

Review of health services for Children Looked After and Safeguarding in Coventry

Children Looked After and Safeguarding

The role of health services in Coventry

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CCGs included:	Coventry and Rugby Clinical Commissioning Group
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Summary of the review

This report records the findings of the review of health services in safeguarding and looked after children services in Coventry. It focuses on the experiences and outcomes for children within the geographical boundaries of the local authority area and reports on the performance of health providers serving the area including Clinical Commissioning Groups (CCGs) and Local Area Teams (LATs).

Where the findings relate to children and families in local authority areas other than Coventry, cross-boundary arrangements have been considered and commented on. Arrangements for the health-related needs and risks for children placed out of area are also included.

About the review

The review was conducted under Section 48 of the Health and Social Care Act 2008 which permits CQC to review the provision of healthcare and the exercise of functions of NHS England and Clinical Commissioning Groups.

- The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.
- The focus was on the experiences of looked after children and children and their families who receive safeguarding services.
- We looked at:
 - the role of healthcare providers and commissioners.
 - the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
 - the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.
- We also checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, Working Together to Safeguard Children 2015.
- Where we found areas for improvement in services provided by NHS but commissioned by the local authority then we will bring these issues to the attention of the local public health team in a separate letter.

How we carried out the review

We used a range of methods to gather information both during and before the visit. This included document reviews, interviews, focus groups and visits. Where possible we met and spoke with children and young people. This approach provided us with evidence that could be checked and confirmed in several ways.

We tracked a number of individual cases where there had been safeguarding concerns about children. This included some cases where children were referred to social care and also some cases where children and families were not referred, but where they were assessed as needing early help and received it from health services. We also sampled a spread of other such cases.

Our tracking and sampling also followed the experiences of looked after children to explore the effectiveness of health services in promoting their well-being.

In total, we took into account the experiences of 93 children and young people.

Context of the review

Coventry residents are almost exclusively registered with a GP practice with 99.6% of the population registered with one of the GP practices within the Coventry and Rugby Clinical Commissioning Group. Coventry's population is approximately 343,680. Children and young people under the age of 20 years make up 25.9% of the population of Coventry and 41.4% of school children are from an ethnic minority group.

The health and wellbeing of children in Coventry is mixed compared with the England average. Infant and child mortality rates are similar to the England average. The level of child poverty is worse than the England average with 25.9% of children aged under 16 years living in poverty. The rate of family homelessness is worse than the England average.

In July 2014, a CQC inspection of Coventry and Warwickshire Partnership NHS Trust's children's services found waiting lists of up to 15 months to access a CAMHS service. This was a particular concern for those who were in a crisis or who needed specialist inpatient care. Whilst the staff at CAMHS worked hard to provide a service and they prioritised urgent cases, they did not have the capacity to meet increasing demand. The lack of qualified school nurses created pressure in the transfer of children's care across services.

Commissioning and planning of most health services for children are carried out by Coventry and Rugby Clinical Commissioning Group. There are several services for children that are commissioned by other agencies, namely Public Health, NHS England and the Local Authority. Joint commissioning arrangements are in place with joint commissioning managers to support delivery.

Commissioning arrangements for looked-after children's (LAC) health are the responsibility of Coventry and Rugby Clinical Commissioning Group (CCG).

The CCG employs a designated nurse for looked after children and the designated doctor for looked after children for Coventry is employed through a service level agreement with Coventry and Warwickshire Partnership Trust (CWPT). The designated nurse for LAC is also employed by CWPT as is the named nurse for LAC. This provides continuity and oversight for all children looked after from the Coventry whether cared for in city or out of city.

In November 2014 there were 853 children on child protection plans in Coventry, which was double the England average.

The designated nurse for safeguarding / child protection is employed by Coventry and Rugby CCG, the designated doctor for child protection for Coventry is employed by University Hospitals Coventry and Warwickshire NHS Trust (UHCW) through a service level agreement.

The looked-after children's health team and operational looked-after children's nurse/s are provided by Coventry and Warwickshire Partnership Trust. The newly formed joint health and social care administrative hub for LAC is situated within the Local Authority.

Acute hospital services are provided by University Hospitals Coventry and Warwickshire NHS Trust. They are a specialist acute tertiary centre.

Adult mental health services are provided by Coventry and Warwickshire Partnership Trust.

School nurse services are commissioned by Coventry Public Health and provided by Coventry and Warwickshire Partnership Trust.

Health visitor services are commissioned by NHS England and provided by Coventry and Warwickshire Partnership Trust.

Contraception and sexual health services (CASH), known locally as integrated sexual health services (ISH), are commissioned by Coventry Public Health and provided by Coventry and Warwickshire Partnership Trust.

Child substance misuse services are commissioned by Coventry Public Health and provided by COMPASS (up to age 18)

Adult substance misuse services are commissioned by Coventry Public Health and provided by The Recovery Partnership.

Child and Adolescent Mental Health Services (CAMHs) are provided by a range of services. Tier 1 and 2 are provided by the voluntary sector and commissioned by Coventry Public Health and the Local Authority. Tier 3 services are provided by Coventry and Warwickshire Partnership Trust and commissioned by Coventry and Rugby CCG. The closest Tier 4 services are provided by Birmingham Children's Hospital and commissioned by NHS England.

Specialist facilities (eg. SARC) are provided by the Blue Sky Centre based at the George Eliot Hospital in Nuneaton. This is commissioned by NHS England.

*The last inspection of health services for Coventry's children took place in 2011 as a joint inspection by Ofsted/CQC, of safeguarding and looked after children's services (SLAC) and a joint report was published in May 2011. 'Overall effectiveness of services for looked after children and young people' were judged to be **adequate** and the Being Healthy Outcome for Looked-after children was **inadequate**. Recommendations from that inspection are covered in this review.*

The report

This report follows the child's journey reflecting the experiences of children and young people or parents/carers to whom we spoke, or whose experiences we tracked or checked. A number of recommendations for improvement are made at the end of the report.

What people told us

We heard from one care leaver who told us;

“My looked after children’s nurse was brill, absolutely amazing. She picked up on some symptoms I had told her about during my last medical and sorted out all the tests and scans for me. She’s always been there as a point of contact and she’s even helped me with career advice too”.

She went on to tell us;

“My final medical was very thorough and afterwards all the information and contact details came in the post. In the past when I was younger and in care there was a CAMHs (Child and Adolescent Mental Health Services) referral for me but I don’t think it went through because there were changes in their systems. But I went to Time4U counselling, and they were really good in the way they talked to you”.

We spoke with another care leaver who told us;

“I remember I had the final medical and got the information afterwards. I also needed my health history and immunisations to go to university but I didn’t know where I’d put them, so when I got in touch my nurse, she got them all together for me quickly. I was very impressed”.

She went on to tell us;

“What I didn’t realise how expensive dentists are. I haven’t been since leaving care some years ago. I think I need to go but as a care leaver and student I can’t afford it. It’s not in my pathway plan and I hadn’t thought to mention it before leaving care”.

We spoke with the foster carer of a young person. They told us;

“We are quite new to it and this is our first experience. We have signed up as long term foster carers. We gained approval (to foster care) in September and we were matched with a child in November. We were a blank canvas when we went to training, having not had our own children, so were willing to learn. It’s been a massive learning curve but we feel blessed”.

“The child we have had their health medical before coming to us so we have no experience of the system yet. We registered our child with a local GP who is helpful and completed some asthma investigations as we were told the child had asthma, but the investigations showed this is not the case. We have also registered with the local dentist and that’s been helpful though there’s nothing major to worry about.”

Another, more experienced foster carer we spoke with told us;

“The first child we fostered attended CAMHs twice a week for three and a half years as they had a lot of attachment problems. They hated going to the appointments, partly because it meant being taken out of school and when they came back all the kids wanted to know why they had been away which made them feel different. More appropriate, out of school hours appointment times would help this as it really matters to kids.”

“There used to be good training courses on health subjects but then it was cut out and training was offered online only which wasn’t as effective. However, face-to-face training is starting up again and this is very good. The recent attachment course was fantastic. Our link worker gives us advice about training and we get a brochure too which tells us what is going to be available.”

The foster carer also told us;

“Foster carers don’t get health histories about children before or after placement. In one case we didn’t know that there was a family history of allergies which is relevant to us so as to be able to help the child.”

We spoke with a young person who uses CAMH services. They told us;

“I have been using the service for about 3-4 months. The first appointment didn’t take too long to come through but at the start I went through a lot of people. First I saw a man, then a lady and then another lady. I get on very well with my current CAMHs person and feel supported and listened to, but it’s not enough.”

When asked if there is anything that could be better the young person told us;

“They could have more people so it’s less rushed.”

We attended a ‘voice of the child meeting’, where we met and spoke with several young people both currently in care or having left care. They told us of their experiences;

“There are long waiting lists for CAMHs, I have been referred but nothing has come of it yet.”

“Some GPs don’t listen to you or understand what it means to go into care, so when I was asking for counselling I didn’t get anywhere.”

“I’d rather the health medical was done by a GP as they know you anyway. They are much better and treat you like you’re a normal person. We don’t want to be different from other kids.”

“Health reviews are not helpful or relevant. They are just something you have to go through because you have no choice.”

