

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

Children Looked After and Safeguarding

The role of health services in Rochdale

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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 Rochdale. 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 Rochdale, 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 2013.

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 59 children and young people.

Context of the review

Rochdale Borough Council lies within the conurbation of Greater Manchester. The Borough includes the townships of Rochdale, Middleton, Heywood and the Pennine area covering the villages of Littleborough, Newhey and Milnrow. Each of these townships and villages has its own diverse and distinct identity. Approximately 212,020 people live in the borough.

The population is ethnically diverse. Children and young people comprise 27% of the population. It is estimated that 33% of school aged children are from a minority ethnic group.

Two fifths of Rochdale Borough residents experience relatively high levels of deprivation and disadvantage. The level of child poverty is worse than the England average with 27% of children aged less than 16 years living in poverty.

The health and wellbeing of many local children and families is poorer than the average for England in some areas. Teenage conception and alcohol and drug misuse related hospital admissions are relatively high. Recent data indicates a higher number of hospital attendances for self-harm among young people aged 10 to 24 years compared to the England average. Infant and child mortality rates are similar to the England average. Rates of childhood immunisation are good.

Commissioning and planning of health services for children is carried out by NHS Heywood, Middleton and Rochdale Clinical Commissioning Group (NHS HMR CCG), Rochdale Council's Public Health Directorate and NHS England Greater Manchester (GM) Area Team. Thirty eight GP practices operate in the area. The GM Area Team commissions primary care and health visiting services.

School nursing services and contraception and sexual health services are commissioned by the Rochdale Council's Public Health Directorate and provided by Pennine Care NHS Foundation Trust (PCFT). Young person's substance misuse services are commissioned by the Council and provided by Early Break.

Adult substance misuse services are jointly commissioned by NHS HMR CCG and the Council and provided by PCFT in conjunction with Sanctuary Trust and Big Life. Adult mental health services are jointly commissioned by NHS HMR CCG and the Council and provided by PCFT. PCFT also provides the specialist Cared for Children¹ health team.

Acute hospital services including emergency care and maternity services are provided by Pennine Acute Hospitals NHS Trust (PAHT). Local people access the Urgent Care Centre at Rochdale Infirmary and travel out of the borough to use A and E and maternity facilities.

A multi- agency and multi- disciplinary team, the Sunrise team; has been established to help children, young people and their families where there are serious concerns about risks of sexual exploitation.

In March 2014, 545 children and young people were looked after. In addition, approximately 286 children had been placed by other authorities in Rochdale. Rochdale Council currently has 55 independent sector children's homes operating in the area.

The last inspection of health services for Rochdale's children took place in July 2010 as a joint inspection, with Ofsted, of safeguarding and looked after children's services. Overall effectiveness of the safeguarding services was judged as adequate. Services for looked after children and young people, including arrangements to meet the health care needs of children looked after was judged to be adequate.

Recommendations from that inspection are covered in this review. A follow up inspection by Ofsted in November 2012 rated the overall effectiveness of arrangements to protect children as inadequate. A Department for Education Improvement Notice is currently in place.

Rochdale has had a very high level of serious case reviews (SCRs) over the past three years. This review comments on the contribution and progress being made in relation to work to strengthen safeguarding practice undertaken by local health commissioners and providers.

¹ Preferred local title for the Looked After Children specialist health team

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

"I come to the Urgent Care Centre because it's difficult to get an appointment with our local GP. Staff are friendly and some staff are really nice". Parent.

"They do what's best for you, it took a while to get there but then it was good." Young person speaking about CAMHS.

"I like it cos it's up to me what I wanna do and where." Young person in care speaking about the flexibility of review health care arrangements.

"It's good to have a dedicated LAC nurse as a point of contact, she's easy to contact if I have any worries." Foster carer.

"It's great, it overcomes young people's fears about going to health appointments and builds consistent relationships with people from health". Manager of council run children's home speaking about the weekly drop in by the Cared for Children nurse

"We get good support from the CAMHS service- young people are supported well to get the help they need. The CAMHS monthly consultation for staff is really useful". Manager of council run children's home.

