Report on the Outcome of the Integrated Inspection of Safeguarding and Looked After Children's Services in Central Bedfordshire

Date of Inspection	**20th February 2012 – 2nd March 2012**
Date of final Report	**10th April 2012**
Commissioning PCT	**NHS Bedfordshire and Luton**
CQC Inspector name	**Tina Welford**
Provider Services Included:	**South Essex Partnership University Foundation NHS Trust (SEPT).** **Cambridge Community Services (Luton)** **Bedford Hospital NHS Trust** **Luton and Dunstable Hospital Foundation NHS Trust**

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 .

NHS Bedfordshire and Luton - Central Bedfordshire	
Safeguarding Inspection Outcome	**Aggregated inspection finding**
Overall effectiveness of the safeguarding services	Good
Capacity for improvement	Good
Contribution of Health agencies to keeping children and young people safe	Adequate
Looked After Children Inspection Outcome	**Aggregated inspection finding**
Overall effectiveness of services for looked after children and young people	Adequate
Capacity for improvement of the council and its partners	Adequate
Being healthy	Inadequate

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 regional director, 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:

Commissioning and planning of child and young peoples' health services and primary care for children residing in Central Bedfordshire are undertaken by NHS Bedfordshire and Luton. Universal services such as health visiting, school nursing, and paediatric therapies are delivered primarily by South Essex Partnership University Foundation NHS Trust (SEPT). Cambridge Community Services (Luton) provide some paediatric therapy services and community nursing services for children living in the southern part of Central Bedfordshire.

The acute hospitals providing Accident and Emergency services for children are Bedford Hospital NHS Trust and Luton and Dunstable Foundation Trust Hospital. Maternity and newborn services are provided by both Bedford Hospital NHS Trust and Luton and Dunstable Foundation Trust Hospital. Children and families access primary care services through one of 29 GP Practices, and the Urgent Treatment Centre / minor illness centres based within the Luton and Dunstable Foundation Trust Hospital. An Out of Hours service is provided in Mid Bedfordshire (M-Doc) which is based at Biggleswade Community Hospital and run by local GP's.

Child and adolescent mental health services (CAMHS) are provided by South Essex Partnership University Foundation NHS Trust (SEPT) (under a Section 75 arrangement). Children with learning disabilities and difficulties and who have complex health needs services are provided by either South Essex Partnership University Foundation NHS Trust (SEPT) or Cambridge Community Services (Luton) depending on where in Central Bedfordshire the child resides.

There are contractual arrangements with a number of other trusts dealing with much smaller volumes of cross border activity. This includes The Lister Hospital in Stevenage, Hinchingbrooke Hospital based in Huntingdon and Cambridge University Hospital based in Cambridge. SEPT is commissioned to provide statutory initial and review LAC Health Assessments and specific CAMH service for LAC.

NHS Bedfordshire and NHS Luton now have cluster arrangements in place and are referred to as the NHS in Bedfordshire and Luton. Two clinical commissioning groups are in place in shadow form within Bedfordshire and Luton.

Central Bedfordshire covers an area of 716 sq. km from Leighton Buzzard and Dunstable in the west to Sandy and Arlesey in the east, and is home to 255,000 people (2008). Central Bedfordshire is situated in the Milton Keynes and South Midlands (MKSM) growth area, with 54,000 new houses planned by 2031. The total population of Central Bedfordshire is set to increase by just over 10% by 2021, but the largest increase in population will be in the 65 and over age range. This population will be set to increase by 53% to 2021. Health and wellbeing is critical for this age group, to prevent or delay deterioration into ill health, social isolation and the need for acute care. Central Bedfordshire's population is forecast to grow from 252,900 in 2009 to 292,100 in 2021 and to 335,000 in 2031. The north of Central Bedfordshire is expected to have an increase of around 14,000 people by 2021, while the south will increase by around 25,000. A quarter of the population of Central Bedfordshire is under the age of 20. Around 10% of school children are from a black or minority ethnic group and 13% of children under 16 are living in poverty. An estimated 11% of people living in Central Bedfordshire were from ethnic minority backgrounds in 2007, with a large proportion living in south Central Bedfordshire.

