2 Each of the professional leads for LAC, YOT and adoption and fostering services meet regularly with service managers from the mental health trust to ensure continued and improved communication. This enables sharing of good practice in regards to safeguarding and influence the development of care pathways.

5.3 There are a number of specialist posts including midwife for vulnerable families and teenage pregnancy that support vulnerable and hard to reach CYP and families. Good multi-agency work and relationships are reported that support more effective interventions and improved outcomes for CYP.

5.4 There are plans in place within the Thames Valley area to develop a Sexual Assault Referral Services. At the time of the report there is no definitive timescale but CYP in Buckinghamshire who require forensic examination continue to receive a local service. The named GP for child protection also works as a forensic doctor within Buckinghamshire and continues to complete forensic examinations on children and young people using facilities at Wendover Police Station.

5.5 Care is delivered within special schools across the county for CYP with multiple complex needs. Nurses within the team report heavy caseloads but that they feel well supported by named and designated professionals both in health and social care. Also the team support CYP in mainstream schools with complex needs and report good support from other health agencies, social care and education.

5.6 Capital funding was obtained for developments in leisure centres to fund adjustments to the environment to enable CYP with disabilities to access more community facilities and improve integration with the wider community. It was reported that the local leisure centres were very proactive in undertaking this project and embraced improvements to allow better access for CYP.

5.7 The common assessment framework (CAF) is becoming more effective across partner agencies. However staffing difficulties amongst health visitors and school nurses are impacting on their ability to undertake the lead professional role in CAF.
Early intervention panels are reported by some health professionals to be slow in responding in some cases when children are identified as requiring additional support. Others feel that CAF can raise the expectation of families but then CAF drift and little is achieved.

5.8 The Walton Court and Southcourt Children's Centres incorporating Sure Start and managed by The Healthy Living Centre provide a wide range of facilities including a crèche, cafe and computer suite. Services include parent and toddler groups, benefits and debt services, exercise classes, adult learning classes, a stop smoking service and credit union. Additional funding is provided by the PCT. There is a positive impact on the lives of BME families, particularly young mothers, who would normally be very hard to engage. Attendance is good and continually improving from this group. Women have been assisted in accessing domestic abuse support and also to access classes in English.

6 Outcome 7 Safeguarding

6.1 The Children in Care health team comprising of the Designated Dr and Designated Nurse has recently been enhanced by the appointment of a nurse specialist into the established team. The nurse specialist role is to engage specifically with hard to reach CYP and carry out the required health interventions. This includes CYP who are placed out of LA. All health services are offered at one time during any engagement that may be initiated.

This post is funded by a Service Level Agreement with Social Care - Care Matters funding (funded until 31.03.2011). A business case is already on going to propose that this becomes a mainstream joint funded post between health and social care.

6.2 There is appropriate health representation on the Children's Trust and the Local Children's Safeguarding Board (LCSB). All health providers are represented on both the LSCB and 8 out of 9 its sub-committees. There is a non executive lead on the PCT board who effectively monitors and provides challenge in regard to child protection and safeguarding issues. Health professionals contribute well to child protection conferences and core groups either by attending or submitting reports.

6.3 The Designated Nurse for Children in Care sits on the Professional Executive Committee of the PCT Board and this provides good opportunity for ensuring that safeguarding remains a high priority across health services and also allows professional expertise to be readily available.

7 Outcome 11 Safety, availability and suitability of equipment

7.1 Within Buckinghamshire Healthcare NHS Trust (RXQ) and the location visited at Stoke Mandeville Hospital (RXQ02), care for CYP is provided in safe and dedicated environments. The maternity ward, children's wards and out patient settings have secure entry and some areas have CCTV in place.

7.2 Emergency care for CYP is provided in a safe and dedicated environment in the Paediatric Decisions Unit (PDU) within the hospital. It has 10 rooms in total including cubicle areas. There is secure access at all times, with CCTV in place. Safeguarding is well embedded in day to day practice. During the visit to the department a Student Nurse was very confidently able to describe the flow of any CYP attending the department and in detail was able to discuss how child protection and safeguarding issues would be raised and acted upon.

7.3 If a CYP has to be transferred into main A&E resuscitation area a different coloured patient information board is used to raise awareness that there is a CYP in the unit. There is a separate resuscitation bay for CYP, which is appropriately equipped. When a poorly CYP is transferred into the department via ambulance, a dedicated phone with different ring tone is used to again alert staff that a CYP is to be admitted.

7.4 It is reported that there are no issues with procurement of equipment across children's services within the Acute Trust.

7.5 Equipment provision for disabled CYP is good. Stream lining of procurement processes via joint commissioning frameworks have meant that equipment is generally available much quicker.

8 Outcome 12 Staffing recruitment

8.1 Safeguarding is clearly embedded in the culture of all the healthcare agencies and included in all areas of recruitment and selection, induction of staff and ongoing training and development.

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8.2 Recruitment policies across the PCT and provider trusts are in place and include the requirement of appropriate pre employment checks and criteria. Databases are maintained to monitor renewal dates of membership to professional bodies both for Medical and Nursing staff.