None of the children we spoke with felt happy about their health reviews or valued what they were about. We were advised by them that young people are not asked for feedback about their health reviews or other health services. One young person told us;

“Who does it (the health review) is really important but you (the children and young people) don’t get any choice. If you don’t get on with them (the health professional undertaking the health review) you’re not going to say much. They just say the same things about visiting a dentist or optician every year even though my optician has said I don’t need to go for two years. The medical still says I have to go every year just because I’m in care so I feel it’s a waste of time.”

Another young person told us about their health reviews;

“Having the same person do them is good if you get on with them, you’re more likely to tell them things. If I don’t like someone, whoever they are, I just don’t co-operate and I turn off. I had one before who had a really bad attitude, made me feel like I was naughty. This puts you off.”

Another told us;

“This time I had the LAC nurse come to the house. She was alright; she was professional and did her job.”

“Going out of school to go to medicals and things because you’re in care makes you feel different and we don’t want to feel different. The other kids ask what you’re doing all the time and you don’t want everyone to know.”

In relation to staff recruitment, young people told us of their increased involvement in the decision making process;

“It’s good that young people have been involved in choosing the last few LAC (looked after children’s) nurses as we are now always on decision panels. The LAC people were the first ones to take our views seriously on interview panels and we have even had the last word when it’s been close. All the people we’ve chosen have been really good”.

We spoke with young people who use CAMH services. They told us;

“Seeing the psychiatrist on my own was really good. On a one to one basis, I was able to say things without other people being there. It felt more personal.”

“There was too long to wait between appointments with my psychiatrist. It was hard though, to ask to see them more frequently although this is what I needed.”

“I did get good support from my GP but she was only there for a few months. She understood really well and I saw her regularly. She has left now and the new one doesn’t understand so well.”

“More frequent contact with the psychiatrist would be helpful. There are long gaps between when we meet.”

Parents of young people engaged with CAMHs health professionals told us;

“We’ve had very positive experience of CAMHs. It’s been fantastic. My daughter has really improved. We understood we would have to wait but were disappointed with the length of time. She started to deteriorate and we went back to the GP who referred her urgently to CAMHs. The appointment was brought forward by two months. I was listened to and taken notice of. She has had a massive increase in self-esteem and motivation since the CAMHs treatment started. It is quite remarkable and due to the CAMHs intervention.”

“My daughter became unwell and had to go into hospital. She spent four days in the paediatric ward and then went to a unit in Birmingham. She got amazing support at the unit, 24 hour support and one-to-one every day. She felt safe and comfortable that they were monitoring her so closely. Her Coventry psychiatrist came to see her in Birmingham and she felt he was on her side.”

“There was a gap between the inpatient unit and her coming home however. It was such a massive change from loads of support to virtually none. She was allocated a psychiatrist but they went off sick and she had no chance to build a relationship with them. I was given strategies to help support her and that was helpful and I took time off work. My biggest concern is the lack of staff in CAMHs with practitioners having to come in from elsewhere to support the team. There is a lack of manpower in CAMHs”

We spoke with several parents on the University Hospitals Coventry and Warwickshire NHS Trust midwifery unit. They told us;

“The group discharge meeting with other mothers was great, I wish I’d had that with my first child, it was very helpful, told us what to expect, what to do and what not to do.”

“There was a risk that my baby may have had something wrong and we were given options and information about screening.”

“I’m an older mother and my pregnancy was risky, we discussed coming to Coventry and chose to come here... overall the standard of care has been excellent, I don’t think they could do better.”

“The midwives talk in a language that we can understand and they are informative. Our midwife was a star; she made the whole experience memorable for us.”

“They go out of their way to offer support; you don’t have to chase it.”

“They enforce the visiting policy so that it’s not overcrowded and noisy.”

The child's journey

This section records children's experiences of health services in relation to safeguarding, child protection and being looked after.

1. Early help

- 1.1 The integrated, early help initiative known as 'acting early' operating from the Tile Hill children's centre is helping to identify concerns about vulnerable families and children at an early stage and engage them with a range of early help support services, including through children's centres and the independent sector. This initiative has been in place since April 2014 and involves midwifery and health visiting services as well as the children's centre staff. We considered this to be an excellent model of integrated working within the health sector to facilitate families' engagement with early help.
- 1.2 Six local GP practices have also adopted the programme and actively refer cases into the scheme which is positive. However, overall GP engagement with the initiative has been slow. Although GPs and practice managers are routinely invited to these forums, active engagement from GPs is patchy. The health visitors we spoke to had not seen attendance from GP practices in the 'acting early' meetings they attended (**Recommendation 3.1**).
- 1.3 The initiative empowers staff to identify children and families where early help would benefit with readiness for school and possibly help to avoid entry into the safeguarding system. Children who are identified are discussed at weekly meetings and an integrated programme of support can then be put in place, including support channelled through a common assessment framework (CAF) if considered appropriate.
- 1.4 We heard numerous examples of the positive impact of the 'acting early' forums, particularly in the CAF processes. Our review of the outcomes documented in the individual cases presented to us and the initial data collected by public health (such as the increase in breast feeding initiation, smoking cessation and new birth and milestone reviews) shows that this programme has already had a positive impact on the health and wellbeing of vulnerable families in Coventry.

Case Example: *A Romanian family with three small children were living in rented accommodation. The family came to the attention of services when Mum went into hospital and Dad went with her. It was quickly identified that the family were struggling to cope with three small children including an infant, when Mum was unwell.*

The case was discussed at an Acting Early meeting and a CAF led by the children's centre was put in place

Joint visits to the family were undertaken involving the health visitor and CAF co-ordinator from the children's centre

A dietician was brought in promptly to assess the children's dietary needs in response to a concern identified through the CAF. The dietician assessed there was no need for further intervention

Outcomes

The family were in significant financial difficulty. In part, these were due to them paying rent arrears accrued by the previous tenant. This issue was addressed and the debt written off enabling the "line to be drawn" for this family.

Pressures on family reduced due to the multi-agency support

The family is making good progress with effective CAF support in place.

- 1.5 Community midwives hold antenatal clinics in GP practices. Home visits are not universally undertaken unless an area of vulnerability has been highlighted. However, due to there being good information sharing processes in place between midwifery services and health visitors this is not considered a risk.
- 1.6 The midwifery services' building at University Hospital Coventry and Warwickshire NHS Trust (UHCW) is excellent and it is evident that layout ensures effective continuity of care and promotion of early attachment between parents and the new born baby. We were advised how staff members in the service actively promote the involvement of fathers in the care of new born children. All mothers are expected to be seen alone during pregnancy on at least one occasion in line with good practice, enabling the woman to disclose information away from her partner. Practice against this standard is due to be audited in the summer, demonstrating good governance in the trust.
- 1.7 Effective follow-up arrangements are in place in the midwifery service to address and follow up any "did not attend" (DNAs) and missed appointments.

- 1.8 Specialist clinics within midwifery services include: female genital mutilation (FGM), cardiac, diabetes and HIV. These are effective in providing targeted support to vulnerable expectant mothers. Midwifery services overall are patient centred, having been developed and improved in response to women's feedback and requests. This is facilitating good outcomes and we heard very positive feedback from the parents we spoke to during our visit.
- 1.9 There is a foetal wellbeing unit that is midwife led for those mothers with poor obstetric histories. Mothers are seen on an "as needed" basis. We were advised that this provision has reduced the need for prolonged hospital admissions during pregnancy.
- 1.10 Following a service user survey of maternity services, several women complained about the slow discharge process from the maternity ward. As a result, the service was streamlined and the role of discharge midwife was developed. This has resulted in a marked reduction in the discharge process waiting times. Women had also said that they would like their partner to be able to stay with them during their stay on the unit. As a result, rooms were re-designed to accommodate as many partners who wish to remain and be more closely involved in the post-natal time on the ward with their partner and baby. This actively promotes closer bonds between families at the early stage of an infant's life.
- 1.11 The unit has family rooms which contain double beds and an area where siblings can stay with parents if the new-born is to remain in hospital. The same area is used in surrogate births providing a room for the surrogate couple and one for the birth mother, again promoting good attachment for mother and baby.
- 1.12 Health visitors told us that they routinely receive good and timely notification of pregnancy from midwifery services. Information sharing is facilitated by weekly meetings at Coventry children's centres involving midwives, community midwives, health visitors and children's centre staff. Notifications and Information are passed by midwives to health visitors ensuring the mother can be supported by the health visitor at an early stage. Practitioners told us they feel this works well and gave case examples which demonstrated this.
- 1.13 Joint visits involving health visitors and midwives are undertaken when risks have been identified in cases but are not undertaken routinely as this is not considered necessary due to good information sharing between services.

Case Example: *Involving a traveller family. The health visitor had booked an antenatal visit to a mother with a small child. The mother had been staying in another area and disclosed that she had not accessed any midwifery antenatal care.*

The health visitor liaised promptly with the community midwife to facilitate engagement between the mother-to-be and midwifery antenatal care.

An older child had not had appropriate developmental checks which the health visitor undertook promptly.

Outcomes:

The health visitor developed good rapport with the expectant mother which facilitated and secured the mother's access and engagement with appropriate antenatal care.

An overdue developmental assessment was undertaken on the older child.

This case demonstrates good inter service liaison between health professionals to ensure the health and wellbeing needs of a vulnerable family were met.