Central Bedfordshire is classified as predominantly rural with just over half of the population living in rural areas. The largest towns are Leighton-Linslade, Dunstable, Houghton Regis, Biggleswade, Flitwick and Sandy. In terms of overall deprivation, no areas within Central Bedfordshire are in the 20% most deprived nationally. However, for some of the individual aspects of deprivation (such as education, crime and income) communities in parts of Houghton Regis, Dunstable, Leighton-Linslade and Sandy do fall into the worst 10% nationally. The areas with the highest levels of deprivation are in Houghton Regis and Dunstable Downs wards.

General – leadership and management

The Children and Young People Plan (CYPP) priorities are challenging and demand joined-up service development and commissioning of resources and, partnership working, including child and adolescent mental health services (CAMHS). The priorities include; obesity, teenage pregnancy, looked after children's health and early intervention services are being achieved through good performance monitoring and holding partners to account, through the various strategic boards reporting structures, including to the shadow health and well-being board. There have been recent challenges in ensuring appropriate representation at the local safeguarding children boards (LSCBs) following the reorganisation of health services, this has recently been resolved.

There is strong engagement and challenge from joint health and local authority strategic boards and from health provider trust boards, effectively scrutinising both annual and quarterly safeguarding and looked after children reports and action plans. There is good engagement with the corporate parenting board. Partnership working with the children's social care team, within all health organisations and at all levels was improving.

Health organisations have concurrent safeguarding policies and procedures, with a number recently reviewing their training strategies. The monitoring of the implementation is too variable. Designated and named safeguarding professionals are well engaged with the LSCB and the various sub groups.

There is good engagement from children's social care and health staff including contracted voluntary sector services such as Plan B (substance misuse services) and Brook (sexual health services) on the Looked After Children Health Improvement Group.

The Child Death Overview Panel (CDOP) has good engagement with all partner agencies, including police and ambulance services. CDOP has recently recruited lay members, although they have still to attend their first meeting. There are good links with the LSCB's serious case review sub-group, including sharing of the overview and summary reports. Monthly meetings are held to review child deaths with annual reports presented to the Central Bedfordshire LSCB. There has been some evaluation of the effectiveness of the CDOP's campaigns although embedding in practice remains a challenge. The LSCB are currently mapping child deaths in Central Bedfordshire with those across the region, to improve the quality of benchmarking data. Maternity staff have good engagement and awareness of CDOP, with robust investigation processes when there has been a baby death. Awareness of campaigns such as the 'bed sharing' and 'rollover' campaign is less well developed within community and primary care services.

Health commissioners have issued safeguarding children guidance to dental practices; however, the application in practice is not been evident in this inspection. Commissioners visit dental practices on the performers list every eighteen months, to review compliance with safeguarding and guidance. No evidence of outcomes from these visits was available.

Executive health directors have taken immediate action to ensure swift implementation of learning from the inspection of neighbouring services [1]which are shared across and into the Central Bedfordshire Council authority area.

Outcome 1 Involving Users

1. Child and adolescent mental health services (CAMHS) have the You're Welcome quality accreditation programme criteria for young people friendly health services standards accreditation programme. Young people are also actively involved in the production of a website and information leaflets about CAMHS provision and also on specific conditions such as anxiety and anger management. CAMHS use a wide range of outcome focussed treatment and intervention measures as well as patient user satisfaction and experience questionnaires, which show a good level of satisfaction with services.

2. School nursing service user feedback related to the, is collected through a number of questionnaires and experience measures. Results show that young people value the 'drop-in' sessions (which are well attended); as they provide a full range of health services including sexual health services.

3. The genito-urinary medicine clinic (GUM) provides good open access with a dedicated young person clinic. This provision has been reviewed by young people from the youth participation team, as part of the process to gain the You're Welcome quality criteria for young people friendly health services standards accreditation.

