### Report on the Outcome of the Integrated Inspection of Safeguarding and Looked After Children’s Services in Warwickshire

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<tr>
<th>Date of Inspection</th>
<th>31st October 2011 to 11th November 2011</th>
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<tr>
<td>Date of final Report</td>
<td>16th December 2011</td>
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<td>Commissioning PCT</td>
<td>NHS Warwickshire (Arden Cluster)</td>
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<td>CQC Inspector name</td>
<td>Tina Welford</td>
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<td>Provider Services Include:</td>
<td>South Warwickshire NHS FT (SWFT)</td>
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<td>University Coventry and Warwickshire NHS Trust (inspected directly as part to the Coventry inspection May 2011)</td>
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<td>Coventry and Warwickshire PCT’s</td>
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<td>George Eliot Hospital NHS Trust</td>
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<td>Warwick Hospital NHS Trust</td>
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<td>Coventry &amp; Warwickshire Partnership NHS Trust (CWPT)</td>
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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](#).
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<td><strong>Aggregated inspection finding</strong></td>
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<tr>
<td>Overall effectiveness of the safeguarding services</td>
<td>Good</td>
</tr>
<tr>
<td>Capacity for improvement</td>
<td>Good</td>
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<tr>
<td>Contribution of Health agencies to keeping children and young people safe</td>
<td>Adequate</td>
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| **Looked After children Inspection Outcome** | **Aggregated inspection finding** |
| Overall effectiveness of services for looked after children and young people | Good |
| Capacity for improvement of the council and its partners | Good |
| Being healthy | Good |

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

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

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:

The commissioning and planning of child and young peoples’ health services and primary care are undertaken by NHS Warwickshire (now part of the Arden Cluster, NHS Coventry & NHS Warwickshire). Universal services such as health visiting, school nursing, and paediatric therapies are delivered primarily by South Warwickshire NHS Foundation Trust (SWFT). Accident and emergency services for children and maternity and newborn services are provided by South Warwickshire Foundation NHS Trust, George Eliot Hospital NHS Trust and University Hospital Coventry & Warwickshire NHS Trust (UHCW). Children and families access primary care services through one of 76 general practitioner (GP) practices, 2 walk in centres, Camphill in Nuneaton and Rugby St. Cross Hospital, and the Urgent Treatment Centre/minor injury centres at Rugby St Cross Hospital and Stratford Hospital. The primary care out of hours service is supplied by Badger Harmoni. Child and adolescent mental health services (CAMHS) are provided by Coventry & Warwickshire Partnership Trust (CWPT). Children with learning disabilities and difficulties and who have complex health needs services are provided by Coventry & Warwickshire Partnership Trust, South Warwickshire NHS Foundation Trust and Warwickshire County Council.
Joint commissioned services with Warwickshire County Council include the health provision at young offender’s institution. NHS Warwickshire provides a funding allocation to Warwickshire County Council who commission the service.

Health safeguarding services are hosted by Arden Cluster. The designated professionals are located in the commissioning arm of the cluster and the named professionals within the provider trusts. Looked after children health services are provided by South Warwickshire NHS Foundation Trust.

**General – leadership and management**

1. There is good partnership working and engagement of all the health organisations with the council and other partners in the joint children and young people service planning, the Local Safeguarding Children Board (LSCB) and the Health and Wellbeing Board. The voice of the child within health strategic safeguarding planning is less apparent than within the looked after children health service. All safeguarding policies are readily available and have been revised in line with both statutory guidance and intercollegiate guidance. There are a number of effective joint commissioning appointments which are improving the health and social care interface and the child’s journey through care services. There is good commitment from general practitioners (GPs) with dedicated children safeguarding leads established in the new clinical commissioning groups.

2. The contribution of health agencies to keeping children and young people safe is adequate. Annual safeguarding reports, which include a section on looked after children, have all been subject to effective levels of scrutiny, through the respective organisations governance arrangements, by the relevant health trust boards. Only NHS Warwickshire annual report is well scrutinised at the LSCB, the other health providers’ reports are not presented. The level of detail and statistical analysis in the looked after children section of all the annual reports is inadequate. The section 11 safeguarding and the Laming audits with the associated action plans are effectively monitored by the LSCB and the health sub-committee. There is good attendance by health representatives, including the lead safeguarding GPs from the clinical commissioning groups, at the LSCB health sub-committee. The designated nurse and designated doctor are highly valued by both health staff and the LSCB members.