- 1.14 Health visitors are beginning to take on the lead professional role in common assessment frameworks (CAFs).
- 1.15 A perinatal mental health assessment is routinely undertaken by health visitors facilitating early engagement for mothers-to-be with the perinatal mental health service.
- 1.16 There are two community psychiatric nurses with a specific remit to work with perinatal mental health. Workers said that a recent restructure of adult services had impacted upon their capacity to provide timely early help and some delays had resulted in pregnant women with mental health needs receiving intervention. The role of the specialist psychiatrist for perinatal mental health had been revised to no longer provide a perinatal service. This has recently been reinstated in line with NICE guidance which sets out an expectation for the provision of a specialist perinatal mental health service under the leadership of a specialist consultant and we understand that proposals are being considered to expand the service to include a specialist psychology and additional support staff.
- 1.17 Practitioners in the perinatal mental health service described a very good working relationship with midwifery services some of which they attributed to a stable midwifery workforce who were confident in being able to pick up the phone to discuss cases. The interface with health visitors is not as well developed, attributed at least in part to many health visitors being new in post as a result of the increase in health visitor resource delivered through *Call to Action*.

- 1.18 Increased capacity in the health visitor service as a result of *Call to Action* is beginning to demonstrate improved outcomes. Practitioners can respond more flexibly and promptly when mothers are motivated to engage in good parenting behaviours such as breastfeeding their new baby. Where a new mother may be having difficulties in breastfeeding, a delay in the provision of professional support and guidance could result in the mother losing motivation. We saw a case example of this increased health visitor capacity leading to a good outcome for mother and baby.

Case Example: *A new mother requested a home visit from her health visitor four days after discharge from maternity as she was keen to breast feed but was having difficulty.*

Due to increased capacity in the health visitor service as result of Call to Action, the health visitor was able to respond promptly to the mother's request.

The health visitor visited the new mother and supported her to successfully breastfeed her baby, ensuring beneficial skin to skin contact which facilitates positive attachment between mother and infant.

This helped to ensure a good start for the new-born baby and although the mother only breast fed for a very short time, none the less, the benefit to babies is well evidenced through evidenced based research.

This demonstrates the local strengthening of the universal health visiting offer to new mothers ensuring that good practice becomes routine.

- 1.19 Children and young people are able to access emergency care at University Hospital Coventry & Warwickshire NHS Trust (UHCW) in a dedicated children's emergency department (CED) which is bright and welcoming with its own entrance and reception area. Careful consideration of care pathways mean that contact with adult patients is minimised and a child-friendly culture maintained throughout a young person's visit. We saw that one of the dedicated paediatric treatment cubicles has been adapted as a 'sensory room' with additional equipment to help calm those children who need additional support, such as those living with learning disabilities.
- 1.20 Children are greeted by a receptionist and their demographic details are taken, including next of kin details, who is accompanying them and the school they attend if applicable. Signage displayed around the department informs parents and carers that details of the attendance are shared with the child's GP and health visitor or school nurse.

- 1.21 One case we examined in CED demonstrated that the relationship detail of adults attending CED with children and young people is not always recorded correctly. It is important to routinely record who has accompanied the child and what their relationship with the child is. This is important in relation to being aware of children who may be subject to child sexual exploitation (CSE) and particularly where children are unable to articulate who is accompanying them (**Recommendation 2.1**).
- 1.22 Repeat attendances in the CED are recorded on the front of the patient record, although we did not see evidence that this information is always being considered as part of the consultation. In one record we reviewed, a mother had brought her baby to the CED three times in a short period of time and practitioners had not considered that she may need some additional advice and support (**Recommendation 2.2**).
- 1.23 Not all records kept in relation to children and young people's attendance at CED provide a clear audit trail of actions taken and outcomes following attendance. We saw that a mother had attended with a five year old child but that she had self-discharged with the child 10 minutes later. Recording of the reason for attendance was limited. There was no recording of the reason for self-discharge or if any discussion had taken place between health professionals and the mother so that follow up proposals could be made and actioned. There is risk therefore, that children attending the CED can leave before being assessed and any safeguarding risk adequately considered. (**Recommendation 2.3**).
- 1.24 Older young people attending CED are given the choice whether they are seen in the CED or the adult ED next door. Currently, those young people choosing to receive their care in the adult ED environment are not given a paediatric record. This means there is a risk that adult ED practitioners may overlook the vulnerabilities that some young people face and this could undermine the robustness of the safeguarding risk assessment for older teenagers (**Recommendation 2.4**).
- 1.25 Where young people need to be admitted to a hospital they are usually cared for in the adolescent ward. However, if young people choose to go to an adult ward or if an adult care environment is considered the most clinically appropriate place for them, we saw that there are good arrangements in place to protect them with good oversight from paediatric trained clinicians during their stay.
- 1.26 Young people attending CED following substance or alcohol misuse are routinely followed up by the local substance misuse service provided by Compass. This means that young people who may potentially need additional care and support are identified at the earliest possible opportunity.

- 1.27 Staff working in the CED report good access to a telephone interpretation service to help communicate with children and families whose first language is not English.
- 1.28 Where GP practices have established ‘families of concern’ or ‘vulnerable families’ practice meetings, these are effective in sharing information across disciplines and helping vulnerable families engage with appropriate support at an early stage. Health visitors linked to these practices routinely attend these meetings and they told us of how they are helping to strengthen multi-agency and multi-disciplinary working. However, these meetings are not established in all practices and school nurses, an often valuable source of information pertaining to children at risk, are not involved in the process. (**Recommendation 3.2**).
- 1.29 Timely access to CAMHs is well understood locally to be a significant challenge due to lack of capacity within the service. This is a key concern of young people and their families in Coventry. The local Coventry Healthwatch England team advised us of cases they had been made aware of regarding young people’s poor experiences of waiting for CAMHs intervention. We also heard examples from young people and parents of deteriorations in the mental health of the young person following assessment while waiting for intervention. In these instances, we were told that GPs had responded quickly in re-referring to CAMHs and the appointment being brought forward (**Recommendation 1.1**).
- 1.30 Once engaged with the CAMHs service, we heard about and saw positive outcomes as a result of this engagement and associated therapeutic interventions.
- 1.31 Young people with mental health needs in Coventry do not have access to an intensive home treatment service which has proven successful elsewhere in reducing admissions to Tier four (in-patient admission) provision and facilitating early and well supported discharge into the child’s home community. The CCG and CWPT recognise the lack of this provision as a gap. The trust is looking at models of best practice in areas where these services are in place as a guide to developing a local intensive home treatment model.
- 1.32 Young people have good, seven day access to fully integrated sexual health and contraception services (ISHS) in good accommodation at the central hub in the NHS healthcare centre; and with fast track clinics at the universities, a college and a children’s centre. ISHS is aware of its responsibilities to protect confidentiality whilst sharing information appropriately where a young person is at risk of harm.

- 1.33 The ISHS uses an IT system which includes personal information, assessment and history. Satellite services use hard copies which are then uploaded onto the system at the hub so there is an overview of attendances, tests and prescribing for an individual. The IT system flags the age of a young person under 16 and includes a mandatory risk assessment proforma for under 18 consultations. This covers appropriate risk indicators, consent and Fraser competency assessment. However, the system has no triggers or mandatory evaluation to ensure that the practitioner takes appropriate action where there are multiple indicators of risk, or a few very significant risks. We saw one case where there were risks indicated but the practitioner had not completed the assessment template.
- 1.34 ISHS Managers were unable to identify or search for vulnerable young people by age, by referrals made to other agencies or by other risks factors, other than from memory. There is no system for recording decision making on cases of concern or the outcomes. Coupled with the lack of regular quality assurance or opportunities for management oversight of cases, this presents risks that individual practitioners may not recognise CSE and other abusive patterns. **This has been drawn to the attention of the Director of Public Health who commissions this service.**
- 1.35 Despite capacity pressures, school nurses have maintained drop-in services at secondary schools, and with increased visibility in targeted schools. Drop-in services are valuable in providing opportunities for young people to access help or disclose concerns such as child sexual exploitation (CSE) and personal health and wellbeing issues. School nurse teams understand the demographics of their area well and plan accordingly to try to engage young people in different ways. Parents of primary aged children are encouraged to access early help through the school nursing service's annual drop-in sessions, 'top tips' displayed in schools and other advertising and publicising of the new generic school nursing email address.
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2. Children in need

- 2.1 Discharge meetings within maternity services at UHCW are held routinely for families with new babies where there is known vulnerability. Multidisciplinary attendance at these was seen to be good in cases we reviewed.
- 2.2 Health visitors currently undertake antenatal visits on a targeted basis according to assessed need. However, the increased capacity beginning to be realised within the service is enabling the service to move towards antenatal visits becoming part of the universal offer in line with nationally expected good practice.