4. There are good volunteer support networks for families who have children with disabilities, such as the highly valued Family United Network, which is well supported by health staff.

5. Health staff have access to interpretation and translation services, however, there was no evidence seen during the inspection in health files of the use of these services. Equality, diversity and cultural issues were not always fully addressed in the records and documents seen, with the exception of some of the patient/family information produced by the health professionals working with children who have disabilities. No evidence of the use of interpretation and translation services was seen in health files but these services are available to health staff. Information about the needs of foster carers for example those who are hard of hearing and the agreed communication contact routes, are not shared by children's social care. This has resulted in delays in the looked after child's health review taking place.

[1]The integrated inspection of safeguarding and services for looked after children at Bedford Borough Council and NHS Bedfordshire and Luton (2012)

6. There is good engagement of service users within substance misuse services with a 94% response rate to feedback questionnaires. Looked after young people have been involved in the recruitment and selection of staff for the substance misuse service. However, it is still recognised that there remain gaps in using young people's views within service design and delivery, including in the youth offending system. Recently, work on identification of trends and frequent attendees have at Dunstable police station. This seeks to prevent criminalisation and improve the choices given to young people but it is too early to measure the impact of the scheme.

Outcome 2 Consent

7. Consent is obtained before all looked after children health assessments. However, delays in obtaining the signed consent forms from childrens social care impacts on the number of health assessments completed on time.

8. Bedford Hospital Trust A&E department's process for determining parental responsibility is not robust. Audits of consent have not been robust or inclusive of all groups of children and young people that have visited the department, which is a missed opportunity.

9. Fraser competencies are effectively used within the sexual health services to ensure young people are appropriately safeguarded.

10. Dental staff seen during the inspection were unaware of the need to determine parental responsibility when consenting for treatment involving a child, especially a looked after child.

Outcome 4 Care and welfare of people who use services

11. Young people report good access to the education curriculum relating to personal health and well-being, which includes sexual health education and reducing risky behaviours. School curriculums across all age ranges are effective in helping young people keep safe. Universal curriculums have been developed to promote awareness of how young people can keep themselves safe from harm including sexual exploitation. Alternative curriculum approaches for young people at greater risk of harm, including from domestic abuse, effectively use the Triple PPP parenting programme. This is well established and highly valued by participants, including teenage parents and educationalists.

12. The judgement for the Every Child Matters outcome '*Being Healthy'* is inadequate. Health outcomes for looked after children (LAC) are below England averages and have declined over the preceding twelve months (December 2011). The reported health assessments rate is 73%, immunisation rates 78% (a lower rate than that of the general population which are between 77%-89%), and dental checks at 66%. Although the reliability of the data and differences between health and social care data are recognised as not being robust, this is still to be reconciled. The strength and difficulties questionnaire (SDQ) scores are showing a worsening trend in emotional well being, which are higher than national averages.

13. Review health assessments are undertaken by health visitors or school nurses in the 0-19 team, depending on the age of the child. There is very limited choice and flexibility in the location and time of health assessment appointments offered.

14. The sexual assault referral centre (SARC) is located outside of the Central Bedfordshire authority area. Referral pathways are understood, with improving communication reported by health staff. The SARC only provides services for young people over thirteen years of age, who are referred by the police, and wish to pursue their case through the courts. Young people under thirteen years old have an agreed pathway to attend Peterborough SARC; however, it is too early to measure the effectiveness of this pathway. There is currently no provision for victims to self refer to the SARC, or for other professionals to refer to the service. There are plans in place to address this but are dependant on employing sufficient crisis workers. Although progressing, this remains ongoing at the time of the inspection. There is still a gap in provision of specialist forensic and sexualised behaviour and post traumatic support services although the Exceptional Treatment Panel has funded treatments in some individual cases.