3. Although each health trust board has good processes in place to monitor compliance of safeguarding training, there remains an inconsistency and lack of robustness in safeguarding data collection, which adversely affects the levels of assurance. There is good and effective use of the safeguarding thresholds multi-agency escalation process up to director level. There are inconsistencies at trust board and governance committees related to the information reported from the child death overview panel.
Outcome 1 Involving Users

4. Service user feedback is used, within some services, to evaluate effectiveness. However, this is not systematic or robust especially across CAMH services. A website to advertise and promote ‘what CAMHS does’, has been developed in conjunction with school aged children and young people.

5. Whilst there is recognition of the limited communication with, and involvement of, children in health safeguarding arrangements and procedures at strategic level, involvement is more apparent at frontline service level. For example, school nurses complete a health assessment with the child/young person prior to a case conference, in order that the school nurse can advocate on behalf of the child. Involvement of children and young people is more developed in the looked after children service (LAC) where young people have been involved in staff interviews and selection processes, as well as the development and design of information based websites.

6. The Children in Care Council were involved in, and selected the name for, the recently established emotional wellbeing service, ‘Journeys’ and the child and adolescent mental health and emotional well being website ‘Happy Pies’. ‘You’re Welcome’ quality standards or equivalent has not been used in CAMHS or sexual health services. However, in the south of the county CAMHS, a service user satisfaction survey is used six months after discharge. Outcomes have been used for service developments; there is no similar system in the north of the county.

7. There is good access to interpretation services for LAC health staff undertaking the annual assessments/reviews, especially for the dedicated LAC unaccompanied asylum seeker services. There is a limited range of locations from which a looked after child or young person can choose to attend their annual health assessment. Looked after children and young people were consulted on the format, provision and type of health ‘care leaving’ information, and the results of this consultation have been effectively implemented.

8. There is effective monitoring of attendance at equality and diversity training at all health trust boards. There are some good examples of services meeting the diverse needs within the local population, such as the well established dedicated Polish women maternity service. Due to its success, the service is currently being rolled out across other areas of the county, where there are high numbers of Polish women living, to bring the service closer to them.
Outcome 2 Consent

9. Consent is obtained and recorded in the health records, from the person with parental responsibility, before the looked after child/young persons’ health assessment or review is undertaken. However, ascertaining who has parental responsibility for children and young people attending accident and emergency (A&E) services, especially for looked after children, (as this group are not easily identified), is less well developed.

10. All LAC health assessment requests received from social care, contain the strength and difficulties questionnaire (SDQ) score and consent, if on the rare occasion consent has not be sought, or the SDQ score is not included, the appointment will be postponed until received.

Outcome 4 Care and welfare of people who use services

11. The grade for the looked after health outcome ‘being healthy’ is good. All initial looked after childrens’ health assessments/reviews comply with statutory guidance and the initial and annual assessments, seen by inspectors, completed by staff from South Warwickshire NHS Foundation Trust (SWFT), followed the recently updated integrated care pathway for health assessments. Children and young people who have complex needs have their health assessment/reviews carried out by a medical practitioner. Most children with disabilities or who have special needs (who are looked after), and who are seen regularly by a community paediatrician have their health assessment/reviews as part of their routine clinic appointments, although this practice is not consistently applied. Six core health files (as well as 18 other related health files from a range of professionals) were reviewed; all but one was of good quality and complied with statutory professional guidance. However, health action plans in two cases were not written in a ‘smart’ fashion, preventing effective monitoring.

12. The rate of health assessments remains below both statistical neighbours and England averages (2010/2011 data) although the trend is improving, with the current rate at 80.2%. Immunisation and vaccine rates are in line with England and above the statistical neighbours at 83.2%; although the trend shows that this rate is declining. Dental rates have also fallen, although still above both England and statistical neighbour averages, at 86.9%. No rationale or analysis for the changing rates has been undertaken.
13. Action plans from the looked after children/young people health assessments are inconsistently shared with primary care and community staff, although if the practitioner has been assigned ‘an action’ in the action plan, they do receive a copy, however, there is no outcome monitoring for the completeness of actions. Although information technology solutions to improve communication are being developed by George Eliot Hospital, these are yet to be fully implemented. There is good and effective joint LAC panel meetings where all new looked after children health assessments are identified and reviewed. However, health visitors and school nurses are not invited to looked after children panel/review meetings and frequently do not receive information from these meetings to enable them to support the child or young person, or ensure that they are working in line with the agreed individual’s plan.

14. All Warwickshire out of authority placed looked after children and young people have their initial health assessments undertaken by Warwickshire health staff and then, depending on location, health reviews are undertaken by the authority in which they live or if they remain close to the local authority area, the Warwickshire looked after children named nurse undertakes the assessments/reviews. Currently, there are no delays in assessments; however, with more authorities starting to charge this is being closely monitored to ensure that this does not impede assessments taking place on time. There is improving engagement with the Independent Reviewing Officers (IROs) and by the named LAC health staff, to monitor the effectiveness of health action plans.