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 Midwives, health visitors and school nurses have a strong focus on the public health agenda and deliver a range of health and wellbeing initiatives to promote the health and safety of mothers and their babies. Immunisation rates for the area are good. Good attention is paid to children's development in line with expected milestones. Partnership working with a wide range of statutory and voluntary sector organisations, co-ordinated through the work of Children's Centres, is helping to secure better outcomes for some children and their families.

1.2 Health professionals have a good awareness of early help support available in the local area and are proactive in signposting parents who would benefit from help with parenting. Midwives and health visitors are working closely with others including children's centre staff, adult mental health and substance misuse staff to identify risks on a whole family basis. Over the last year, the levels of engagement of health staff in early help work, including those undertaking lead professional roles have steadily increased. This is helping to promote individually tailored support to parents who need assistance to effectively nurture their children and provide safe care.

1.3 The contribution of health professionals to early help work is closely monitored by senior managers. The school nurse team employs innovative methods to reach as many young people as possible, including working closely with schools in advance of their new September intake. This approach includes making joint visits to children and their families, and supports early identification of concerns with prompt action to help improve health and education outcomes. Adult mental health professionals are actively involved in Common Assessment Framework (CAF) and 'Think Family' work.

1.4 Further work is being undertaken to understand why health figures for CAF related activity in Rochdale are lower than other areas where PCFT delivers community health services. Limited administration is currently available in Rochdale to support health professionals when they undertake the lead professional role. As a consequence, some health professionals are spending lengthy periods of time on paperwork and case co-ordination tasks. This runs the risk of negatively impacting on their clinical roles and Healthy Child Programme targets. (Recommendation 1.1).

1.5 Capacity issues are affecting the school nurse team's ability to provide a universal offer at primary schools. However the team have taken a pragmatic approach to making best use of current resources by using healthcare assistants and assistant practitioners to deliver work in primary schools. New appointments have recently been made to strengthen the capacity of the school nursing team.

1.6 Information sharing and communication between individual health professionals, teams and agencies overall is adequate, with appropriate management of consent on most cases seen. Communication between health visitors and GPs is improving, with evidence of some effective joint working. For example, we saw good use of a communication book in one GP practice to support follow up and review of concerns about children who fall below the threshold for intervention by children's social care. However, in some cases seen, referrals between health agencies and written correspondence are not sufficiently child focused and provide only limited detail of areas of risk. (Recommendation 1.2).

1.7 Local health organisations are at different stages in their move to electronic child health systems which is a barrier to timely and efficient information flows between agencies. There remain some gaps in partnership working and communication between teams and agencies. This includes information sharing between GPs and midwives; and between sexual health services, the Children in Care health team and GPs. (Recommendation 1.3).

1.8 Recent work led by the GM Area Team with practice nurses aims to make better use of 'Well Woman' clinics to promote holistic identification of risk, including in areas such as domestic abuse. This is an example of preventative action being taken on a sub-regional basis to embed a stronger focus on safeguarding children and adults. It recognises the transient nature of some vulnerable women and families as they move between Rochdale and other areas of Greater Manchester.

1.9 Adult substance misuse staff are alert to domestic abuse in families as evidenced in this case.

When A., the wife of a service user came to ask for advice and support, she made a disclosure of domestic abuse and neglect of the children. The substance misuse service is accessible in the local town centre and is staffed by workers from a range of ethnic backgrounds. A. approached the service as she felt staff would understand her specific cultural needs and she felt unable to access support anywhere else.

Workers acted quickly, liaised with children's social care and undertook home visits. Positive outcomes are that children are now being monitored closely via the CAF process and A. is being supported in addressing her own needs via local support groups.

1.10 The new integrated adult substance misuse service provides a well co-ordinated and responsive service to adults with alcohol or drug related needs. The service can offer same day consultation and clinical interventions within 5 working days from referral. This denotes a significant improvement in local service delivery. Tight management systems ensure staff remain vigilant in recognising the vulnerability of young children, and safe storage boxes for drugs medication/kit are routinely provided. An initial home visit is undertaken to all people using the service that are in contact with children under 5 years, with further home checks made on a quarterly basis. Good joint working with midwives and health visitors is evident in joining up support around the family. Improved outcomes include a significant reduction in the number of adults misusing alcohol or drugs within the family home.

