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.

<table>
<thead>
<tr>
<th>Coventry City Council</th>
<th>Aggregated inspection finding</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Safeguarding Inspection Outcome</strong></td>
<td></td>
</tr>
<tr>
<td>Overall effectiveness of the safeguarding services</td>
<td>Good</td>
</tr>
<tr>
<td>Capacity for improvement</td>
<td>Good</td>
</tr>
<tr>
<td>Contribution of Health partners</td>
<td>Adequate</td>
</tr>
<tr>
<td><strong>Looked After children Inspection Outcome</strong></td>
<td>Aggregated inspection finding</td>
</tr>
<tr>
<td>Overall effectiveness of services for looked after children and young people</td>
<td>Adequate</td>
</tr>
<tr>
<td>Capacity for improvement of the council and its partners</td>
<td>Good</td>
</tr>
<tr>
<td>Being Healthy</td>
<td>Inadequate</td>
</tr>
</tbody>
</table>
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 the CQC 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.
Coventry is a diverse city in the West Midlands with a total population of 312,000. Approximately 68,000 children and young people aged 0–17 live in Coventry, representing 23% of the population and 35% of children and young people are from minority ethnic groups compared with the national average of 23%. In February 2011, there were 362 children and young people subject to a child protection plan in Coventry and 594 looked after children and young people. This included a small number of unaccompanied asylum-seeking minors. The rate of looked after children in Coventry is well above that of similar councils. The council and its partners currently support 198 care leavers.

The Children and Young People’s Commissioning Board, chaired by the Chief Executive of Coventry City Council, with the Chief Executive of NHS Coventry as vice-chair, plans and commissions universal, targeted and specialist child health services. Resources are aligned, rather than pooled, to agreed priorities and outcomes detailed in the Children and Young People’s Plan. These include comprehensive CAMHS, Aiming High for Disabled Children, residential care services for children with disabilities, the Continuing Care Panel, Healthy Schools work, Healthy Weight work and Drug, Alcohol and Substance Misuse services for young people. The Partnership also has a number of joint commissioning posts. Prior to March 2011 a joint children’s commissioner was in post, however this post was vacant at the time of the inspection.

Health visiting, school nursing, community paediatric services and speech and language provision are provided by Coventry Community Health Services. Specialist Child and Adolescent Mental Health Services (CAMHS) are provided by the Coventry and Warwickshire Partnership Trust. The main provider of hospital services, including accident and emergency services for children and maternity services for children and families in Coventry is University Hospital Coventry and Warwickshire (UHCW). Children and families access primary care through one of the 67 GP practices in the city. A minor injuries walk-in clinic operates from a city centre location.

General – leadership and management

1 The Coventry Children and Young People’s Strategic Partnership (Children’s Trust), chaired by the council’s Chief Executive, is well established. NHS Coventry is a member of the Children and Young People’s Partnership and contributes to both the development and delivery of the Children’s Plan. The Community Health Services’ Children and Young People service specifications reflect the aims of the plan. Aligned rather than pooled budget arrangements operate between health and the city council and are directed to agreed Children and Young People’s Plan priorities and outcomes. These are overseen by the joint Children and Young People’s Commissioning Board. A new Health & Wellbeing Board will be established from May 2011 to which the Children’s Board will report. This new board will also give an opportunity to better secure effective governance of the health and wellbeing needs of children who are looked after, current arrangements not being robust. An effective CAMHS service partnership is in place led by Coventry and Warwickshire Partnership Trust (CWPT).
Governance arrangements between the Coventry Safeguarding Children’s Board (CSCB) and Children’s Trust have recently been strengthened. The CSCB, chaired by the Director of Children’s Services, provides effective professional leadership for safeguarding across the city. Health is well represented on the CSCB and its sub-groups, which include a Health Panel, and there is cross membership with Warwickshire’s safeguarding children’s board through the designated nurses of each authority. There is a clear supporting infrastructure of multi-disciplinary safeguarding link groups through all levels into frontline services facilitating effective communication about safeguarding issues. The Designated Nurse provides bi-monthly updates and an annual report to CSCB based on the work plan of CSCB Health Panel. In addition reports, where audits are led by health professionals, or as chairs of CSCB sub committees, are provided by named doctors and nurses. The annual PCT safeguarding report is the basis for an annual health safeguarding children newsletter cascaded to the safeguarding link groups and other professional forums. These groups afford opportunities to share common issues and learn from good practice and are generally valued by attendees. Attendance is intermittent from some departments of UHC&W however and these may be less well engaged with the safeguarding agenda.