15. The child health database ‘flags’ all known looked after children to ensure effective communication of new notifications and health assessment/review action plans to health staff. GPs and practice staff spoken to during the inspection do not always receive information about looked after children and young people on their practice caseloads/catchment area. Further, due to a lack of systematic notification processes as well as a lack of supervision and support, frontline health staff are not always fully aware of all looked after children and young people on their caseloads and often find out about a new looked after child/young person from foster carers or educational services, especially those children placed in Warwickshire from other authorities.
16. There are two CAMH services one in the north and one in the south of county, both commissioned to provide services from 5 to 17 years old. There is no outreach service commissioned. Acceptance of referrals to CAMHS remains a challenge, with disparity between the north and the south of the county. A new integrated care pathway has just been implemented to try and improve access and shorten waiting times, however, it is too early to measure the impact. Urgent appointments are then seen within two to three days, with non urgent cases waiting up to three months in the south, although routine interventions may commence sooner, than those in the north of the county. The service in the north uses CAPA, (choice appointment and partnership approach), with waiting times for treatment and intervention, (due to the delays in getting responses from clients as to their choice of appointment time and venue), being up to three months post acceptance of the referral. If, after initial assessment, CAMH services are identified as not being the most suitable, the young person is ‘signposted’ to the third sector provision, which is accessed through self referral. The professional referring the young person to CAMHS does not routinely (unless it is the GP) receive feedback, resulting in no effective follow up of the young person case, or ensuring that the young person is access the third sector provision.

17. Child and adolescent mental health services (CAMHS) are not commissioned to provide a looked after children and young people service, this is provided by Journeys who only offer a tier two service. This provision, although only established for six months, is highly valued by foster carers and service users and access to psychological support for LAC has improved. Currently referral and joint working pathways are under development between Journeys and CAMHS to ensure that there are no gaps in service provision. There is good use made of strengths and difficulties questionnaires (SDQs) scoring as part of the assessment process and onward referral to Journeys or CAMHS.

18. There is good provision of dedicated teenage pregnancy midwives and other supportive maternity services at George Eliot Hospital, (covering the north of Warwickshire). This service has been redesigned in light of demand, over the last two years. However, GPs are still not referring pregnant teenage women to the service, delaying the support that they and their partners receive. Pregnant teenagers and their partners do not have to pay for the antenatal classes, unlike other pregnant women, which is improving their attendance and engagement at these classes. There is good close partnership working with the family nurse partnership (FNP), education services, social care and housing to support the young women. Within the north of Warwickshire teenage pregnancy rates are higher than the rest of the county, although overall rates still remain below the England averages. There is good access to the contraception and sexual health services. There is adequate use of the local ‘SOS bus’ to support young people in ‘hotspot’ areas, and outside night clubs assisting in the reduction of vulnerabilities, due to alcohol usage or other risk taking behaviours.
19. Within south Warwickshire there are no dedicated teenage pregnancy midwives, there is adequate use made of the FNP service. There are good working relationships with the Family Support Workers, who undertake initial assessments after a safeguarding referral has been made. There is flexible visiting and support for pregnant teenagers, based on the individual young women and partners’ needs, ensuring that early identification of need is addressed. The consultant led obstetric service in south Warwickshire differs from that in the north, where the service is for all under 17 year olds based on medical need, in the south the service is for all under sixteen year olds, irrespective of medical need, consequently causing confusion for some service users and professionals. In the south of the county, the pregnant teenager (under 17 years of age) has multiple appointments to attend; as the maternity and consultant led services are not complimentary, increasing the risk of non-attendance.

20. There are inconsistencies across the county in the provision of sexual relationship and personal health sexual education structures due to service delivery styles. There has been a targeted provision in the ten schools classified as ‘hotspot’ areas for teenage conceptions. There has been ongoing engagement with the education strategic partnership to reduce conception rates, through consistent sexual education and support for schools, although the impact is yet to be realised.

21. Midwives seen during the inspection reported that there are few opportunities within some schools to hold antenatal appointments for young women, which had aimed to reduce the time away from education for the young person. Midwives reported that within some schools, there is a ‘denial cultural’ of teenage conceptions and pregnancy; although other midwives had the opposite experience, with very good support given to the teenage parents. Maternity and health visiting staff interviewed reported that there is a low rate of concealed pregnancies. There is good engagement with the local traveller families, relating to both pregnant teenagers and teenage parents.