9 Outcome 13 Staffing numbers

9.1 Health Visitors are attached to GP practices, based in 8 localities. Vacancies are high and this has lead to capacity issues resulting in less universal services offered to new Mums and babies**.** The majority of the role is reported to be spent on child protection and it is felt that there is a loss of opportunity for earlier health intervention. A review of service delivery is to be undertaken.

9.2 Similar concerns were expressed by some School Nurse's, who reported no capacity to deliver full time health school agenda along side education colleagues.

10 Outcome 14 Staffing support

10.1 Attendance and availability of safeguarding training is good across health. Training is accessed both internally within the NHS trusts or via the multi disciplinary training from the LSCB.

10.2 There are effective training and development strategies across the Primary Care Trust, Acute and Mental Health Trusts with appropriate evaluation and monitoring of the training delivered for child protection and safeguarding.

10.3 Within the Acute Trust, 81% of staff have received training at level one, and staff working with children have received either level two or three, as appropriate to their role and contact with children and young people. Local Practice development nurses allocated to each department monitor attendance at training.

10.4 The health strategy group meet quarterly, chaired by the Lead Professional. This is used as the forum to discuss any safeguarding concerns and disseminate information across the acute trust. There is evidence of dissemination of learning from SCR via named leads and clinical governance meetings. Staff development days always have session on SCR. Attendance again is monitored.

10.5 Levels of staff training is good within Oxfordshire and Buckinghamshire MH NHS FT (RNU) - 91% at level 1 - 94% level 2 and 80% at level 3.Attendance is monitored by the

training dept and non attendance flagged with line managers. Attendance at safeguarding training is mandatory and forms part of PDR requirements and discussions at appraisals.

10.6 Joint training events are held with other health groups such as sexual health outreach, DAT and RU Safe teams. These have been successful in raising awareness across health about the complex issues within LAC and have resulted in a "no wrong door" shared protocol amongst health and Social care so that wherever or to what ever agency a CYP presents they can be assured that they are appropriately directed to and receive the right intervention

10.7 Supervision is available for staff across health via a range of forums, either 1.1, peer or group. However, there has been no monitoring of uptake or evaluation of the quality of supervision in either the PCT or Acute Trusts.

11 Outcome 16 Audit and monitoring

11.1 An audit of case files by Named Nurse LAC showed some delays in receiving referrals to undertake initial health assessments from social care. In one case the referral was received 22 days after the placement was agreed. In response in the North of the County a weekly children in care clinic has been instigated to ensure CYP are seen in a timely manner and to monitor referrals. In the South extra clinics are booked when necessary. A repeat audit is on going.

11.2 A&E attendance for CYP audit report – Stoke Mandeville and Wycombe Hospitals April 2010, demonstrated that Clinicians were not always completing the Paediatric A&E report forms with the required detail. Also the CAS cards used in the two units were different, with the one in use in Wycombe not documenting if the CYP was subject to CP. Since then the CAS cards have been harmonised to contain the same criteria for assessment and the CP box included in both. Also there is reported to be an improvement in the documentation of presenting injury or symptom and the audit is to be repeated.

11.3 .Performance reports against the health priorities within the CYPP are undertaken by the children's commissioning team within the PCT and action plans implemented as required

11.4 The Strategic Health Authority lead for CYP and Maternity reports good commitment and shared responsibility across the health economy in the promotion of safeguarding. Compliance statements are in place for all healthcare organisations. Section 11 audits are completed and these are appropriately monitored through the quarterly designated safeguarding lead professional meetings.

12 Outcome 20 Notification of other incidents

12.1 There are satisfactory arrangements in place across the PCT, Acute and Mental Health Trusts to ensure that appropriate and timely notifications are made in relation to the required alerts into the various agencies NRLS, NPSA and CQC.

13 Outcome 21 Records

13.1 Health records for LAC examined were well organised, with good chronology of significant events. Assessment and contact sheets are up to date, signed and dated in all files. All files contained on going health care plans. Health needs are appropriately assessed.

13.2 There is good evidence that non attendance for health assessments or other clinic sessions are followed up in a timely manner. Young people confirm they are supported to be healthy and live active and healthy lifestyles. They are each registered with a GP and dentist and can access other specialist care as required.

13.3 LAC reviews are communicated between health and social care appropriately and are retained within healthcare files.

14 Recommendations

Within 3 months (from report)

- NHS Buckinghamshire and Buckinghamshire Healthcare NHS Trust should monitor attendance and evaluate the effectiveness of supervision arrangements for health professionals.

- A vacancy review and review of service provision for Health Visitors and School Nurses should completed to ensure appropriate service delivery within the requirements of the core frameworks.

- Buckinghamshire Healthcare NHS Trust should review the capacity and service provision of the Paediatric Health Visitor Liaison role.

Next steps

An action plan is required from the commissioning PCT within 20 working days of receipt of this report. Please submit the action plan to your SHA copied to CQC through childrens-services-inspection@cqc.org.uk and it will be followed up through the regional team.