Health safeguarding policies are current and embedded. Health staff across acute and community services overall have good levels of awareness of child safeguarding issues, indicators of risk, thresholds and referral arrangements and are committed to keeping children safe. Staff report that they are aware of the content of their respective policy and where to locate the operational procedures, which accompany these should they be required. Themed reviews of provider organisations are undertaken by NHS Coventry as commissioners of the service. Audits are regularly undertaken by the named doctors and named nurses, with provider organisations having in place agreed audit programmes, action is taken to improve safeguarding performance. The safeguarding lead doctors and nurses are committed and passionate about safeguarding, providing good leadership and advice.

The overarching leadership and management of health services for looked after children however, has been under resourced, with protracted vacancies in the key roles of designated doctor and designated nurse and health outcomes for looked after children are inadequate. Following a review of the LAC services, plans are in place for the designated looked after children professionals to take a more strategic role, similar to those of the designated child safeguarding professionals, with reduced operational responsibilities. The newly reconfigured Coventry and Warwickshire Partnership Trust (CWPT) will have a general manager for children’s services giving a potentially clearer strategic focus for looked after children.
5 The Care Matters steering group, chaired by the Director of Children’s Services, has engaged with senior officers across the partnership. Now the infrastructure is in place the emphasis is on improvement in outcomes for looked after children. The current focus is appropriately on perceived areas for development: accommodation and education, training and employment for care leavers. It has been agreed by the health sector that increased engagement is required to ensure strategic and operational ambitions are delivered for looked after children. The recent Department of Health guidance on health needs for looked after children is being used as a framework to improve partnership vision and commitment and representatives from health are involved in the Care Matters Operational Group.

6 Issues impacting on the future capacity for Coventry NHS to improve include the rising local birth rate which passed 6,000 last year and the transferring of maternity services from George Elliot hospital in Nuneaton to UHC&W. The ratio of births to midwives is high. It is not yet known whether some George Elliot resource would transfer to UHC&W. The new paediatric model for GE requires a radical overhaul of maternity and neo-natal services at UHC&W to ensure ongoing capacity.

7 The PCT is committed to deliver services more effectively through increased co-location and integration of services where possible and community services, including CAMHS and the GUM are co-locating in the autumn in a newly developed site and transitioning into the Partnership Trust. An awayday with clinicians is planned to look at how the new pathways will work.

**Outcome 1 Involving Users**

8 Young people’s engagement is developing well in health with some very positive examples such as Health and Young People’s (HYPe) contribution to the Be Savvy website and the Healthy Mind Booklet. HYPe are keen to be involved in wider health developments than their current brief of sexual and mental health. There have been a number of other measures put in place to capture feedback and the experiences of children and young people of health services, including touch-screen facilities in the emergency departments at UHC&W. Advocacy support is also available to children and young people using health services. The Celebrating School Nursing Day held recently was planned with a strong input from young people.

9 The Child and Adolescent Mental Health Service (CAMHS) undertakes regular surveys of young people using services and their family carers. In the last survey, 94 per cent (159 respondents) said something positive. Ninety-seven per cent said that they were listened to and 96 per cent felt their views were taken seriously. Most young people said that appointments were at times they found convenient. There is scope for further strengthening of engagement by health services however, particularly for those young people with disabilities and complex conditions who may find it more difficult to get their opinions and experiences across.
Frontline health staff report good access to translation and interpreting services, which aim to comply with gender specific requests wherever possible. There is a strong health commitment to using interpreters who are not family members. Health information is available in different formats and languages. The maternity department at UHC&W is piloting a computer based translation service. This gives gender neutral translation and acts as a fast tool which is sometimes a benefit. It has taken some time to be adopted but is now increasingly becoming used routinely. Some trained staff on the emergency departments are able to use British Sign Language. Services are aware of the need for gender balance in their workforce and the sexual health service has both male and female nursing staff. Community staff report that some young women do find it difficult to access acute services when faced with male reception staff and male voices if telephoning for advice or appointments and health providers should be mindful of this issue and take corrective action as necessary.

Outcome 2 Consent

Consent to assessment and treatment is sought from the child or young person if competent and staff are aware of the need to assess a young person’s competency prior to gaining consent. Accident and emergency staff do not have access to the social care database to ascertain who is able to consent on behalf of a looked after child or young person and in an urgent situation act in the child’s best interest, or rely on the accompanying adult to give consent. A range of approaches to gaining consent are adopted with the aim being to gain compliance. Use of the British Association for Adoption and Fostering (BAAF) form is not always consistent however.