22. All looked after children and young people, based on their preference, have good access to either dedicated or health promotion and sexual education sessions within schools. College based ‘drop-in’ session for older looked after young people have been successful with good levels of engagement.

23. Transitions for young people who have disabilities are less well developed than for those young people who have a mental illness. Although transition starts early within education and social care, this is not the case within health, where transition planning starts at the age of sixteen, which is frequently too late to ensure all the required resources are in place.

24. The speech and language service are not part of the social care integrated disability service (IDS) and as such are party to different thresholds and funding, which can lead to disagreement around funding streams within statement of educational needs (SEN) process. However, education will fund provision if health will not, but this may mean a delay.
25. There is a north and south county divide in services provided by Coventry and Warwickshire Partnership Trust to support disabled children and their families. These differences are most notably in the provision of community children nurses and the services to improve the quality of life, training for education, health staff and parents. The Triple P parenting training programme for those parents living in the south of the county has been positively evaluated and changes to enhance the programme further are planned based on participant’s feedback. However, this programme or equivalent is not provided for parents living in the north of the county, who felt disadvantaged.

26. There remains a lack of support and only adequate identification of siblings who do not have a disability and may have caring responsibilities, within families who have a disabled child, to ensure an appropriate level of support is provided. There are only a limited number of, and access to, sibling support groups. Identification of young carers for other sectors of the community is improving, with good support provided through a range of social care interventions.

Outcome 6 Co-operating with others

27. Safeguarding referral thresholds remain unclear and subject to frequent change, with different interpretations reported, based on individual social worker’s perspectives. Further, confirmation of risk factors applied to thresholds by the five social care teams/districts remains inconsistent. Health staff (including GPs) seen during the inspection believe that safeguarding thresholds are too high in the north of the county, which has higher rates of deprivation and social need than the population in the south of the county. A number of illustrations where given by health staff where the common assessment framework (CAFs) had been used as a gatekeeper to child protection services, rather than a child protection plan being used. Health staff remain concerned that even when the family refuses to be involved in the CAF processes and there has been a previous history of other children being subject to a protection plan, safeguarding referral are not accepted by social care. It was reported by community practitioners, that CAFs, are being insisted upon by social care staff, rather than accepting the safeguarding referral. Health staff report good use of the escalation policies in these cases to resolve concerns. CAF support officers are viewed as being supportive. The high risk CAF case meetings frequently have no social care representative, health staff reported that social care staff attend CAF meetings only as a result of an incident and to accept a referral when a CAF is viewed as failing, demonstrating a lack of understanding of the lead professional role.
28. Safeguarding referrals thresholds are clear for unborn baby planning, and for SWFT midwives, this starts at ten weeks gestation. However, this is not the same with George Eliot Hospital maternity services, as referrals are not accepted by social care in this area, until 25 weeks gestation, which may delay the child protection procedures and causes confusion within the services especially when women transfer to another area of the county. Pre-birth planning processes are variable, with frequent short notice of meetings (staff report frequently within 24 hours despite the date of the meeting being known to social care for a number of weeks). Reports are submitted if maternity staff are unable to attend meetings. However, communication of actions and minutes from meetings is inconsistent, with health staff frequently having to chase up social care for information and written copies of the birth plan for the maternity notes. Changes in social worker are not notified to midwives in a timely manner which contributes to delays in case progression with examples being quoted of the baby being born before the agreed plans is in place.

29. There is effective sharing, once agreed, by social care of the pre-birth plans within health, with good use made of flagging systems for maternity and baby notes and electronic patient systems, with copies of the notification sent to both unscheduled care and accident and emergency settings, in case the pregnant women attends these departments. SWFT maternity staff make good use of the out of area, national and regional, alert communication systems for those women who are at risk of absconding or moving out of the area at the time of the child’s birth to protect the child. However, communication between maternity staff at SWFT and GPs is only adequate; there is poor attendance at case conferences and child protection meetings by GPs, when invited. Further, there is minimal contact with the family nurse partnership, which misses an opportunity to share both the pre-birth and post natal information.

30. Maternity staff at George Eliot Hospital, as a result of the delays in court processes and the need to find mother and baby placements, are finding that ‘well babies’ and mothers are staying in hospital longer than necessary, increasing security and absconding risks. There have been a number of incidents when social care staff have attended the maternity unit to retrieve a baby without the correctly signed documentation or identification, resulting in a change in practice being introduced by the hospital to safeguard the baby.