15. Rates of teenage conception remain below England averages at 31.6/1000 for under eighteen year olds. There is however, a number of 'hotspot' areas, where rates are double those of England and most of Central Bedfordshire, such as in Houghton Hall ward, a rate of 79.9/1000, (the latest unqualified health data shows that the rate has fallen to 66.3/1000) and Manshead with a rate of 78.2/1000, (with the latest unqualified health data showing that this rate has risen to 86.4/1000). Whilst there is good access to a range of flexible sexual health and contraceptive services, the impact on the rate of teenage conceptions is yet to be fully realised, resulting in a slow rate of decline especially in hot spot areas. There is a good integrated range of provision provided by Brook and the Terrance Higgins Trust, which is highly valued by the young people. As a result of the good use of the sexual health outreach workers and the 'boys outreach worker', attendance rates have increased by 70% at some sexual health services. A range of well accessed 'drop in' sexual health clinics are held within schools, especially those in the areas of high teenage conceptions, although their impact on reducing conceptions is yet to be seen. As a result of the wide ranging and flexible sexual health services, including the family planning midwifery service, there is a reported 50% drop in the rate of second conceptions. The 'undercover' condom card scheme for under sixteen year olds was re-launched in September 2011, and is yet to be fully embedded and evaluated. Adequate support is provided to young women post termination of pregnancy, but with little evidence of audits of the quality of the provision.

16. The LSCB has issued updated guidance relating to families in which there is substance misuse. As a result of the supplementary countywide training programme, there is improving partnership working with substance misuse services. The CAN service provides a dedicated worker for children, aged five to twelve years old, who are affected by hidden harm. However, those over twelve years old have to access support provided by the core CAN team, which is not focussed on the needs of young people and does not meet their needs.

17. As part of personal health and sexual relationship education (PHSE) in schools, teachers have received 'risky behaviours 'training. Individual and group workshops for students about substance misuse have resulted in more referrals being made.

18. PLAN B is commissioned through NHS Bedfordshire to provide an outcome focussed treatment service for substance misusers. The service is now to contribute to the mandatory foster carer training on a formal arrangement. The number of looked after young people accessing services is monitored and shows that only 6 cases were seen in the last 12 months and currently out of 10 identified LAC substance misusers, only 4 are in treatment. Training and support to foster carers and residential childrens homes is being given to try and address this shortfall and support young people to reduce their risk taking behaviours. The tier 2 specialist substance misuse services have good links to the early intervention services and the common assessment framework (CAF) processes. As a result of the needs assessment and improved pathways, young people with substance misusing habits have improved access to services and those not in education or employment due to substance misusing habits are reducing. Staff working in substance misuse services report that thresholds for safeguarding referrals are too variable for their clients and that they do not always receive feedback on referrals within 48 hours, consequently, this leads to a number of re-referrals. In the case of pregnant women unborn babies referral are only accepted where there is a clearly identified risk, rather than the opportunity being taken to be proactive in focus protecting the unborn baby from harm at an early stage.

Outcome 6 Co-operating with others

19. There is no commissioned care leaver or after care 'looked after' health service. There is no permanent designated LAC doctor or designated LAC nurse in post. These gaps were identified in the recent Bedford Borough safeguarding and looked after children inspection, as a result commissioners and providers responded very quickly to put interim arrangements in place, with a developing business case for permanent arrangements. GPs are unaware of their responsibilities for looked after children, and are unaware of the statutory guidance for health services related to LAC.[2]

[2] Department of children, schools and families and Department of Health - Statutory Guidance Promoting the Health and Well-being of Looked After Children.

20. There is inconsistent collaboration with the children disability health services to ensure that looked after children, who are also due their disability health review, have a joint appointment to reduce the number of appointments.

21. Health service provided training for foster carers and carers in residential children's homes has been limited in range. This is recognised as an area for further development and plans are well developed to improve and increase the range of training provided.

22. The LAC health team are not always informed in a timely manner by children's social care of changes in LAC status and to placements, (including out of the authority placements).This affects the timeliness of health assessments and reduces their ability to continue to monitor the health status of a looked after child. There are now monthly meetings with children's social care staff and a commitment to improve data, performance monitoring and working relationships. Further, health staff are not informed of the independent reviewing officer LAC reviews and as such, health information and monitoring of action plans from health assessments/reviews are not well communicated.