The issue of consent is a high priority theme throughout training. Consent and complex guardianships have also been discussion topics at the Safeguarding Link Group. There have been occasions where one parent gave consent to treatment and one did not which were complex to work through and experience from past cases is used to inform improving practice.

Outcome 4 Care and welfare of people who use services

There are some good quality health services for young people. Examples include HIV, sexual health, CAMHS and Early Years Mental Health, asylum seekers and substance misuse services. Substance misuse services pay attention to identifying self-harm and indicators of hidden harm and work effectively with other services for young people. There are good working protocols guiding the transition of young people from other neighbouring geographical areas’ substance misuse services. The service operates a cautious approach to issuing repeat prescriptions dependent on the child’s history and individual needs, working to avoid this where possible. There are also LAC specialist workers within the substance misuse team.
14 Young people aged 16 and over attending UHC&W can choose either to access the children’s emergency department (CED) or the adult emergency department (ED). This also benefits parents with children when both need to access the emergency services at the same time. Some staff work across both departments which is also beneficial. The departments offer the same treatment pathways with those who have self-harmed being seen by a CAMHS professional. The treatment received by 16 and 17 year olds accessing the ED is not subject to the daily notes review by the named nurse or doctor however, whereas this is part of the daily quality assurance process in CED. This cohort of young people should not be subject to any less rigorous quality assurance process as a result of exercising choice.

15 Parents from Traveller groups who are not registered with a GP do bring their children to attend CED. If they have no other recourse to health support, staff at CED do allow Travellers to return to the department if their child requires follow-up treatment.

16 Performance information shows good health outcomes are contributing to keeping children safe. There has been a lack of clarity in some services in the thresholds for the existing CAMHS services and some families report experiencing delays in accessing the service. Outcomes are consistently reported as good once families can engage with the service. The new CAMHS model being introduced from April 2011 with low level needs being met by a third sector provider has a clearly mapped pathway and community health staff view this change as potentially beneficial. High levels of need for LAC with enduring mental health problems will continue to be dealt with by the Partnership Trust CAMHS service. There is a well-established early intervention mental health team (EIMH) working with children under five. Social workers and health professionals work co-operatively within this project to support children and their families and are achieving good outcomes.

17 The teenage pregnancy rate has been a longstanding issue in the city. The rate continues to be high with Coventry currently having the highest under 18 conception and termination rate in the West Midlands. The partnership has identified this as a priority area of work. Significant multi-agency effort and resources are directed to deliver the teenage pregnancy strategy and reduce the incidence of first and second pregnancies. While some schools are highly engaged with the strategy and demonstrate good practice with some innovation around psychological state assessments, this engagement is patchy with some schools very disengaged.

18 Young people, as members of HYPe, are actively involved in delivering the strategy including the seasonal poster campaign and in publicising the widely available C-card scheme. The C-card scheme is well established and valued by young people although not all health services are aware of it. A Family Nurse Partnership service is in place. Attention is being given to preventing second pregnancies with information and advice targeted at young men as well as young women and sexual health advisors attend fresher’s week at both universities. Recent performance data shows some improvement but the partnership has yet to demonstrate that the strategy is having a significant and sustained impact on its current position.
19 There is no local Sexual Assault Referral Centre (SARC) in the city currently and children and young people have to go to a neighbouring authority for forensic examination. This has a potentially significant detrimental impact on young women who are already dealing with extreme trauma. There is also a significant gap in the SARC pathway in relation to follow-up health support for young women returning to Coventry after forensic examination outside the area. While there are plans to develop a local SARC, progress has been slow. No site for the SARC has been identified and no delivery date set.

20 There is a high incidence of pregnant women with HIV accessing maternity services in Coventry due to expertise in city health services. The asylum seeker service and refugee centre offer good support to pregnant women and their young children. Some city estates demonstrate a history of a high incidence of late maternity bookings, often for teenage girls and a transient population. Health staff generally have a good awareness and understanding of the needs of both established and emerging minority communities and teams based in relevant areas have specialist workers. The high levels of teenage pregnancy are identified as sometimes having a cultural context within the young person’s home community.

21 Health specialists work co-operatively to minimise the trauma of invasive procedures for children with physical and learning disability by co-ordinating treatments which involve anaesthetics into single events whenever possible. A mobile dental unit visits schools where children can often be seen more regularly. This has been found to be effective where non attendance of health appointments (DNAs) are known to be an issue in particular families.