31. Family nurse partnership (FNP) staff report that safeguarding referrals are not always accepted, due to a lack of understanding within social care that FNPs do not undertake child protection work, (the designated nurse has provided training to help to improve the understanding of the FNP role in safeguarding). This equally applies to those referrals relating to the family or another sibling which the FNP is not directly working with.
32. Timeliness of communication relating to the date and time of strategy and other child protection meetings is inconsistent. Frequently, community staff receive very short notice of strategy meetings, making it difficult to attend or send reports, for example, two hours notice when the meeting had been planned for six hours. Health visitors report that even though they are actively involved with a family, they are not always invited to attend these meetings and therefore not always aware of care proceedings or that a child is subject to a protection plan, until in some cases, health visitors were informed by a family member. Communication from meetings is often verbal with no written follow up. Minutes of meetings are not produced in a timely manner and in some cases minutes of a previous meeting are tabled at the next meeting; resulting in action not being undertaken and often delayed. Audit data on the circulation of minutes shows that there is an inconsistency in meeting the agreed timelines for circulation. Action plans from meetings are not fully implemented and lack robust monitoring, causing delays in the decision making processes.

33. General practitioners (GPs) report a lack of timeliness in notification to attend case conferences and that requests are often sent by Royal Mail post system, which further increases delays. Audits show that GPs are not always notified of conferences or invited to attend even though they should have been present. There remains confusion within primary care and especially with GPs, regarding confidentiality and the need to disclose information principally concerning hidden harm cases, despite clarification being given to the local medical council and medical defence union.

34. Communication between GPs and health visitors has been negatively affected by the restructuring of health visiting services into geographical teams, the new communication process have not been implemented fully. GPs are not always aware of whom to contact and do not routinely contact or communicate with school nurses, this is a missed opportunity to improve practice and share information. There has been some very recent improvement, with GP making referrals to school nurses for behaviour and enuresis clinics. Some primary care practices invite a representative for health visiting services to their clinical meetings where A&E notifications and vulnerable families are discussed, however, this is not consistent.

35. Frontline health staff based in the Rugby area, communication with social care staff, although improved, remains challenging at times; there is rarely feedback on referrals within 48 hours. Often the first time health staff are aware that a referral has been accepted is that they receive a request to attend a strategy meeting. Staff in A&E and the out of hours services report that feedback is improving, but remains inconsistent and that they do not routinely get invited to strategy meetings, even if they had initiated the safeguarding referral.

36. Care leavers from the looked after care service are given good information relating to their health histories, in the form of an individualised ‘letter’ containing all the relevant and known health history, as well as significant health events and their immunisation and vaccine status.
37. There is a dedicated young person transition co-ordinator for mental health services, which has been in existence for 12 months at time of inspection. However, the role has been able to demonstrate a positive impact on the prevention of silo working within adult and children mental health services and the challenges that this had had on transitions. Staff in both children and adult mental health services highly value the post. However, there remains a challenge with the transition of young people with neurodevelopmental disorders and also borderline intellectual ability conditions although there have been some recent improvements. Mental health tier four/ highly specialised transition work remains an ongoing area for development. There is good joint working within the early psychosis team and transitions staff providing for smoother transitions for the young adult. Systematic service user feedback measurements is planned, individual evaluation of the impact of transition services for both the young person and their families has been positive.

38. Early intervention psychosis service provision for Warwickshire is provided by two discrete teams; one in the north, the other in the south. The team in the north has had fewer referrals, partially attributed to the lack of close working with the local CAMHS team, unlike in the south of the county were close working has provided for seamless provision of services. The CAF is positively viewed with good outcomes for children and young people; along with the care programme approach has improved the participation of all partners especially when transferring between different tiers of the service.

39. The LAC named nurse provides a good range of training opportunities for foster carers to maintain placement stability and for new adoptive parents, which are well attended and positively evaluated.

40. The domestic violence policy is adequately implemented at SWFT maternity services. Identification of domestic violence is ascertained by asking pregnant women alone at the booking appointments and then again at the 28 and 34 week appointments. There are no flagging systems in place to identify high risk cases. However, this is not the case at George Eliot Hospital, whilst domestic violence assessments are undertaken at antenatal sessions, the women is not assessed alone to enable disclosure to be made in confidence.

41. There has been an increase in the identification and referral of domestic violence and hidden harm cases Health managers have identified that information sharing relating to domestic violence needs to be improved between midwives and health visitors; to further strengthen responses where the identified risk is not ‘high’ when cases do not meet the thresholds of the multi agency public protection arrangements (MAPPA) and local police force. This is yet to be implemented. Hidden harm awareness is improving, however, the sharing of information and confidentiality remains unclear. When women move on from the local refuge, the details of their new GP are not systematically forwarded to their old GP and therefore case notes are not shared.
42. Outcomes from national and regional serious case reviews (SCR) are effectively shared through training and newsletters. Following a case review at George Eliot Hospital, maternity documentation at Warwick Hospital has improved, resulting in improved recording and a review of the robustness of risk identification systems.