- 2.3 Transfer-in case handovers when families move health visitor areas within Coventry are done by internal post rather than face-to-face. We did not see transfer summaries on case records that would help ensure that the new health visitor is aware of key issues, service plans and activity. While we identify this as an area for development, we understand that this has also been identified as a gap in a recent local serious case review (SCR) with a recommendation to strengthen this area and that work is in hand to address this (**Recommendation 1.2**).
- 2.4 The family nurse partnership (FNP) is a voluntary home visiting programme for first time young mothers (and fathers), aged 19 or under. A specially trained family nurse visits the young parents regularly, from early in pregnancy until the child is two. This programme is well established in Coventry, and cases reviewed highlighted positive outcomes for young people and their infants supported by this service.
- 2.5 There are specialist health visitor roles in place within Coventry. These include: specialist health visitors for vulnerable families, statement of educational needs (SEN), feeding, domestic violence (seconded post under a CQUIN), travellers and asylum seekers and clinical supervision and preceptorship. We note that there are no specialist substance misuse roles in either health visitor or midwifery services. However, this has not been identified as a local need and affirms our finding that the substance misuse pathways are well established and robust so that people needing support are promptly accessing specialist services.
- 2.6 Health visitors report good liaison and communication with adult substance misuse service, Recovery Partnership (Addaction). This is good practice in identifying the needs of children and young people living with or in regular contact with adults who misuse alcohol or drugs.
- 2.7 At UHCW's emergency department there is no formal safeguarding triage as recommended by NICE, although patient notes we reviewed demonstrated a good awareness in the recognition of potential safeguarding and child protection issues. Parent and child interactions and consideration of mechanism of injury was a common feature in case records we reviewed. However, the absence of a triage within the documentation, places an over-reliance on practitioner knowledge and expertise and therefore a risk that not all risk indicators may be considered (**Recommendation 2.5**).
- 2.8 All paediatric attendances at CED are checked by senior nursing staff during a night shift. Those attendances that would benefit from a more targeted approach or consideration by the child's health visitor or school nurse are brought to their attention through a health visitor/school nurse liaison form. Basic details of all attendances by children and young people are copied to the GP and public health nurse.

- 2.9 UHCW has an effective electronic alert system in place to identify where there are additional medical or social concerns about a child and this is used effectively. CED staff routinely tick and initial records to indicate that they have considered and checked the content of the alert. The named nurse told us that Coventry children's social care provide a weekly list of all children with a new child protection plan in place and those children who are no longer subject to plan. This information is then used to update the child's hospital electronic record.
- 2.10 Children and young people who attend the CED following an incident of self-harm or requiring emergency mental health care are supported well. Most young people are admitted onto the adolescent ward and are cared for by children's nurses who have received in-house additional training on caring for this vulnerable cohort of young people. Staff members have also been trained in managing actual and potential aggression (MAPA) to help them understand and de-escalate challenging situations that can rapidly develop with young people who are unwell. The appointment of a CAMHs liaison nurse has had a significant impact on the effective risk management processes. This nurse provides oversight of care records and care pathways for young people in the acute environment until they are either discharged home or admitted to a specialist CAMHs tier four in-patient bed.

Case Example: *A young person was admitted to the adolescent ward following an attendance at CED following self-harm. The young person was well known to both CED and CAMHs, and a working agreement was in place to provide an appropriate care pathway to support the young person following any incident of self-harm. The presence of the working agreement was indicated as an alert on the young person's hospital record.*

The pattern of self-harm on this occasion was outside the working agreement and so clinicians made the decision to admit the young person to the adolescent ward for review by CAMHs.

On admission to the ward full risk assessments were carried out; these included assessing the young person's physical environment on the ward and also their mental health needs and potential for risk to self. Hourly observations were put in place and records examined indicated good compliance with this requirement.

We also saw that a CSE screening assessment had taken place, with no additional risk being identified.

CAMHs carried out a rapid assessment and arrangements were made for the young person to return home with an appointment made to see their own therapist at the earliest opportunity.

- 2.11 A new team of senior CAMHs nurses is being recruited to provide a rapid response to young people admitted to the adolescent ward to carry out timely mental health assessments.
- 2.12 Where young people require 'tier four' in-patient treatment for mental ill health, we were told that this can usually be found in units close to Coventry by way of NHS England's specialist commissioning. However the length of time to identify an available bed can vary. CWPT are usually able to continue to provide active engagement and support to young people while they are receiving such tier four treatment. When there are delays, this can create considerable issues for clinical staff and the patient and their family. It is more of a challenge to the service to provide CAMHs support to young people with complex needs placed in 'out of area' residential units long-term; also for young people with CAMHs needs who are placed in Coventry by other authorities.

Good Practice Example: *During this CLAS review in Coventry, we heard about two specialist CAMHs posts based in the youth offender service (YOS) and a multi-systemic post situated in the local authority and managed by the CAMHs lead professional.*

The multi-systemic post targets offending behaviour, non-attendance at school and those on the cusp of care. The post holder has forensic psychology background which will better aid their understanding of young people living with mental health problems and the way this can affect their offending behaviour.

We further heard that this service is providing demonstrably good outcomes for young people and as a result, has recently been made into a substantive post demonstrating good partnership between social care and health.

- 2.13 While we did see good use of an outcome measure tool with parents in one case, CAMHs clinicians are not always sharing written information with parents of children with mental health needs in a format and style which is effective in keeping them informed about the treatment of their child. We saw case evidence of this where the practitioner had copied a letter to another clinician to the child's parents. The letter was clinical in nature and language which, while appropriate to another clinician, was unlikely to be accessible and easily understood by the child's parents. We did see very clear communications written by the designated doctor for looked-after children to foster parents, explaining the child's treatment very effectively which would provide a good model for other clinicians (**Recommendation 1.3**).
- 2.14 CAMHs practitioners and therapists routinely see young people alone which practitioners felt is valued by the young people with whom they engage.

- 2.15 Clinical and safeguarding assessments in CAMHs are all very individual to the clinician undertaking them and most practitioners we met told us that they did not use the standard template. Some assessments, including hand written ones, although varied in format, were comprehensive in their content. Overall however, there was a high level of inconsistency and quality. Where the service's standard template was used, those seen were incomplete and undated. Most information about the safeguarding assessment was contained in the letter to the GP. This is a document which should follow the assessment rather than replace it. We also saw no evidence of managerial oversight of the assessments undertaken (**Recommendation 1.4**).
- 2.16 Following assessment in CAMHs, care plans based on the child's goals were not produced to frame and steer the work. This therefore makes reviewing and monitoring progress difficult for the practitioner, young person and managers alike. The lack of a care planning approach in the service also undermines practitioners' ability to ensure that CIN and child protection plans are well embedded within the young person's CAMHs support (**Recommendation 1.5**).
- 2.17 Transitions from CAMHs into adult mental health do not always work well, although this was not an area identified specifically as challenging by clinicians, with one telling us the pathway worked well. The adult early intervention team will work jointly with CAMHS in assessing young people who have early identification of psychosis. The referral point is as the young person approaches their 16th birthday. We did hear of some examples where transition had not been effective and the CAMHs practitioner retained the case on their caseload for longer than they should in order to provide the young person with support after transition into adult mental health provision (**Recommendation 1.6**).

Case Example: *A young person aged 16+ with ASD and Tourettes syndrome experiencing command hallucinations and episodes of self-harm. The young person is subject to a Community Treatment Order and has a longstanding involvement with CAMHS,*

Presently the young person is in an educational residential placement out of area with regular visits back to Coventry. A young person's safety plan was seen in file, set out with age appropriate style and use of language.

CAMHS made a referral to the adult mental health Early Intervention team. The Early Intervention worker had been invited to a discharge planning meeting at residential placement as part of the referral process.

Within the transitional arrangements it was agreed that CAMHS retain the lead responsibility for care co-ordination with the Early Intervention CPN administering the young person's medication.

The Early Intervention worker maintained good and regular contact with other professionals in the area outside of Coventry where the young person is presently residing.

As part of the transition process joint visits are undertaken by the CAMHS and Early Intervention worker with a planned final case transfer by age 17. This is an example of good transition pathway planning likely to provide effective support to the young person as they move into the adult mental health service.

- 2.18 Addaction's Recovery Partnership adult substance misuse service has clear and robust processes for identifying situations that might give rise to risks of harm to children. We saw good professional curiosity demonstrated by practitioners and they were proactive in chasing up information from other agencies. A clear pathway for referral to children's social care is in place and for recording that a referral has been made. The service's recording system routinely contains practitioners' narrative of the dialogue with children's social care including; who was passed information, what information was passed, the outcome of the discussion and the rationale for any decisions. This is for the initial information shared about the case as well as the follow up referral by the worker. We did not, however, see evidence of use of the multi-agency referral documentation or that a copy of the referral is retained. This creates some potential for misinterpretation of information exchange at the point of referral and reduces the provider's ability to quality assure referrals. We saw no evidence of effective safeguarding managerial oversight or quality assurance. **This issue has been drawn to the attention of the Director of Public Health who commissions the service.**

- 2.19 We saw clear and explicit Child in Need (CIN) plans on most health case records examined. Practitioners across services told us that they find the clear structure of CIN plans helpful, setting out their roles and responsibilities in a way that supports them to help and protect children in need effectively.
- 2.20 However, not all health case records of children subject to CIN status contained the CIN plan. In one instance for example, the practitioner said they had never received the plan from children's social care. While it is the responsibility of children's social care to send CIN and child protection plans to all relevant practitioners, health providers and their workers have a responsibility to ensure that they have this in order that they can discharge their responsibilities effectively. We did not see a sufficiently proactive approach across the health community in this regard and this is a key area of development for health providers (**Recommendation 1.7**).
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3. Child protection

- 3.1 While we did see chronologies being used in health visitors case records, these are not used consistently. Practitioners and managers acknowledged that the approach to the use of chronologies is down to individual community health practitioners and there can be some overlapping of recording in the chronology and the running health record. Guidance for practitioners to ensure a systematic and consistent approach to the use of chronologies is not in place. We understand that guidance is currently being developed in the safeguarding sub-group in response to learning from a recent serious case review (SCR) (**Recommendation 5.1**).
- 3.2 Across community based health services provided by Coventry and Warwickshire Partnership Trust, we did not see the use of care plans and understand that these are not developed within this provider's services. Effective care planning is commonly standard and routine practice in services. Care plans can be instrumental in facilitating intervention that is focused; meeting identified need and so the client knows what they can expect from the practitioner. Care planning enables progress and the impact of intervention to be reviewed at regular intervals by the practitioner, the child and their carers as well as operational managers. Where children are subject to child protection procedures and who are therefore explicitly identified as being most at risk, the absence of effective care planning and monitoring in health services is of particular concern. Given that practitioners told us that they are not always clear on their role and responsibilities under the child protection plan recommendations when they leave core groups and child protection conferences, this requires addressing as a priority across the health disciplines provided by CWPT (**Recommendation 1.5**).