23. Adoption medicals are undertaken by a dedicated paediatrician who is also acting as the medical advisor to the adoption panel, with good support provided to adoptive parents. However, the sharing of health information from health provider services to the medical advisor is variable. This results in challenges in ensuring comprehensive information is given to adoptive parents.

24. The CHUM and Relate services for emotional health and well being (tier 2 services) have good and further developing processes in place to review all referrals to themselves and CAMHS. This is ensuring that the most appropriate services is provided for the young person, especially for those who are looked after. There is good engagement with schools and colleges providing a range of mental health and emotional well being workshops and support. Sixty four schools, and the virtual head, have received training on assessment of mental health needs to ensure timely and appropriate referrals' to CAMHS, CHUMS and Relate. There is good joint work with the dedicated CAMHS worker for the Youth Offending Service. Additionally, good use is made of case discussion and review meetings to ensure that optimal care is being provided to clients. Social care staff and foster carers make good use of the consultation sessions.

25. At the time of the inspection there are minimal waiting times to access mental health and emotional well being treatment or interventions. CAMHS provide a range of well accessed GP practice based outreach clinics, with the flexibility of home visits for 'hard to reach' young people. Further, there are a number of joint assessment processes in place when inappropriate referrals are made by GPs, helping to ensure that GPs refer to the correct services. GPs spoken to during the inspection were unaware of the range of services provided by CHUMS and Relate.

26. There are no services provided by CAMHS to young carers. Adult mental health services have recently started to identify this cohort, as well as those subject to hidden harm. Although still not comprehensive, all other adult services have started to improve their identification of hidden harm (including the identification of young carers) from a low base.

27. There is a well established transition protocol in place. Transitions to adult mental health services have improved through good joint working of client cases, although there still remains a challenge. The Home Treatment Team ensures, through the effective use of the care programme approach, repatriation from the out of authority intensive highly specialist service inpatient beds (tier 4). There are no specific adult services to support young people leaving children's services with Autistic Spectrum Disorders (ASD) or Attention Deficit Hyperactivity Disorders (ADHD), that do not require ongoing medication. This is perceived by family and carers as a gap in provision.

28. Common assessment frameworks (CAFS) are used within the multi professional meetings as an approach to ensuring that all staff are involved in the care of a pregnant woman to provide support for her and the unborn baby. CAF and team around the child (TAC) meetings are well embedded within school nursing services, with school nurses acting as lead professionals. This has positive outcomes for service users, such as frequently preventing families going into crisis. However, the limited number and high caseloads of community practitioners has a negative impact on the quality of the provision and the range of services that are provided.

29. As a result of a local domestic violence and homicide review, (which is nearing completion), learning from domestic violence cases and the quality of information that is shared between professionals were assessed as not being robust. The police notification of domestic violence incidents that do not meet the threshold for a multi agency risk assessment conference (MARAC) are triaged by social care staff and only if there is an initial assessment, will the information be shared with health staff. This process has weaknesses, notably that the lack of information sharing limits the ability of health staff to fully identify and risk assess any concerns that they have about an individual or family. As a result of training, high rates of domestic violence incidents are being reported by staff at Luton and Dunstable Hospital. Good use is made of the 'DASH' forms to ensure that information relating to victims of domestic violence is effectively shared between health staff within acute health provider services.

30. Learning from serious case reviews (SCR) is starting to become embedded as a result of training. It has been further enhanced as a result of staff receiving training in challenge case conference decision. Health staff reported feeling more empowered as a consequence.

31. A cultural shift has resulted in greater openness, effective joint working and improved multiagency working with the children with learning disabilities and physical disabilities services. The good support provided through these improved partnerships is ensuring, where practicable and respecting the choice of the child/young person, that those with disabilities are enabled to attend mainstream schools. Safeguarding needs are addressed through joint working with social care with average engagement of social workers in review meetings. A good range of targeted work with parents of children have learning disabilities and difficulties, supports the family to stay together rather than the child becoming looked after.