Outcome 7 Safeguarding

43. The designated nurse’s, capacity remains stretched whilst covering two authority areas, despite additional support, compounded by different processes and systems and a lack of administrative support. The named nurse for safeguarding children post is vacant at George Eliot Hospital. The named midwife post is currently part of head of maternity post. There are plans to separate these roles, due to the increased work load of the named midwife role; this will become part of the newly appointed named nurse role. However, the impact of this change and the capacity of the new role to fulfil both roles remains unclear.

44. All designated and named safeguarding staff have appropriate reporting structures with regular developmental, managerial meetings and supervision. There is no named GP however, 90% of practices have a nominated safeguarding lead. There is good commitment and good rates attendance at the LSCB and the health subgroup, as well as good health representation at all other LSCB subgroups, attendance is effectively monitored. At the time of the inspection the designated nurse post for looked after children was being recruited to, the role had been covered by the named nurse.

45. A&E settings have flagging and alert systems in place; the effectiveness is yet to be audited at George Eliot Hospital. Notifications of attendance of children and young people from unscheduled care and A&E settings are received by both community and primary care services. However, these do not always identify if the child is known to social care, the content and quality is too variable, which prevents primary care and community staff identifying if there are concerns and effectively addressing them. Staff report good access to social care duty teams both in hours and out of hour services. Unscheduled care notifications do not identify children known to social care. Information on the notification forms is often illegible and the reason for attendance and treatments given are unclear and in some cases not documented. Frequent attendees are not always identified and there is no sharing of attendances between all the county’s unscheduled care and A&E settings. Warwick Hospital A&E health visitor liaison post reviews all the A&E records, as well as the adult safeguarding referrals to ensure that all children safeguarding concerns (including hidden harm) have been identified. However, this system is not in place as George Eliot Hospital with a school nurse visiting the department twice a week to review the children A&E records only. There is no consistent approach to identifying young carers.
46. National guidance is adhered to for all young people who are classified as a ‘self harmer’, although the implementation is different within the north and south of the county. ‘Self harmer’ services are provided out of hours through adult mental health services initially; with an in hour CAMHS follow-up on the paediatric wards for the next working day, all discharged patients, including self discharged young people are offered follow up appointments, attendance is adequately monitored.

47. There is a lack of urgent tier four in-patient mental health beds. Many young people are placed out of county, increasing their social isolation and causing challenges in repatriation; when ensuring appropriate services, especially if they no longer requiring a CAMHS but need adult mental health services. The Mental Health Act Section 136 designated place of safety has only recently been addressed with a new unit in Coventry (last 6 months), the new system is working well.

48. The child death overview panel (CDOP) reports are subject to a good level of scrutiny with the content and data analysis subject to effective challenge. The membership of CDOP is highly motivated and dedicated with good lay representation. There is good rapid response system and bereavement support. Some GPs and practice managers interviewed during the inspection, had received copies of child death investigation reports, ensuring that the lessons learnt were effectively shared. Maternity staff have good understanding of child death procedures. There has been some measurement of the effectiveness of campaigns such as ‘safe sleep’.

Outcome 11 Safety, availability and suitability of equipment

49. There is no dedicated sexual assault and referral centre (SARC) in Warwickshire. The current provision is not forensically clean. There are plans for a new dedicated SARC to be built by summer 2012, with dedicated funding, granted by the Home Office, for new colposcopies and other equipment.

50. The secure provision at Brooklands (residential health funded secure Tier 4 home) is described by staff interviewed as not being fit for purpose, with limited access for patients to fresh air and outdoor activities since an error in installing the secure fencing and the lack of a secure gate on the driveway. The broken trampoline that was used as a therapeutic intervention to reduce stress and as part of anger management has not been replaced and staff have reported an increased number of safeguarding incidents, which correlates to the time this piece of equipment has been out of action.
51. The accident and emergency department at Warwick Hospital has a small dedicated child waiting area, although the area contains some health and safety risks, such as the seating and lack of door hinge guards, staff are fully aware of these and attempt to mitigate the risks. Plans to enhance both the waiting area and the dedicated treatment rooms and also to provide dedicated facilities for adolescents are being developed. The resuscitation bay, although contains suitable equipment for children and young people, is next to the ambulance bay entrance and major patient area egress, which results in adult patients and other adults visitors going past the bay and entrance reducing the privacy and dignity for the young person. There is adequate screening between the paediatric bay and the adult bays.