- 3.3 Overall in most services seen in Coventry, the quality of referrals to the MASH was good. However, quality assurance of referrals by operational managers or periodic audits to help drive up or ensure consistent good quality was not routine. In the CED at UHCW for example, we examined one safeguarding referral to children's social care which lacked sufficient detail highlighting the extent of risk and potential impact on the children of a family where domestic violence had taken place. Notes made on the clinical record were detailed in highlighting risk, but the notes had not been transferred in full to the referral form. Had this taken place, children's social care would have better informed of the fact that several children had witnessed an assault on their mother by their father for which he had been subsequently arrested. By not clearly highlighting risk on a safeguarding referral there is a possibility that children's social care might not consider appropriately that risk to children and young people. Similarly, use of overly clinical language or not explaining the potential safeguarding implications of a specific medication that may affect parental behaviour is not always helpful to social care decision makers (**Recommendation 4.1**).
- 3.4 In the CED, referrals to children's social care are made by the treating CED practitioner using the local authority's multi-agency referral form. Copies of the form are sent to the trust's safeguarding team and a copy is kept in the patient record. Outcomes from referrals are sent to the trust's safeguarding team and the named nurse has good oversight on the progress and outcomes of referrals. We were told that the named nurse provides feedback to practitioners on the quality and content of referrals, although not all the referrals we saw demonstrated that this was fully effective in ensuring best practice.
- 3.5 In UHCW adult ED, there is a clear expectation that if an adult attends following an episode of self-harm and they have children in the household, then a referral to children's social care should be made. Most adults who attend the ED following risk taking behaviours such as self-harm, substance and/or alcohol misuse or with mental health concerns are asked about their access to children. However, we found a lack of rigor in the recording of this detail and in some records seen it was not possible to establish if a conversation had taken place about the patient's access to children, either their own or other children to whom they had access (**Recommendation 2.6**).
- 3.6 There is also a gap in notifying health visitors and school nurses of adults who attend the ED with risk taking behaviours who have children in the household. This is important information that will inform their assessment of risk in a family and support effective follow-up in the community to safeguard children and young people (**Recommendation 2.7**).
- 3.7 In health visiting, where cases are recognised as CIN or child protection, they are retained on the caseload on the original health visitor team until transfer of the case is deemed appropriate. This is good practice.

- 3.8 Safeguarding referrals to children's social care by health visitors were comprehensive, clearly setting out recognised risks to children and thus facilitating an effective decision making process.

Case Example: *A couple with small children who had been subject to child in need (CIN) procedures due to domestic violence between the parents. The case had been closed to children's social care as the adults relationship had come to an end and the male had moved out thus removing the risk to the children.*

A recently qualified health visitor was given the family as a part of their caseload and at their first home visit encountered an adult male at the home, the mother of the children was unavailable and the children were being looked after by an 'aunt'.

The health visitor discussed the visit and her concerns about what she had found with her team leader who advised to make a further visit to ascertain the identity of the male. The visit took place and the male was found to be the original partner, the couple having got back together.

With this new information the health visitor made appropriate referral to the MASH. The referral was concise and clearly set out the key issues and information and the risks of harm to the children. This represented a very good quality referral facilitating prompt and effective decision making in children's social care who undertook a prompt assessment thus effectively safeguarding the children.

- 3.9 All young people admitted to the adolescent ward identified as requiring further CAMHs assessment are routinely screened for potential CSE. UHCW has developed the CSE questionnaire for adolescents accessing the acute services, it being specifically focused on self-harm and used as a tool for clinical staff to identify cases of vulnerability at the earliest opportunity. The effectiveness of the form and its subsequent use is monitored by the quality and effectiveness sub-committee of the safeguarding board and initial findings were planned to be presented imminently. Despite it being early in the pilot phase, five young people previously unknown to services have been detected. This is good practice with the potential to be highly effective in the detection of children at risk or who are victims of exploitation.
- 3.10 The mandatory reporting process for female genital mutilation (FGM) is well understood across UHCW and a clear referral process is in place for those women who deliver a baby girl or if there are female children in living in the household.

- 3.11 There is a clear expectation across CWPT that health visitors, school nurses, CAMHs and adult mental health practitioners will attend core groups and child protection case conferences as well as submitting a written report in advance. This expectation is well monitored within the trust. Where inexperienced health visitor practitioners attend these meetings, they are accompanied and supported by their preceptor or manager in an individually tailored approach.
- 3.12 We did not see health practitioners within CAMHs being proactive about ensuring that they had been sent child protection minutes and the dates of key meetings. While it is clearly a children's social care responsibility to ensure these are sent out, it is beholden on health services and individual practitioners to ensure that they have key child protection documentation and dates of forthcoming meetings. We were made aware in discussion with practitioners and in reviewing case records, that CAMH practitioners were not always clear on their role when they had been in child protection conferences other than to visit the young person concerned and work with them. It is essential in order to safeguard a child or young person known to be at risk, that health practitioners have a clear understanding of their role in any CIN or child protection plan before they leave the decision making meeting. This is important in helping the practitioner determine whether or not a child protection plan is being complied with, inform the development of the child's care plan within the service and facilitate the practitioner in reporting back to conference thus assisting future conference decision making (**Recommendation 1.8**).
- 3.13 Child protection documentation, including child protection minutes and child protection plans, were also not routinely secured as part of the case record in health visitor services. We saw only one exception to this where the health visitor was ensuring that these were filed within the main case record. For the most part, we saw cases where this documentation was kept in a brown envelope separately from the main case record. This increases risks that these key documents become separated and that practitioners and managers do not have immediate access to key child protection documentation which should be informing and steering day to day practice. Overall, health visitor record keeping and management was poor (**Recommendation 1.8**).
- 3.14 Within the Recovery Partnership (Addaction) adult substance misuse team, we heard that practitioners are routinely attending child protection meetings and are subsequently members of core groups. However, we did not see documentation from child protection conferences on the case records we reviewed. Managers told us that the documentation is not routinely received. The absence of written records of meetings and child protection conferences highlights a potential for lack of clarity about the service's precise role in protecting the child. Practitioners told us they are not always clear what their role is and we did not see evidence of practitioners making attempts to obtain this essential information to ensure their safeguarding work was fully informed. **This issue has been drawn to the attention of the Director of Public Health who commissions the service.**

- 3.15 GP practices visited are equipped to consider well the welfare and safety of children and young people because they have processes in place to identify when there are concerns about children and to share information appropriately with the MASH. In one GP practice visited we saw that there were clear procedures in place for recording and tracking progress on children about whom there were concerns. This was by way of a monthly meeting between the GP and the midwifery and health visiting services when all children who were subject of a child protection plan were discussed and their progress noted.
- 3.16 GP practices in Coventry use an electronic patient records system that enables them to share information about risks to children or their families across different health providers, such as the school nurse and health visiting teams. This system also alerts the practice staff to any child about whom there are concerns such as those children subject of a child protection plan or those who are looked after. The system also identifies people in the same household, such as parents and siblings and GPs are able to explore linked records if they had any concerns. This enables practices to consider opportunities to observe children and to ensure they gather information which might later be shared with other relevant professionals.
- 3.17 However, we found that this system was not always being utilised as effectively as it might be. For example, in each of the cases we reviewed we saw that the GP had been unaware that key information emanating from child protection procedures, such as records of child protection conferences, core group meetings or strategy meeting notes, had been placed on the system within the child's records. There was also a lack of clarity as to whose responsibility it was to update the system with this information, whether it was the GP or the child's allocated social worker from the 0-19 team. We saw a number of instances where the electronic records in relation to children who were subject of a child protection plans were either incomplete or not known to the GP. In one instance we saw that an action from a core group meeting requiring the GP to carry out a medication review of a parent had been overlooked. This highlighted a gap in information sharing and effective communication between statutory services and primary care that had not been previously identified (**Recommendation 3.3**).
- 3.18 In the CWPT adult mental health service, case records did not clearly identify children in the client's household or children that the client had regular contact with. There was an over reliance upon the narrative in assessments to identify potentially 'hidden' children. There was no clear embedding of the 'Think Family' model but dip sampled cases did show individual workers identifying risks to children. There were no flags to clearly alert or identify the presence of children and particularly children subject to CIN or child protection plans to practitioners or managers accessing records. This was acknowledged by managers and practitioners as a gap and missed opportunity to identify children in the household promptly (**Recommendation 1.9**).