32. Seamless transfer/discharge processes for children with disabilities and life limiting conditions is delivered through the support of the dedicated discharge liaison post. This post holder ensures that funding is arranged for equipment. However, this is more challenging with the tertiary centres, where some poor discharge planning, results in a less robust service for some young people. Sibling support was a gap in provision until very recently this is now improving through the use of the carers grant funding from NHS Bedfordshire. There has been a good range of, as well as dedicated training for parents and siblings of children with disabilities. As a result of the ongoing disabilities review, partnership working is being enhanced Aims to move services 'closer to home' and address the transition gaps to adult services are starting to be realised. A recognised lack of data, locally and nationally, to assist with service planning and redesign is now being addressed.

Outcome 7 Safeguarding

33. The judgement on the contribution of health agencies to keeping children and young people safe is adequate. There are highly visible and fully embedded named and designated safeguarding nurses and midwives and the recently appointed designated doctor role is becoming established. All have direct access to or report to their respective organisations' executive director. The named GP has a high profile within the LSCB; however, their profile is less apparent within primary care.

34. There is a commonality of understanding of referral thresholds to social care children safeguarding teams. There still remains a challenge for CAMHS staff in ensuring that the quality of information in referrals is sufficient to ensure that referrals are accepted first time. There has been minimal but successful use of the escalation policy, although some issues were not successfully resolved until they reached assistant director level in children's social care.

35. There is mostly good attendance of health professionals at child protection meetings and conferences. However, GP engagement is too variable leading to poor communication and information sharing, with some GPs reporting that there is no purpose or reason for them to attend these meetings. GPs will occasionally get minutes of meetings only if they have an action point. This does not enable them to effectively support the family or be aware of circumstance changes to those for whom they provide primary health care. GPs have inadequate understanding of their safeguarding children and looked after children responsibilities. Information management systems within GP practices enables the 'flagging' and identification of children subject to child protection plans however these are not always used and there is no 'flagging' of looked after children.

36. Dental services engagement in safeguarding arrangements is yet to be fully operationalised, as partnerships and awareness of other health and social care service provision and responsibilities is not well known. Dental staff seen during the inspection were unaware of the contact details for childrens' social care, in order to make a safeguarding referral, or for 'cases of concern' related to domestic violence.

37. Notification of attendance forms from A&E and the walk-in centres are not routinely sent to the looked after health team. The LAC team rely on health visitors or school nurses communicating any concerns, resulting in a lack of strategic overview of health services being used by looked after children. Information sharing challenges remain with hospitals outside the authority's area, from whom notifications of a child or young person's attendance are not received in a timely manner.

38. The self harming pathway is robust and there is good liaison with the child and adolescent mental health services (CAMHS). However, community practitioners do not always receive information from the adult acute wards when an over 16 year old is admitted, even when they are still in receipt of services from the 0-19 team. The 0-19 team do not receive information from CAMHS about the action being taken and ongoing action required, to protect the young person and reduce their risk taking behaviours. Further, there are significant delays in receiving discharge information from the acute providers, resulting in delays in ongoing support from community health staff. The highly valued Home Treatment Team, (established November 2011), through engagement and work with the emergency duty teams is now preventing and reducing hospital admission and length of stay, however, the full impact is yet to be measured.

39. Core child and adolescent mental health services (CAMHS) have recognised gaps in provision which include CAMHS preventative and comprehensive family assessments. The commissioners have a current work programme reviewing the service specification for CAMHS, the new service commenced November 2011. There are no waiting lists, all patients/ clients are seen within six weeks of referrals being accepted. The CHUMS and Relate services have recently been commissioned to provide early intervention emotional well being support for all young people (including LAC), early feedback is positive, although too early to measure fully the impact.