22 While the list of children in Coventry with a child protection plan is shared with UHCW, there is no shared information system between health and social care with regard to LAC. Health staff are not always aware that a child is in foster care. Social care recently agreed to share the LAC list which will need to be kept updated. There is no dedicated care leaver health service and looked after children and young people are not routinely provided a copy of their health histories or their immunisation and vaccination records. This lack of health information may result in children and young people not having access to critical familial and personal health information, which they will need during the rest of their lives.

23 The Asylum Seeker Service, co-located with the refugee centre is regarded nationally as a good practice model. A very specialised GP practice is based in the service which deals with a lot of single mothers with toddlers. These women may also be pregnant and may have left children behind in their country of origin. The service plays an important role in identifying risks to children and young people within the asylum seeker community.
Outcome 6 Co-operating with others

24 Health is well engaged with the CSCB and their contribution to the safeguarding agenda is directed effectively through the health panel sub-group to the board. Good collaborative working also takes place operationally. Good partnerships underpin services at all levels of involvement from universal to specialist provision. At level four, for example, child protection conferences and core groups are well attended, and partners communicate regularly.

25 Transition arrangements for young people moving from CAMHS to adult mental health services are becoming increasingly focused on delivering positive outcomes. A new transition policy is being implemented which pays attention to issues of equality and diversity and has been impact assessed. The care programme approach (CPA) is being introduced to young people at age 16 depending on individual need and readiness and following liaison with the Early Intervention Team where this is involved. Leaflets explaining the process and level of support young people can expect are to be introduced imminently. The young person's experience immediately following transition and then six months later will be captured through questionnaires and used to inform service improvements. The transitions co-ordinator is also strengthening engagement with adult mental health colleagues to help increase their understanding of adolescent development. This is likely to ensure increasingly beneficial support to young people with enduring mental health issues as they move into adulthood.

26 The small cohort of 25 LAC Children and young people with learning disability and their families are well supported by the multi-disciplinary community team which includes Speech and Language Therapy (SALT) and occupational therapy (OT). Two health provided short term break residential facilities support young people with learning disability and challenging behaviour and physical and sensory impairment respectively. These form part of the short term break matrix which had been developed by the health and social care partnership to extend respite opportunities and better support parents. CAF provides the route into these services with increasingly complex need being supported through health funding. Short term breaks are available to all young people who need them. A consultant psychiatrist and paediatrician are part of the team. All children engaged with this service are seen regularly by the relevant consultants even if placed out of city. School nurses take responsibility for ensuring regular dental checks and immunisations are up to date. Maternity services for young people with learning disability are in place and outcomes are positive. The psychiatric and paediatric consultants work closely to ensure end of life services for children with life limiting illnesses, including respite provision, are in place.

27 The transition arrangements for young people with complex health conditions, including learning and physical disabilities, are well managed. Health support for LAC children with complex disabilities through the special schools is multi-disciplinary and of good quality. Transition into adult services for this cohort is well planned and managed and the early initiation, two years before the point of transfer to adult services, will benefit the young person. A range of specialist clinicians, including the epilepsy nurse and the neurology consultant for adult services, attend these transition clinics as required and the duration of the session is flexible depending on the needs of the child. Parents’ feedback to the service shows that parents find this approach reassuring.
28 There is some good liaison between the Coventry health team and local health services in other authority areas where children have been placed outside of the city although this is not consistent. Designated nurses have responsibility for out of area LAC placements and for liaison with clinicians where the child is located. There are occasions however, when health are not kept informed of a child placement changing and clear risks arise from health’s information lagging behind the actual situation. There are good links with health providers in neighbouring authorities such as Warwickshire. Similar policies operate in both council areas. There is a strong network of lead professionals geographically including a nurse consultant for complex cases across Coventry and Warwickshire.

29 The Common Assessment Framework (CAF) is embedded in practice with good access to CAF training for health staff and most health staff have a clear understanding. CAF champions are in place across health services. We found several examples however when health practitioners have not known that CAF was in place for particular children even when they had been working with the child for some time. There is scope for further strengthening of communication and engagement between health, education and social care to ensure full agency engagement in CAF is consistently secured.

30 Occupational therapy report good operational links with the partnership trust’s learning disability team and regular attendance at their team meetings. Community nurses work closely with schools and residential homes for children with disabilities and jointly developed health policies and protocols are in place between the different locations. These are well served by specialist therapy services such as occupational therapy, physiotherapy and speech and language therapy (SALT). There is strong commitment to multi-agency public protection arrangements and multi-agency risk assessment conferences. Community based health staff report that out-of-hours responsiveness by the crisis resolution home treatment team is good. There is good exchange of information between daytime and out-of-hours services about potential crises as well as relating events that have taken place.