4. Looked after children

- 4.1 Coventry's looked-after children (LAC) can expect to have their health needs assessed and reviewed in a more timely way and to a much higher standard since we undertook the joint inspection in 2011. Performance on ensuring that looked-after children have their health needs reviewed within expected timescales was good, with 100% compliance at the time of this CLAS review. Where children had been placed out of area, 92% had their review health assessment (RHA) within timescale and this is positive practice.
- 4.2 Initial health assessments (IHAs) are undertaken by appropriately trained practitioners. It is only by exception that the specialist looked-after child nurse undertakes these under the close supervision of the designated doctor. New born babies taken straight into care are usually brought to CWPT clinics as this ensures the comprehensiveness of the clinical assessment.
- 4.3 The looked after children's health team routinely undertake IT system checks to examine any CED or GP attendances, but they do not actively seek information from CAMHs or GPs prior to initial health assessments (IHA) and review health assessments (RHA) being undertaken. There is therefore, a significant gap within LAC in information sharing which undermines holistic planning and management of children and young people's needs. We were advised by staff members that information from CAMHs to inform health reviews tends to arrive retrospectively and that LAC staff tend to rely on foster carers or the young people themselves to give an up-to-date account of their involvement with CAMHs and therefore there is a risk of contradictory evidence being received or provided. We were told by CAMHs health professionals that progress is being made with the LAC health team beginning to request information to inform health reviews more regularly and in a timely manner and that this forms part of Coventry's development agenda. The establishment of a single, quality assured pathway will facilitate this becoming more embedded in practice (**Recommendation 1.10**).

- 4.4 Children and young people are routinely given the choice of where and when their RHA takes place, including health centres, schools or at home. The LAC nurses also visit children and young people in their current placement to discuss with them their health care needs as and when requested to do so. The specialist nurses are determined in their efforts to engage young people who are reluctant to have their health needs assessed. The children looked after (CLA) nurses are flexible and proactive in their approaches in securing an initial health contact visit with the young person. Time is spent helping the young person understand the purpose and importance of having their health needs assessed and met. As a result, the number of young people declining health assessments had been reduced from 76 in 2011 to zero and this is commendable.
- 4.5 We reviewed both IHAs and RHAs and saw that in one record there was a drawing by the young person at the time of the assessment on which she had written "I am ready to be checked out." Encouraging young people to consent to their own health assessments is a good practice standard in engagement and participation in the process. However, consent was not always recorded as having been routinely given by young people who were in a position to give it, either verbally or in writing. There is a risk that young people will not fully engage with the health assessment process if they are not fully aware of the reasons for the assessment taking place and with whom the information might be shared (**Recommendation 1.11**).
- 4.6 While there is more to do to ensure that quality assurance (particularly with regard to IHAs) is fully robust, we did see evidence of prompt action being taken in a case where sub-optimal practice by a clinician was identified by one of the specialist nurses from the IHA. Prompt action was taken to ensure the health needs of the young person were properly assessed and addressed and that the quality issue was further addressed with the clinician (**Recommendation 1.12**).
- 4.7 The service's bespoke RHA proforma continues to be improved and is a positive development to bring greater focus on the voice of the child. It contained good prompts aiding discussion with the young person at the time of the assessment taking place. However, details of the discussions were not always evident in the records we reviewed.
- 4.8 LAC nurses facilitate workshops and drop in clinics at a local residential unit in the role of link LAC nurse as a means of engaging young people in their own health care and wellbeing. This is good practice which facilitates relationship building and engagement in services for children who are vulnerable and who can be difficult to engage in health provision.

- 4.9 In one record examined, we saw how one young person had sought advice with regard to their own sexual health, smoking cessation and ensuring their own immunisations were brought up to date as a direct result of the positive engagement with the link LAC nurse. The link LAC nurse undertakes reviews with residential home staff to ensure there are no outstanding health tasks in relation to young people about to leave care. This is an example of good practice in engagement of young people in order to ensure access to medical services prior to transition to adult services.
- 4.10 We saw evidence in records of tenacious work by LAC nurses in obtaining records of immunisations and checks undertaken with GPs to ensure accuracy of information contained within the health records of children and young people looked after.
- 4.11 We saw that some young people transitioning into adult services were provided with a 'health summary record' detailing important health information such as immunisations and a précis of their own health history from childhood. However, we were advised that this was not always routine practice for all young people leaving care. There was a risk therefore, that some young people leave children's services unaware of their health history which can be important to them in adulthood. Staff told us that there is a plan to develop a system for providing a health history in the form of a health passport for care leavers but this is not yet routine practice (**Recommendation 1.13**).
- 4.12 We were advised that there were few unaccompanied asylum seeking children (UASC) that are seen for IHA's and RHA's in Coventry. At the time of undertaking our review we were not assured if this was because of the limited number of asylum seeking children and young people either entering into care or currently in care.
- 4.13 IHA's of unaccompanied asylum seeking young people are always undertaken by a qualified doctor and never by a trainee. In one case we reviewed the IHA only contained clinical observations and basic information shared between services. Staff told us that questioning was limited due to language difficulties and the need to use an interpreter which creates difficulties in assessing emotional health and wellbeing. There were no plans to review the young person within the next year unless requested to do so by social care. This was a missed opportunity to better engage with the young person to ascertain in more detail their health history and any previous, current or potential health concerns that they might have (**Recommendation 4.2**).

- 4.14 LAC health practitioners have not had access to training in relation to the specific needs of asylum seeking children in Coventry. The assessment of emotional health and wellbeing and mental health of asylum seeking children is complex, due to unusually stressful experiences and marked by the likelihood of trauma, separation and uncertainty. Mental distress may differ from typical westernised presentations. Confusion might be significant when the child is presented to a markedly different westernised health system in contrast to what they may have previously experienced. It is essential therefore, that practitioners undertaking initial and review health assessments and, if possible interpreters for UASC, are trained to understand the complexities and experience of the asylum seeking young person (**Recommendation 4.3**).

Case Example: *An unaccompanied asylum seeking child's IHA had been undertaken in 2014 and reviewed by the school nurse in the week preceding this CLAS visit. Notes of the review were not yet on the young person's health file due to staff sickness absence. LAC staff verbally reported that a more detailed review had taken place and that the young person is now beginning to talk about earlier traumatic experiences prior to arrival in the UK.*

However, the case record contained no record of screening for tuberculosis, blood borne infections or other diseases not common in the UK. Immunisations were recorded as 'having no information'

This is a concern given that the young person has been in the UK and subject to LAC processes for a significant period of time.

There is a reference on the initial health assessment to a 'scar left by an industrial injury' but there was no exploration as to the full cause. There was also no evidence that the young person's experiences as an unaccompanied asylum seeking child had been understood or considered as part of the IHA, health plan or subsequent review.

- 4.15 LAC staff told us that a tool kit has been devised within LAC services in response to an audit of cases in which 'no issues' or 'no concerns/information' had been written. This is for use with young people aged 11 to 16 years and provides structured questions to prompt staff to obtain important information that might otherwise be missed during the health assessment process. We saw evidence on file of the questions from the toolkit being used to identify emotional health and well-being of a young person and a subsequent referral to CAMHs. This demonstrated that the toolkit is beneficial in helping practitioners to engage young people effectively in productive discussions about their emotional wellbeing.

- 4.16 Children's social care do not routinely advise on a child's LAC status so these are not flagged on the hospital electronic record system. This means there is an over reliance on children, young people and carers self-reporting and the potential for consent to be inappropriately given in the absence of a trigger question being contained within CED triage documentation (**Recommendation 2.8**).
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Management

This section records our findings about how well led the health services are in relation to safeguarding and looked after children.

5.1 Leadership and management

- 5.1.1 In child protection work in Coventry, there was more to do to ensure that the interface between health and social care worked well both across provider services as a whole and in individual cases. We found health services with a weak approach to care planning. We also found that frontline health practitioners found it difficult to identify their role in protecting the child from the child protection recommendations constituting the child protection plan. It was our view that this was unlikely to be reducing risk to children effectively and at least until a robust system of care planning was established in health services, had the potential to increase risk to the child. This was due to potentially misplaced assumptions about what multi-disciplinary partners roles were in child protection cases. This concern was brought to the attention of strategic leaders across health, social care and the LSCB during the review and we were confident on leaving Coventry that these issues were being taken forward at the appropriate level as a matter of priority (**Recommendation 6.1**).
- 5.1.2 In CWPT services, we found no systematic approach to assessment, care planning and review. This was well evidenced in each service and practitioners confirmed with us that they do not formulate care plans. This is poor practice across the services and of particular concern in cases where CIN or child protection plans are in place given that child protection recommendations were frequently unclear in relation to health's role (**Recommendation 1.4 and 1.5**).

- 5.1.3 There is strong leadership and drive from the CCG in improving safeguarding practice across the health community. This was particularly demonstrated by the chief nurse and the designated lead professionals. The CCG has been proactive in commissioning independent expertise to support this improvement agenda; working with the CCG on implementing a new deep dive, comprehensive safeguarding self-assessment diagnostic tool. This was innovative and likely to facilitate practice improvement.
- 5.1.4 Partners have learned from local serious case reviews (SCRs) and strengthened working arrangements where there were concerns about individual children. We saw case examples in all services visited where health practitioners were undertaking joint visits and having direct liaison with other health professionals and social workers outside of formal child protection procedure meetings. Although there was more to do to ensure this practice becomes embedded as routine, operational managers understand this and progress is considered 'ongoing'.
- 5.1.5 The development of the Coventry multi-agency safeguarding hub (MASH) by the partnership is positive. There is a clear pathway in place for cases referred and an operating framework which is able to be matched to the numbers and priority of incoming referrals on a daily basis. The health component is able to gather information from across the health community to facilitate early decision making in the MASH to assist in the safeguarding of vulnerable children and young people. The health practitioners currently based within the MASH are highly committed, speaking with confidence about the beneficial outcomes and faster responses to vulnerable and at risk young people since the MASH began.
- 5.1.6 However, there were some areas that required further development: At the time of this review, there were two rather than three 'whole time equivalent' health practitioners in the seconded posts. Administrative support was identified as being required early on in MASH development and is in place, but the health practitioners had yet to be fully informed of the substantive arrangements. Supervision arrangements are not sufficiently robust as the original planned model of supervision has not yet been established. The health practitioners are resilient but identified this as an area in which they needed further support. There were no cover arrangements when one of the practitioners was on leave and this created significant capacity pressure on the MASH's health component and the individual practitioner. Permanent placement in a MASH can be difficult to sustain and some of the most successful and sustainable models we have seen, operate a rotation of MASH health professionals, enabling practitioners to build confidence and expertise while having a regular break from what is often an intense environment (**Recommendations 1.14 and 3.4**).