40. There is good capacity within maternity services, with good use of the maternity notification networks to share information. However, there is limited dedicated time for the named midwife at Bedford hospital who frequently works longer hours than contracted. Although recently recognised, plans are still being implemented to address this. Unborn baby planning is well established, with good partnership working with other agencies. Although there are different systems in place at Bedford Hospital and the Luton and Dunstable Hospital, this is not negatively impacting on the quality of services and the safeguarding duties. At the Luton and Dunstable hospital (L&D) maternity service, following the outcome from a serious case review, staff ensure that all teenage pregnant young women are visited antenatally at home at least twice, includes all pregnant women. Referrals all have a 'cause for concern' form completed at Luton & Dunstable hospital, which are reviewed by the named midwife and triaged, ensuring that cases are referred as appropriate to childrens' social care. Midwives review the general health records for further information to ensure robust case planning, with previous birth history and any known domestic violence incidents for example, are also assessed.

41. All unborn baby plans are filed in the maternity health records, or at Bedford Hospital in a dedicated folder on the labour ward for easy and timely access. Good use of flagging cases of concern within the local A&Es ensures that maternity services are notified when a pregnant woman attends the department, and where there are concerns for the welfare of the mother and/or the baby.

Outcome 11 Safety, availability and suitability of equipment

42. The Joint Allocation Panel for Complex cases and Continuing Care (JAP) is effective in allocating funding, when the right information is presented, with creative solutions found for individual cases, and timely decision making. This includes the funding of generic workers who successfully work with and support the young person; at home, within schools and on school outings.

Outcome 12 Staffing recruitment

43. Safer recruitment guidance is followed within all organisations; all staff interviewed had a current enhanced Criminal Records Bureau (E-CRB). However, at the Luton and Dunstable Hospital the CRB status of staff is not rechecked on a regular basis, resulting in limited assurance of the staff's fitness to practice. Whilst there is, within primary care, some adherence to safer recruitment guidance, this is not robust.

Outcome 13 Staffing numbers

44. Capacity within school nursing and health visiting services is very limited although well developed plans are just being implemented, supported by commissioners. Universal and general health programmes for children aged five to nineteen years is provided through targeted intervention for those classified as being at high risk and/or vulnerable, in an attempt to manage increasing workloads within the reduced capacity.

45. Robust plans have been implemented to improve the number of school nurses and health visitors through offering funded student health visitor and school nurse programmes placements; however, the impact on increasing the number of qualified professionals is yet to be seen.

46. As recognised at the very recent inspection of safeguarding and looked after children, Bedford Hospital NHS Trust accident and emergency department has an insufficient number of registered children nurses to ensure that there is a registered children nurse on duty at all times when children are seen in the department as not all children are seen in the paediatric assessment unit where childrens qualified practitioners are available.

Outcome 14 Staffing support

47. Safeguarding training compliance rates are too variable. The GP compliance rate is not well monitored; the compliance rates are variable from 18% at level 3, to 44% at level 2, with the GP safeguarding leads training rate at level 2, only 89%, these post holders should be level 3 trained. Plans are being implemented at the time of the inspection to improve GP compliance rates. Those GPs interviewed during the inspection were unaware of their safeguarding training requirements, and a number of those interviewed were unable to provide assurance of recent training. Dental services compliance rate is only 15% at level 2 and 10% at level 3 which is inadequate.

48. Training compliance rates at Bedford Hospital are; for group 1- 77% and group 2, 73%, which is inadequate, for group 3 the rate is 93%, however, the overall trust compliance rate is only 78% which is inadequate. NHS Luton training compliance is inadequate, with a reported rate for levels 1-5 only 40%. Luton and Dunstable training compliance trust wide is 88% for all staff, excluding medical staff, whom the compliance rate is only 34%, which is inadequate. The impact of safeguarding training on practice is not sufficient. There has been however, the introduction of an improved lone worker policy as a result of feedback from training.