31 Domestic violence (DV) is given a high priority within the partnership and was recently discussed at length in the CSCB. When someone aged under 18 attends the UHC&W Emergency Department, and domestic violence is indicated the child pathway is invoked and staff contact children’s social care. There is also a DV pathway established in maternity services. In Coventry a domestic violence score of 12 goes through MARAC. Warwickshire have also recently agreed to this threshold from their previous threshold of 14. Less priority is given to medium levels of domestic violence and these may be taken through the CAF process.

32 There is a good level of awareness about the incidence of female genital mutilation among some minority communities within the city. Some schools as well as acute health services are alert to this issue. A specialist obstetrician takes particular interest in this issue and female babies of mothers with female genital mutilation (FGM) are referred to the safeguarding team for monitoring. The high incidence of teenage parents where the children are on child protection plans is being reviewed across the partnership.
Outcome 7 Safeguarding

33 The Solihull, Coventry and Warwickshire child death overview panel (CDOP) is linked closely with the CSCB and is an effective driver for operational improvement across the partnership, having led a number of initiatives such as the sub-regional ‘Safe Sleep’ campaign to reduce sudden and unexpected infant deaths. As result of this campaign, maternity staff at UHC&W now routinely check where mother and baby are staying after discharge and that sleeping arrangements are satisfactory and safe. The CDOP manager is well connected across the partnership’s network and chairs the regional CDOP network. Her previous experience as a local police officer is an asset.

34 The designated nurse for LAC retired in 2010. Since then recruitment processes have been hampered by delays although the new appointment is now due to take up post imminently. In the interim, lead nurse provision has been in place for only two days per week, provided by the retired post holder. Health managers acknowledge that services for looked after children are not securing good enough health outcomes. There have been similar protracted gaps in the provision of a named GP for safeguarding in recent years although safeguarding arrangements are more securely embedded than arrangements to ensure good health provision for looked after children. The designated nurse for safeguarding is instrumental in driving local improvement and in ensuring national guidance is understood and complied with. She presents an annual report to PCT board, and develops this into a newsletter that is distributed to stakeholders and undertakes routine service audits and reviews which have informed improvements. There are close operational links with Warwickshire with the two designated nurse leads for safeguarding working very closely and attending each others health panel sub-group to their respective boards. The Warwickshire designated nurse will be taking on the role in Coventry on the imminent retirement of the Coventry post holder. Some additional resource will support this expanded role.

35 Named doctors and nurses for safeguarding have independent safeguarding supervision from a professional in a neighbouring authority. This is valued and felt by recipients to be of high quality. The network of support across agencies in relation to safeguarding practice is good. Peer reviews are undertaken and case discussions routinely take place in community forums. Dates had been altered to facilitate the UHC&W named doctor’s attendance. Although the doctor does not have formal supervision of her child protection work she is well supported through the local network and she experiences an element of supervision at the health panel. The named and designated nurses meet on a regular basis. Doctors have an annual regional safeguarding event which has both training and issue sharing components. Recent topics include shaken baby syndrome and female genital mutilation.
36 Systems are in place at UHC&W to alert staff to children subject to child protection or other indicators of risk and staff were alert to identifying a range of risk indicators at the point of access to ED or CED. There was scope to further strengthen this however. The UHC&W computer records system had an effective "alert" system whereby staff attention was drawn to a known issue eg a child protection plan, in relation to a child attending CED. The safeguarding named nurse receives an updated list of children subject to child protection every week from social care although there is as yet no shared database. Although both health and social care have the capability to introduce secure e-mail to exchange the list on a daily basis, no agreement between them is in place to facilitate this and so there is some risk that hospital staff may not pick up on a newly registered child. Warwickshire requires telephone contact to ascertain if a child has a child protection plan; it does not share its child protection list with health providers. The hospital's default position is to admit a child if concerns about them or the accompanying adult are identified. The 18 week pathway is embedded into policies at UHC&W and notifications go promptly to social care. The system is monitored by the named nurse and named doctor.

37 The policy of every child under two years of age being automatically seen by a paediatrician has been re-established following a local Serious Case Review (SCR) last year.

38 In the acute setting, there is automatic referral to safeguarding if an adult with parental responsibility presents with substance misuse or other concerning issue. The lead consultant for safeguarding at UHCW oversees the effectiveness of operational safeguarding protocols.