- 5.1.7 There were significant improvements in the health service provision and performance for children looked after in Coventry. Progress was positive although the service recognised there was more to do. IHAs are conducted in an increasingly timely way and by appropriately qualified practitioners. Progress towards a whole systems approach across health and social care has been slower than might have been expected but is ongoing. The health of looked-after children group (Helac) is an effective forum for the partnership to continue to take the service forward. In health there is a strong lead from the designated doctor and nurse well supported by the team of specialist nurses. CCG governance arrangements are in place and are effective.
- 5.1.8 The named GP for safeguarding vulnerable children and adults was very recently appointed at the time of the review having joined the CCG in May 2015. The named GP is experienced in the role and this will strengthen safeguarding expertise across Coventry and Rugby. He brings extensive experience, commitment and enthusiasm to the role and has a clear vision about how to take GP safeguarding practice forward. He also has a tried and tested plan of implementation for the primary care safeguarding model he has developed. He and the designated nurse were already working closely and purposefully to ensure best practice in safeguarding vulnerable young people in Coventry.
- 5.1.9 UHCW has a full time named nurse for safeguarding children who is supported by an administrator. Appropriate arrangements are in place for her to receive supervision from the designated nurse and she has accessed recent level four safeguarding training. The named nurse reports to the head of midwifery who in turn reports to the chief nurse who has the executive lead for safeguarding children. Although this does not meet the recommendations of the intercollegiate guidance in terms of a direct report to trust lead, the named nurse feels she is able to access the chief nurse as needed.
- 5.1.10 Access to CAMHS was well understood locally to be a significant challenge at the time of this CLAS review. Up to 50 referrals to the service were being made daily and the CWPT was looking to introduce a clinical triage model to strengthen this process at the single point of entry. The CAMHS service reported that it was achieving targets relating to assessment but that there were still, too frequently, significant delays between assessment and intervention. The service redesign that was underway was expected to have a significant impact in improving service delivery. We also heard about the resilience project pilot being launched in seven local schools in the summer and other initiatives that were planned which were likely to improve the support to young people with emotional health needs.
- 5.1.11 There was no intensive home treatment service and the CWPT and CCG recognise this as a gap. The trust was looking at models of best practice in areas where these services are in place to inform the development of a local model (**Recommendation 1.15**).

5.2 Governance

- 5.2.1 Overall, in community health services, operational governance arrangements and processes were underdeveloped. While there were appropriate and clear governance and performance monitoring processes in place to trust board in CWPT and into the CCG; across the trust's services we saw numerous case examples evidencing there were not sufficiently robust operational governance arrangements in place at a team level. This is a key area for development, particularly in light of the lack of clarity in health practitioners' roles and responsibilities in child protection cases (**Recommendation 1.16**).
- 5.2.2 Case records we reviewed highlighted significant deficits in the approach to case recording and records management. For example, we were told that health visitor case records were periodically reviewed by managers in one-to-one supervision. Given the absence of a systematic approach to case recording and case record management, we were not assured of the effectiveness of this arrangement. A robust case recording model was not in place and was not set out in the health visitor standards guidance. With the current approach of cases consisting of a single, detailed running record but no recorded evidence of any identification of the reason for contact, actions undertaken or planned and any analysis of risk, it was difficult for practitioners and operational managers to easily identify and demonstrate effective risk assessment and evaluation.
- 5.2.3 The intended move to electronic recording across CWPT will help to facilitate the application of robust case recording model and a stronger approach to recording practice and records management. The transitional arrangement of a hybrid, part paper, part electronic system in place at the time of this review was too complex. Key information and child protection documentation was not easily and immediately accessible to practitioners and managers. This was not supporting effective safeguarding risk assessment and management organisationally and at individual case level and there was significant risk that important information would get 'lost in the system'. It is to be hoped that full transition to electronic recording in CWPT and across health in Coventry will be expedited quickly. (**Recommendation 1.17**).

- 5.2.4 The Recovery Partnership (Addaction) had good and robust governance processes enabling them to monitor and assure quality in their safeguarding performance. Safeguarding was considered as an agenda item on the monthly provider-wide clinical social governance group (CSGG) and had its own dedicated section on the monthly data dashboard. Learning was cascaded to all staff through this dashboard and also through the clinical incident review group bulletins issued by the provider and derived from incidents reported by all staff. Staff working within the adult substance misuse services were empowered to raise concerns about safety through the incident reporting processes.
- 5.2.5 For CAMHS, CWPT was looking to introduce a clinical triage model to strengthen the triage process at the single point of access (SPA). The CAMHS service reported that it was achieving targets relating to the timeliness of assessment but that there were still, too frequently, significant delays between assessment and clinical intervention. The service redesign underway was expected to have a significant impact in improving service delivery. Additional resource had been invested into CAMHS by the CCG for additional short-term posts, although recruitment into these had been challenging. CWPT had recruited these as substantive posts, with all but one filled at the time of this review and this is seen as a positive move (**Recommendation 1.1**).
- 5.2.6 Within ISHS, we found a lack of systems in place for managerial oversight of work with particularly vulnerable young people or for monitoring and quality assessment of referrals to other agencies. Senior staff spoken with were unable to identify or search for vulnerable young people on available IT systems by age, referrals made to other agencies or by other risk factors other than from personal memory. There is risk therefore that important information pertaining to vulnerable young people might be missed in the absence of those senior staff members. **This has been drawn to the attention of the Director of Public Health who commissions the service.**
- 5.2.7 CQUINS (a payment framework which enables commissioners to reward excellence) are being used to good effect in the health economy to drive improvement. We saw and heard a number of examples of initiatives developed as a result: one being, the resilience project pilot involving CAMHS and school nurses, being launched in local schools in the summer.

- 5.2.8 The CWPT adult mental health service was making progress towards its explicit aim of establishing the 'Think Family' model. However, the service's documentation templates and recording systems did not currently best support this. The presence of children within the household or connected with adults using services was not immediately evident in case records. There was no flagging on the records where there are known vulnerabilities and risks to alert practitioners and managers. The service was unable to identify its cohort of cases where there are children subject to CIN or child protection plans, making it impossible for operational managers to effectively oversee child protection practice or for the trust to understand the level of safeguarding activity practitioners are undertaking (**Recommendation 1.9 and 1.18**).
- 5.2.9 Health visitors physically seeing where a baby sleeps is known to be an expectation and action identified in a local serious case review and now part of the standard operational practice (SOP) in Coventry. However, this is not yet established practice. Needs assessment documentation does not explicitly set this out as an action for health visitors to undertake which would facilitate this very positive improvement becoming embedded as routine practice (**Recommendation 1.19**).
- 5.2.10 The school nursing service continued to prioritise attendance at initial child protection conferences, even where they had no previous involvement with the child. Although core groups were only attended by a school nurse when there was a known health issue, the demands of attending the high volume of these impacted significantly on capacity for other essential elements of the service. We understood that Public Health would re-commission the service under a new specification that is sensible and pragmatic: School nurses will only attend child protection case conferences and core groups where they are actively working with the child.
- 5.2.11 Public Health Coventry had set out its proposed city wide priorities in an action plan for improving sexual health services including a range of responses to CSE and other issues which affect the well-being of young people. This was seen as a positive development.
- 5.2.12 In the CED at UHCW, whereas we found records clearly signed and dated by nurses using a stamp to ensure an effective audit trail and professional accountability, this good practice did not extend to medical staff. It was often difficult to identify the name and staff grade of doctors who had treated children and young people in the CED, weakening an otherwise good approach to quality assurance and professional accountability (**Recommendation 2.9**).