Outcome 12 Staffing recruitment

52. Safer recruitment policies are in place and monitored by trust boards, for trust employed staff, however, less robust systems are in place for independent contractors. George Eliot Hospital confirmed that external agencies are not monitored for their compliance.

53. All staff interviewed reported having an enhanced current criminal records bureau (CRB) check, with good human resources notification process when for example the midwifery notice to practice and CRB checks are required at South Warwickshire Foundation NHS Trust.

Outcome 13 Staffing numbers

54. Health visitors and school nurses seen during the inspection had no concerns with caseloads or capacity to continue to deliver the healthy child programme, all the targets of which are in line with or better than statistically neighbours and England averages. Warwickshire is an early implementer for ‘Action on Health Visiting’.

Outcome 14 Staffing support

55. Looked after children (LAC) dedicated health staff and school nurses involved with the LAC health assessments have good ongoing access to a range of training and professional development; however, access to LAC supervision is not available. LAC training for community practitioners has only recently commenced and is not comprehensive, those staff who have completed the training were positive about the impact on practice and reported improved awareness of the needs of these children and young people. Staff from Journeys have good access to a range of dedicated training, especially relating to attachment and dealing with challenging behaviours training.
56. Health staff including dental staff seen during the inspection, remain confused as to the level of safeguarding training that they should be attending, due to the inconsistent information from the LSCB and recently changed health policies. However, recently published policies have been developed to resolve this are still to be fully embedded. There is a wide range of training available, although access is restricted; by this lack of clarity as to which courses are level two or level three, and the inability to be released from clinical commitments and lack of capacity on the multiagency level three course. There is no use of e-learning to help manage more effectively the release from clinical commitments or for induction purposes. There has been limited training related to domestic violence, genital mutilation and hidden harm for maternity staff and other health staff across the county.

57. The designated nurse has undertaken an evaluation of training using the Carpenter methodology, with variable results depending on health providers. However, there is no systematic evaluation of the impact of training by health providers. There are plans to re-evaluate the impact of training again in the near future.

58. General practices have access to good local practice based training and protected learning events delivered by the designated nurse. Practice staff highly value the training provided by the designated nurse. Those practice staff interviewed reported good levels of training compliance, although there is no robust monitoring of training. The latest data shows that within last ten months only 19% of GPs received training, however, this does not reflect the training received by the total GP population, which is at 87%. There is no measurement of impact on primary care practice following training. There is no use of e-learning in general practice as the LSCB does not approve of this approach, which some practice staff felt would help improve levels of compliance and improve still further that safeguarding is everyone’s business.

59. Identification across all health providers of the percentage of staff trained at the appropriate level and in date is inconsistent. Trust boards therefore cannot be fully assured that all their employees are appropriately trained. At SWFT the cumulative total for staff ‘in date’ with safeguarding training is 85%, the breakdown within each level of training shows a compliance rate above 85% although some data presented, shown that for example, level three training compliance is only at 67%. There is at SWFT good monitoring of locum and agency staff contractual responsibility for training. At University Hospitals of Coventry and Warwick the compliance rate for level three are only 79%. Coventry and Warwickshire Partnership Trust overall training rates are just 80% with only 77% compliance at level one but 100% at level three. George Eliot Hospital compliance with training are only 77% at level one, 27% at level two and only 11% at level three, which is inadequate, however, the cumulative data for August 2011, gives a total compliance rate of 85% although there was no breakdown of the data.

60. Safeguarding supervision is not fully embedded within all services, with variable provision especially within the emergency medicine sector. There is no supervision in place for GPs or practice staff, who discuss any concerns with colleagues who may not have up to date safeguarding training or expertise, which is not satisfactory, only a few some GPS may contact the designated nurse for advice.
61. Health staff working at both George Eliot Hospital and Warwick Hospital have a good range of paediatric focussed training, including life support, pain assessments and pain management. There is effective shift monitoring at George Eliot Hospital to ensure that there are staff on duty at all times with childrens life support qualifications and Registered Children Nurses on duty in the children assessment unit. There is an adequate staff rotation programme in place at George Eliot Hospital with the children assessment unit and children ward ensuring skills and competency are maintained. However, recruitment to Registered Children Nurse posts remains a challenge within both hospital A&E departments, especially at Warwick hospital. There are good induction programmes and use of the training passport for junior medical staff on rotation at both hospital sites. The Badger Harmoni out of hours service staff all have safeguarding training and paediatric life support training, with well embedded pathways for referral to A&E, (which is located next door to the Badger Harmoni service) should a child require emergency care.

Outcome 16 Audit and monitoring

62. Child protection case conference audit reports (which contain recommendations) are submitted to the Local Medical Council with respect to the poor attendance of general practitioners at case conferences, and the poor rate of initial case conference reports submitted. However, no action has been taken from the last audit undertaken in June 2010, some twelve months later, with little improvement in compliance seen.