39 Health professionals prioritise their participation in child protection processes and routinely provide required reports but they report frequently being given very short notice about case meetings. Health visitors, who are already stretched, find this particularly difficult and they and special school nurses report sometimes having to attend on their day off, although they get time off in lieu. The escalation process is occasionally invoked where health staff feel their safeguarding concerns have not been picked up by the social care service. Recently a lack of awareness of this process in a specific service area was identified. In one case there had been a significant delay in effective safeguarding action being taken because repeated referrals had not resulted in safeguarding action by social care and health staff had been unaware they could escalate concerns. This gap in awareness has been addressed and the protocol reaffirmed city wide.

Outcome 11 Safety, availability and suitability of equipment

40 University Hospital Coventry & Warwickshire (UHC&W) has a discrete wing and separate entrance for the women and children's outpatient department which provides a highly child friendly environment, with plentiful play equipment. A play specialist is available and doctor's names on doors are in child appropriate, attractive formats. Sixteen to eighteen year olds have a choice over attending adult or child emergency departments (ED or CED) which are adjacent.
41 The named nurse, who checks the social care child protection list that she gets on a weekly basis, updates the hospital alerts on the electronic system. This is effective in alerting reception and triage staff to any known concerns and risk factors. Previous presentations of the individual at CED are also checked. Hard copies of alerts and child protection lists are retained. Staff check the identity of any adult with a child. Staff are also alert to identifying young people who appear to falsely represent their age. Although there are no specific sleep over facilities for parents, this can usually be accommodated. Privacy is considered and provision made in observation bays. One room can be used to provide a more private environment if there are CAMHS issues for a young person. Due to helicopter transfer facilities, the CED often receives injured children without accompanying parent or adult. This is challenging for staff to manage the child’s response to this separation and they are sensitive to this issue. The child resuscitation facilities are located with adult resuscitation. Although this is not ideal the area was paediatrics orientated. If more than one child requires this facility staff usually move a bed to a ward. X-Ray facilities are shared with adults.

42 As there is no dedicated SARC facility in the city, victims of assault often present at the CED. Staff are sensitive to how to support a young woman who may have been assaulted but physical support was minimal due to the risk of jeopardising forensic investigations. Staff wait with the young person until Police attend to transfer to an appropriate facility in another area. Police response is good but the arrangements are not satisfactory.

43 GU Medicine reception is located in a city centre site and is currently in a poor environment. The area is a thoroughfare and lacks comfort or privacy. Staff are very aware of this problem and have put personalised notices up to ask patients to give each other privacy and put a radio in the area. Once registered, young people are taken to small, more private room with good information leaflets and engaging posters. The service is moving in the new year to a new building with other community services. Managers have consulted a young person expert by experience on the décor of the new facility which will be a significant environmental improvement.

44 Where children in schools need equipment to be regularly maintained eg. catheters, if school nurses are not based on site, they train school personnel to undertake this activity. Occupational therapists and physiotherapists regularly work alongside school staff to support children and also train foster carers as necessary.

Outcome 12 Staffing recruitment

45 The designated doctor roles for LAC and safeguarding are separate as are those for designated nurse. Progress in developing LAC from a health perspective had been significantly hindered by protracted vacancies, for periods of years, and delays in recruitment processes to these key lead roles. The newly appointed designated nurse for LAC has now been cleared through enhanced CRB to start following 6 months delay since their appointment. Managers are confident that they have a strong field of applicants for the vacancy to the other designated nurse post created by the imminent retirement of the post holder.
46 All staff at UHC&W are subject to enhanced CRB check including when changing job internally when they cannot start the new post until CRB is checked. This results in sometimes slow recruitment to vacant posts with a potential detriment to patient care.

Outcome 13 Staffing numbers

47 Capacity issues within the health visitor (HV) service is a significant issue. Currently the service has 22.84 whole time qualified staff against an establishment of 26.84. The problem is projected to worsen as Coventry will need some 82 HV by 2015 to comply with government guidance. This considerable lack of capacity potentially impacts on the work of other health teams as they adapt their own activities to cover gaps in health visitor provision. Plans are being developed to reshape the service to meet future need and the development of specialist HV posts for LAC is also being considered. A specialist health visitor post provides support to asylum seekers and travellers, however due to the numbers of asylum seekers, capacity to support travellers through this post has been limited.

Outcome 14 Staffing support

48 Overall, health staff are well supported in their safeguarding role. Staff have access to good quality safeguarding training at the appropriate levels and it is updated regularly. In order to address recognised difficulties in releasing staff for training, plans are in place to set aside block training days well in advance to help facilitate staff attendance. Safeguarding champions have been identified in most services and are accessible to colleagues. Supervision arrangements are embedded although making these a priority in services such as health visiting with significant capacity issues is challenging.