49. There are various models of supervision in place although all staff report that there is good timely access, (including the designated and named professionals) there is limited evidence of the impact of supervision changing practice. There is good debriefing support provided by the named midwife at Luton & Dunstable Hospital when there has been a traumatic removal of a baby from its birth parents to the foster carers, enabling midwives to provide support to both the birth parents and colleagues.

50. Health staff who are involved with looked after children and young people only access to LAC supervision as part of the safeguarding supervision arrangements. Consequently, health staff who do not have a child/young person who is subject to child protection arrangements on their caseload, receive no looked after children supervision. There are good professional development opportunities for the named specialist LAC health staff, to maintain their competence in caring for looked after children. There has been very recent dedicated British Adoption and Fostering Form (BAFF) training which has very recently started to improve the quality of health review assessment recording.

51. There has been limited use by health organisations of the Local Authority Designated Officer (LADO) in investigating complaints. There has been some analysis of the low rates of referral and action plans are in place to improve referral rates.

Outcome 16 Audit and monitoring

52. Good use is made of the learning from serious case reviews (SCRs) and significant incidents by health providers in neighbouring authorities. There is also good monitoring of health action plans. Learning is being embedded into training programmes, where the limited evaluation is showing that practitioners are starting to share learning in their practice and within their teams, although the direct impact on changes to practice is less evident.

53. There is good data collection and monitoring by commissioners of the contracted services for substance misuse. The commissioning of adult services to monitor and ensure that hidden harm cases are identified through the use of regular questioning and recording of responses has improved, although remains a challenge.

Outcome 20 Notification of other incidents

54. Whistle blowing policies are in place and have been linked to the need to improve the use of the Local Authority Designated Officer (LADO) role. There were limited examples of successful use in practice.

Outcome 21 Records

55. Health records seen during the inspection were of variable quality and content, none were fully comprehensive. There was no evidence of SDQ scores or analysis being used, although there was some evidence of emotional well being assessments. The files of young people placed out of area whose files were reviewed as part of the inspection did not contain a copy of their health assessment. The health provider has recognised through the pre-inspection self audit of files that there are a number of shortfalls in record keeping and access to health information of looked after children. An improvement plan is already in place, and includes the recommendations from the recent Bedford Borough safeguarding and looked after children inspection, (which shares the same health providers). All initial health assessments are completed by a consultant paediatrician. There was very limited evidence of equality and diversity issues being identified in the health files. Health action plans developed as a result of health assessments/reviews were too variable in both quality and content, with in some cases no timescales recorded to enable monitoring to take place.

56. Records did not always comply with professional record keeping guidance. There was no evidence of supervision being recorded in the files.

Recommendations

(*Including those from the joint report in italics*)

Within 3 months

NHS Bedfordshire and Luton must ensure that all care leavers are enabled to access health services and receive a copy of their health histories to ensure that they are able to make future life choices.

NHS Bedfordshire and Luton must ensure that all looked after children and young people receive age appropriate health education and promotion information.

NHS Bedfordshire and Luton and Central Bedfordshire Council must ensure that the strength and difficulties questionnaire outcomes are reviewed as part of the emotional health and well being assessment during review health assessments.

NHS Bedfordshire and Luton must ensure that all general practitioners and independent contractors are aware of their statutory responsibilities to looked after children.

NHS Bedfordshire and Luton must ensure that all general practitioners and independent contractors are aware of their safeguarding duties and responsibilities.

Within 6 months

NHS Bedfordshire and Luton must ensure that there are sufficient numbers of community practitioners in line with national directives and local needs to provide the commissioned service and universal health child programme.

NHS Bedfordshire and Luton and the local safeguarding children board must ensure an increase in the compliance rates for training especially within primary care and the independent sector, as well as the impact of training in practice to protect children from harm is well embedded throughout all health providers.

NHS Bedfordshire and Luton and South Essex University Partnership Trust must ensure a good well planned transition to adult mental health/learning disability services for all young people with a mental health and/or learning disability or difficulty.

NHS Bedfordshire and Luton must ensure that all health providers use the experience of service users as part of the needs assessment when reviewing service design and delivery.

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.