63. There are inconsistently robust audit programmes, with little evidence from repeated audits that actions have been implemented to sustain change in frontline practice. There is an underdevelopment of audit cycle within maternity services, and a lack of monitoring of the effective implementation of recommendations from previous audits. The latter of which is most noticeable within the A&E services at George Eliot Hospital.

64. There are a number of databases which have been developed to collate performance data however; there is a lack of systematic audit control in place making data collection and monitoring cumbersome and leading to potential data errors. For example, one system monitors part of the LAC health assessments notification of out of authority placed children, whilst another monitors the return of the same health assessments, neither of the two systems are able to ‘talk’ to each other.
65. NHS Warwickshire received a strategic health authority (SHA) safeguarding visit at the end of 2010, with a number of recommendations which have now been incorporated into action plans. These action plans are effectively monitored by the health sub committee of the LSCB. The main areas for concern were the capacity of the designated nurse whilst covering Coventry, which remains an ongoing concern. The lack of the named GP role, has been addressed through the good progress with practice based and clinical commissioning group safeguarding leads. Further, there was a lack of evidence from all trust boards to ensure CRB checks are in place. Concerns were also raised, and supported by evidence, from this inspection of the variable implementation and application of safeguarding threshold referrals that was causing confusion for some health staff.

Outcome 20 Notification of other incidents

66. Warwick Hospital staff are aware of and effectively use the incident reporting systems for the monitoring of safeguarding concerns.

67. There is effective use of policies when investigating allegations relating to staff and whistle blowing incidents.

Outcome 21 Records

68. All the looked after health files reviewed during the inspection where complaint with statutory and professional, guidance, however, many of the files did not contain chronologies.
Recommendations

(Those from the joint report CQC and Ofsted are in italics) –

Immediate

Safeguarding

NHS Warwickshire must ensure that notifications of attendance of children and young people from unscheduled care and A&E settings are of a good quality and that give full information relating to attendance, including frequency of visits, so that concerns can be follow up effectively.

Warwickshire County Council and NHS Warwickshire to ensure that health agencies, including GPs, are routinely promptly notified of child protection strategy meetings and conferences.

Immediate

Looked after children

Warwickshire County Council and NHS Warwickshire must ensure that where appropriate that health visitors and school nurses are invited to attend looked after children reviews.

Warwickshire County Council and NHS Warwickshire to ensure that action plans arising form health assessments are appropriately shared

Within 3 months

Warwickshire County Council and NHS Warwickshire must ensure that referral thresholds for safeguarding are applied consistently across the county to ensure appropriate referrals are made and children and young people are protected from harm.

NHS Warwickshire and Warwick Hospital must ensure that nothing impedes the development of the children and young person A&E department.

NHS Warwickshire, Warwickshire council and the local police force must ensure that information sharing with midwives and health visitors to further strengthen responses where the identified risk of a domestic violence incident, is not judged as ‘high by the multi agency public protection arrangements (MAPPA).’

NHS Warwickshire must ensure that all commissioned services have robust monitoring of safer recruitment to protect service users from harm.

NHS Warwickshire to ensure that all referrers to CAMHS to be routinely informed of closure of contact.
Looked after children

*NHS Warwickshire and all health providers must ensure that the looked after children health annual report compiles with the Statutory Guidance on Promoting the Health and Well-being of Looked After Children.*

*NHS Warwickshire must ensure that staff involved with looked after children and young people have access to supervision, support and advice in a timely manner.*

**Within 6 months**

*NHS Warwickshire and Warwickshire County Council must ensure that there is consistency across the county in the core provision of sexual relationship and personal health sexual education in order that young people given consistent information.*

*NHS Warwickshire to review the different approaches in teenage maternity services to ensure that services are consistent and fully meet the needs of young pregnant women.*

*NHS Warwickshire to review the different approaches in identity domestic violence within pregnant women to ensure that all opportunity is give to women to disclose abuse and ensure that both she and the unborn baby are appropriately protected from harm.*

*NHS Warwickshire and Warwickshire County Council must ensure that nothing impedes the development of a dedicated sexual assault referral centre, and that there is a forensically clean service in place during the construction of the new centre.*

*NHS Warwickshire and Warwickshire County Council must review the demand for specialist safeguarding training by maternity staff, including safeguarding disabled children and young people, genital mutilation, domestic violence and hidden harm.*

*NHS Warwickshire to ensure that there are robust systems in place to collect safeguarding training data and impact that training is having on the improvement of safeguarding health services within each contracted service.*

**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.