49 Regular, good quality GP and dental training and learning forums are on offer but it can be difficult to get some practitioners to attend. The GP response rate to the recent PCT audit, undertaken by the designated nurse and supported by the local medical committee, has also been low at about 30%. In a city with a high number of single-handed practices, the relatively low level of engagement from GPs is an ongoing issue. The GP representative on the CDOP acts as a positive conduit for information and guidance to colleagues and helps to coordinate GP training. GPs have been advised of e-learning available for receptionists to do basic safeguarding awareness training but uptake has not yet been fully implemented. Practice nurses have done level 2 training and further training at level 3 has been secured recently for the GP learning forum. As it is two years since the last safeguarding training was delivered to GPs, this is timely. A database to monitor training taken by GPs is in progress which should help address the historic challenge of keeping track of GP training. The newly established GP consortia will need to ensure that child protection, safeguarding and the needs of looked after children is given a sufficiently high priority and that local arrangements for MAPPA and MARAC are understood and secured as these are acknowledged as areas for development for these organisations.
The safeguarding named doctor and named nurse are accessible for advice and guidance and also provide training at flexible times to facilitate staff attendance. Staff in CED are aware of the CSCB or SCR. The designated nurse is not a safer recruitment trainer. It has been verified that all health providers have in place safe recruitment practices via the themed reviews and section 11 audits undertaken by NHS Coventry and CSCB.

It has been identified that should all health agencies access training offered by the CSCB, capacity issues would arise. To ensure this is not an issue, the Health Economy training strategy is validated by CSCB with level one awareness, and level two multi-professional, training provided ‘in house’. Health professionals access level three multi-disciplinary training via CSCB programmes or bi-annual sessions facilitated by the named doctor at UHCW. At times during the year a waiting list can occur however, once identified, extra sessions are provided to address this. All places are free however, the CSCB charge statutory agencies for late cancellation. Voluntary agencies do not incur this charge and no preference for places is given to statutory agencies. Attachment and neglect training had been planned for some months but has been postponed as not all agencies can attend the planned date. The new collegiate safeguarding training requirements for all clinical staff to have training at level two, is challenging. E-learning plus some face-to-face training and practitioners sharing practice learning by attending each other's team meetings is being explored as a way to achieve compliance.

Due to a wide range of mothers from different cultures coming into maternity, some with traditional cultural norms that can challenge inexperienced health staff, senior nurses set time and space aside to support staff in reflecting on practice issues as they encounter them. This has helped staff to develop a wider understanding and expertise in supporting the diverse population.

Outcome 16 Audit and monitoring

Health organisations have a regular programme of section 11 or Laming based audits in place. These are undertaken jointly between UHC&W, social care and the police in acute services and improvements identified as a result. The most recent took place two months before the inspection and processes around the distribution of conference and strategy meeting minutes and establishing the nature of meetings has been improved. Qualitative data about the arrangements has been presented at the last CSCB. The quality audit of child protection processes has also led to improvements in how case conferences are undertaken. A rolling programme of quality auditing safeguarding cases is in place.
54 Health governance and quality assurance arrangements for looked after children are not robust and there is no joint approach yet developed with social care. There is no clear system to identify and monitor the health needs of looked after children. Health lead professionals do not have sufficient data to be able to identify the cohort of looked after children, or where they live, nor do they have a comprehensive picture of their health needs and how these are being addressed. Independent reviewing officers acknowledge that improving the completion of health assessments and health plans is an on-going challenge.

55 Undertaking reviews of health plans had been problematic with only 87% of annual health reviews completed last year. Given that this should be an identifiable cohort and responsibilities to undertake these reviews are clear, this is a poor level of performance. This has been subject to a number of action plans being formulated which have not yet resulted in improvement. An integrated children’s pathway has recently been developed which includes timescales. Practitioners thought this would give greater clarity around areas of responsibility. There are plans to audit effectiveness regularly in future. Lead professionals are seeking agreement to develop a shared looked after children data base which they see as a key step to ensuring looked after children’s health needs are met. Agreement to proceed with the development of the shared database has not yet been reached between health and social care.