- 5.2.13 Addaction's Recovery Partnership has good governance processes enabling the service to monitor and assure quality in their performance in safeguarding. Staff working in the adult substance misuse service are empowered to raise concerns about child safety through well-established reporting processes. The services' performance dashboard shows current cases with a domestic violence referral or common assessment framework initiation as well as those on child protection plans and this facilitates the provider in having effective operational oversight.
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5.3 Training and supervision

- 5.3.1 The CED at UHCW is appropriately staffed with children's nurses and the trust has also been proactive in supporting adult nurses to undertake conversion training so that they might better provide appropriate care and support to children and young people attending the unit.
- 5.3.2 The training needs analysis for staff across UHCW did not accurately reflect the revised intercollegiate guidance of 2014. Not all key staff whose role requires level three training had been identified and therefore the figures reported were not accurate; this staff group includes nurses working in adult ED, most of whom had only accessed level two training.
- 5.3.3 At UHCW, supervision in safeguarding children is mostly conducted following a request from staff members and is 'ad-hoc' for those staff working in CED and across acute paediatric services. This is therefore not fully compliant with current Working Together guidance. However, there is a culture of de-briefing staff for those individuals that are involved in particularly challenging and stressful cases and there is good support for staff working on the adolescent ward from CAMHS. Safeguarding training and supervision arrangements in the midwifery service are not in line with statutory guidance and this was recognised as an area for development. (**Recommendation 2.10**).
- 5.3.4 Staff in the Recovery Partnership (Addaction) are currently trained to safeguarding level two which is not sufficient to support practitioners in the discharge of their roles and responsibilities. Managers of the service are aware of this deficit. The provider has plans in place to ensure staff undertake safeguarding level three, in order that they are sufficiently knowledgeable about and skilled in safeguarding practice. Managers are currently seeking opportunities for level three face to face, multi-agency training for all their staff members who have routine contact with vulnerable young people. **This issue has been drawn to the attention of the Director of Public Health who commissions this service.**

- 5.3.5 Recovery Partnership in-house safeguarding practice learning takes place supported by a robust supervision process. The locality manager has facilitated the development of a learning culture and embarked on a programme of staff involvement to support a reinvigoration of the Think Family agenda.
- 5.3.6 It was not clear that all CWPT adult mental health practitioners, including the perinatal mental health consultant psychiatrist have undertaken safeguarding training at the appropriate level to support the level of child safeguarding competence required in their role. We found a mixture of training levels amongst the staff group with some having had level three training while others, including the perinatal mental health psychiatrist had only undertaken level two. This is not sufficient to properly equip practitioners in their day to day safeguarding practice (**Recommendation 1.20**).
- 5.3.7 The health visitor preceptorship programme is competency based and is strong. Newly qualified health visitor practitioners are well supported where they have safeguarding cases within caseloads and this ensures they are developing professional confidence in supporting families to achieve best outcomes
- 5.3.8 Specialist health visitors have good access to specialist training to support them in their roles and day to day work with often highly complex cases. Managers in CWPT are proactive in identifying these training opportunities and in supporting the specialist health visitors to attend.
- 5.3.9 Achieving a consistent high level of CSE training for all school nurses has not been the top priority for the service and as such school nurses have had variable levels of training. Most school nurses saw Chelsea's Choice (an innovative theatre play followed by a plenary session) last year to increase awareness of CSE. Police and NSPCC have visited to provide training discussions. However, some band five nurses have not yet completed any CSE training. **This has been drawn to the attention of the Director of Public Health who commissions the service**
- 5.3.10 CWPT is working to strengthen supervision arrangements in recognition that this is an area for development. This is to ensure effective support to staff, particularly within health visiting. Work is being led by the CWPT named nurse. A supervision database has been set up by the CWPT safeguarding team to identify practitioners who have not received supervision and to provide an effective performance monitoring tool. The CWPT safeguarding team is very accessible to discuss and advise on cases as the need arises. While this is a valuable strand of support to practitioners, we have also identified that supervision arrangements; including those in adult mental health and perinatal mental health, are not robust and not in line with current Working Together guidance. This sets out clearly the expectation that practitioners should have regular, planned and recorded supervision and regular opportunities for reflective practice to best support their professional development and practice (**Recommendation 1.21**).

Recommendations

1. **Coventry and Rugby CCG and Coventry and Warwickshire Partnership Trust should:**
 - 1.1 Ensure that young people with mental health needs have prompt access to child and adolescent mental health support that meets their identified needs
 - 1.2 Ensure that when families move health visitor areas within Coventry, health visitor transfer-in case handovers are conducted face to face as routine practice
 - 1.3 Ensure that CAMHS clinicians share written information with parents of children with mental health needs in a format and style which is accessible and effective in keeping them informed about the treatment of their child
 - 1.4 Ensure that CAMHS clinical and safeguarding assessments are of a consistently high standard and subject to effective governance arrangements to support best practice and continuous improvement
 - 1.5 Ensure that child centred care plans are in place in services in line with best practice
 - 1.6 Ensure that the young people's transition pathway into adult mental health service works effectively and is subject to robust governance arrangements
 - 1.7 Ensure that practitioners are proactive in ensuring they have the current CIN and child protection plan and that these are part of the child's case record
 - 1.8 Ensure that practitioners are clear on their exact role and responsibility in cases where CIN and child protection plans are in place and that all CIN and child protection documentation is secured as part of the case record
 - 1.9 Ensure that children who may potentially suffer hidden harm or who are subject to CIN or child protection plans are clearly and easily identifiable on the adult mental health case record
 - 1.10 Ensure that information is routinely sought from GPs and CAMHs in order that looked-after children's initial and review health assessments are fully informed
 - 1.11 Ensure that the consent of young people who are looked after to have their health assessed and information shared is gained whenever appropriate
 - 1.12 Ensure that all initial and review health assessments, including those for children placed out of area, are subject to a robust quality assurance framework

- 1.13 Work with the local authority to ensure that care leavers routinely receive a health passport and health history, including parental health history
- 1.14 Ensure a sustainable model of health practitioner presence in the MASH is in place as commissioned and that practitioners are well supported through robust supervision arrangements
- 1.15 Establish a CAMHS Home Treatment service in line with best practice in order to prevent in-patient mental health treatment and facilitate early discharge
- 1.16 Ensure that effective operational governance arrangements are in place to oversee and monitor frontline safeguarding and child protection practice
- 1.17 Ensure that the implementation of a comprehensive electronic recording system across all services is expedited and that effective recording and case record management is in place
- 1.18 Ensure that trust managers can easily identify CIN and child protection cases on adult mental health team caseloads facilitating effective operational governance of adult mental health child safeguarding practice
- 1.19 Work with Public Health to ensure that the health visitor standard operational practice is revised and operational governance strengthened in order that assessment of the sleeping environment for an infant becomes embedded health visitor practice
- 1.20 Ensure that all adult mental health practitioners have undertaken child safeguarding training at a level commensurate with their safeguarding roles and responsibilities
- 1.21 Ensure that supervision arrangements for all practitioners are robust and in accordance with national guidance

2. Coventry and Rugby CCG and University Hospitals Coventry and Warwickshire NHS Trust should:

- 2.1 Ensure that the relationship between a young person attending the ED and the accompanying adult is accurately recorded
- 2.2 Ensure that information on repeat attendances at the ED is routinely considered as part of the clinical and safeguarding assessment
- 2.3 Ensure that a robust “did not wait” protocol is in place to guide ED practitioners on what actions to take when a child or young person leaves the ED before assessment and treatment is completed
- 2.4 Ensure that young people under 18 years who are seen in adult ED are subject to paediatric documentation

- 2.5 Ensure that paediatric ED assessment documentation includes a safeguarding triage as recommended by NICE to support practitioners in delivering consistent good safeguarding risk assessment
- 2.6 Ensure that practitioners in the ED clearly record that they have considered the potential for hidden harm to children when adults present as the result of risk taking behaviours and that the practitioner has taken appropriate action to protect children if required
- 2.7 Ensure that notifications from adult ED are transferred promptly to health visitors and school nurses in order that children may be protected from hidden harm effectively
- 2.8 Ensure the question of parental responsibility and looked-after child status is routinely explored when children attend the ED for treatment
- 2.9 Ensure that the name and grade of practitioners treating adult and child patients in the ED is easily identifiable in order to maintain a strong approach to quality assurance and professional accountability of safeguarding activity
- 2.10 Ensure that all key staff whose role requires level three training have been identified and appropriately trained and are supported by robust safeguarding supervision arrangements

3. NHS England and Coventry and Rugby CCG should:

- 3.1 Work with primary care to increase GP engagement and participation in Acting Early forums
- 3.2 Work with GP practices to ensure that vulnerable families meetings are established across all primary care practices in Coventry and Rugby and that these routinely involve school nurse services
- 3.3 In partnership with Coventry City Council, work with primary care to ensure that GPs are fully and promptly informed when CIN or child protection procedures are in place for a child in their practice and of any actions the GP needs to take to safeguard the child
- 3.4 Work in partnership with Public Health to ensure that a sustainable health presence is commissioned within the MASH arrangements

4. Coventry and Rugby CCG, Coventry and Warwickshire Partnership Trust and University Hospitals Coventry and Warwickshire NHS Trust should:

- 4.1 Ensure that safeguarding referrals are subject to effective quality assurance and governance arrangements

4.2 Work In partnership with Public Health to ensure that unaccompanied asylum seeking children (UASC) have comprehensive assessments and reviews of their health needs including their emotional wellbeing in light of their experiences

4.3 Put in place appropriate training for clinicians and practitioners undertaking initial and review health assessments of unaccompanied asylum seeking children

5. NHS England and Coventry and Warwickshire Partnership Trust should:

5.1 Work in partnership with Public Health to ensure that community health practitioners have a systematic and consistent approach to the use of chronologies to facilitate effective safeguarding risk assessment

6. Coventry and Rugby CCG should:

6.1 Work with Coventry City Council and the LSCB to ensure that child protection arrangements work effectively across the multi-agency partnership and that health practitioners are clear on their role in individual cases

Next steps

An action plan addressing the recommendations above is required from Coventry and Rugby CCG within **20 working days** of receipt of this report.

Please submit your action plan to CQC through childrens-services-inspection@cqc.org.uk. The plan will be considered by the inspection team and progress will be followed up through CQC's regional compliance team.