56 There is no system in place to review the outcomes of health plan actions. An initial review of 80 cases (13.5% of LAC population of 595) has recently been undertaken which highlights the impact of the lack of a robust monitoring of health assessment reviews. Forty per cent of LAC children reviewed have a medical problem at the time of the health assessment with 29 per cent of LAC children on medication. Thirty-three per cent of under fives in the review cohort have developmental delay and 20 per cent are engaged with mental health services. Information is lacking in the health records to give a comprehensive picture of the number of children engaged in risk taking behaviour. Immunisation and dental check data was above 80 per cent but this was lower than would be expected for LAC. While there are some examples of good practice there are too many overlaps and duplications eg. a child sent an adoption appointment followed just a few weeks later by an appointment for a health review. It is not beneficial for the child to be seen twice in so short a time and is likely to result in non attendance.

57 Hearing concerns for looked after children are identified and followed up. Dental and vision checks are not given sufficient attention however and are not consistently undertaken. In one case, information about a child requiring glasses had not been passed on to the new foster carer at a change of placement and the child did not have any glasses as a result.

58 Some progress has been made over recent months in identifying the areas for development to improve the health and wellbeing of LAC. A task and finish group reporting to the care matters operational group has been set up and an action plan developed. The draft policy to govern joint arrangements has yet to be finalised. Since the joint children’s commissioning manager left in February, progress has stalled.
59 Health staff working with children with disabilities report forty-seven per cent of LAC do not attend (DNA) health appointments. Staff are working hard to address the often poor reasons why this occurs and report an improving picture although this remains a challenging issue. A failed appointment card system is being introduced across some community health services including dentists and OTs to try and address DNAs. Text messaging to remind young people is also being introduced. Physiotherapists have tried this previously but it generated poor responses. Guidance on ways to address DNA is being developed from a digest of national good practice examples and guidance. This is currently in draft form and about to go out to consultation.

60 Information and data sharing across the partnerships is considered a priority area for development by health professional leads as a key stage to improving governance and performance management. Health and social care data managers meet regularly to look at information sharing issues and identify how improvements can be made. The council data manager has modified the BAAF document to enable pre-population of key information that should be shared across agencies.

Outcome 20 Notification of other incidents

61 All staff report being aware of whistle blowing processes. Those interviewed had not been required to use them.

Outcome 21 Records

62 The records held by health for looked after children are not comprehensive and of overall poor quality. Health assessments that have been undertaken do not consistently meet criteria and many of the health plans are task rather than outcome focused. No strengths and difficulties questionnaires (SDQs) are on health records and health assessments do not routinely encompass all aspects of physical health, developmental, educational and emotional wellbeing. There has been some recent auditing of LAC health records but in more than 50% of cases, health auditors have found insufficient health information. There is no evidence that routine quality audits have been undertaken in the past or that effective managerial oversight of the records as evidence of clinical practice is in place. Family information that could influence and inform health intervention and outcomes is often missing.
Recommendations

Within three months (from report)

The Children’s Trust should have plans in place to improve the quality and availability of local facilities for conducting investigative interviews and medical examinations of children and young people who are subject to child abuse investigations. (Ofsted May 2011)

The Children’s Trust should ensure that effective multi-agency arrangements and quality assurance processes are in place to govern the delivery of positive health outcomes for looked after children and young people. (Ofsted May 2011)

NHS Coventry (The Arden Cluster) and Coventry & Warwickshire NHS Partnership Trust should ensure that the health provision for looked after children is comprehensive and consistent for all Coventry looked after children and young people, including those placed out of the authority area and that those leaving care are routinely provided a copy of their health histories and immunisation and vaccine records. (Ofsted May 2011)

UHC&W should ensure that the emergency treatment young people experience is subject to consistent quality assurance processes regardless of which treatment pathway they choose.

NHS Coventry (The Arden Cluster) should ensure that all looked after children are subject to regular dental and optician services.

NHS Coventry (The Arden Cluster) should have plans in place to deliver an effective local Sexual Assault Referral Service within an agreed timescale.

Within six months

NHS Coventry (The Arden Cluster) and Coventry & Warwickshire NHS Partnership Trust should ensure that recruitment is completed for the current vacancies. In addition plans and resources need to be agreed to recruit to the required capacity to meet the targets outlined in the ‘Health Visitor Implementation Plan 2011-2015 – A Call to Action’. (Ofsted May 2011)

NHS Coventry (The Arden Cluster) should ensure that all staff received safeguarding training to the required level in accordance with the new collegiate requirements.

The new GP consortia should ensure they have a good understanding of all multi-agency arrangements contributing to the health & wellbeing of the city’s population; these must include MAPPA/MARAC, children’s safeguarding and child protection and ensuring the health needs of looked after children.
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 the CQC through childrens-services-inspection@cqc.org.uk and it will be followed up through the regional team.