1.11 The focus on young people and adults attending urgent or emergency care services who may be at risk of or who have experienced domestic abuse is growing. An outreach domestic abuse worker regularly visits the Urgent Care Centre (UCC) at Rochdale Infirmary and provides prompt follow up and support to young people and adults who disclose abuse. Confidentiality and consent issues are sensitively handled. Health staff value the feedback they receive on the outcomes of work undertaken by the Independent Domestic Violence Advisor (IDVA).

1.12 UCC has appropriate systems to ensure priority attention is given to the needs of children and their families. Separate waiting and treatment areas are available that are child friendly. UCC staff have encouraged and positively responded to feedback from children and their families. Its facilities now include two rooms equipped with appropriate equipment to help distract or provide a calm environment for children and people with learning disabilities. Staff are welcoming, and take care to ensure the privacy of young people and their families. Facilities for children at Royal Oldham A and E are currently being enhanced.

1.13 The UCC benefits from an experienced team of health professionals, including advanced practitioners, with strong links to and outreach from Royal Oldham's A and E medical staff. However, only one of the current team of nursing staff is trained in paediatric care. Levels of staff with appropriate paediatric training are also low in the A and E department at Royal Oldham hospital. The Trust has identified the need for enhanced capacity in this area given the levels of children and young people attending. (Recommendation 5.2).

1.14 People we spoke to told us that they attend the Urgent Care Centre as it is close to where they live combined with difficulties in getting an appointment with their local GP. Support is provided by the UCC staff to help people understand and make better use of primary care services.

1.15 Rochdale has one of the highest rates nationally of young people presenting at unscheduled care centres in an intoxicated state. The Urgent Care Centre has good links with an alcohol practitioner and the Early Break young person's substance misuse service which enables prompt follow up of risks to the safety and wellbeing of young people.

1.16 Access to psychological therapies is well promoted with good liaison and information sharing with GPs, health visitors and the specialist adult mental health teams. We saw some examples of effective joint working by health professionals in helping parents address long term stress and emotional or mental health needs. Positive outcomes include improvements in general health, higher levels of parental confidence, with good use of attachment and behaviour management strategies in helping them provide safe and consistent care.

Mother B. was referred for psychological therapy by her health visitor. She presented with post natal depression. She reported her stress levels as overwhelming and was displaying obsessive compulsive related behaviours.

The initial assessment work undertaken by the therapist was thorough and helped B. to safely talk about and understand her feelings and the impact of her own needs and behaviours on her young children. Good liaison with B.'s GP and health visitor enabled prompt attention to be given to addressing her depression and anaemia.

B. continues to receive therapy and there has been a strengthening of emotional bonding with her children. Her health visitor remains actively involved given the need for greater vigilance until her therapy is completed.

1.17 Local health organisations are working to strengthen access to interpreting services. This is an area of learning from a recent serious case review. People who do not use English as a first language are usually supported through Language Line, the telephone interpreting service. In some cases interpreters are used to support health consultations or promote the involvement of key family members in meetings. Further checks of local arrangements, including in unscheduled care settings are required to ensure frontline health staff with other language skills are appropriately used. Health visitors and community midwives valued the contribution of bilingual support workers attached to some children's centres in promoting the engagement and understanding of parents.

1.18 The new multi- agency screening service (MASS) has been in operation for the last couple of months. The team includes a health co-ordinator role. The post holder is seen to provide good support to frontline health professionals and partner agencies including helping strengthen the accountabilities of health professionals in early help work. Re-referrals are closely reviewed to enable further analysis of why previous offers of help have not led to the desired outcomes for children. Initial findings of the work of MASS denote improvements in practice including tighter scrutiny of risks to children and timely responses to individual need. Health professionals reported the new arrangements, including escalation, are helping to prevent drift in cases that have been managed at the CAF level for some time.

2. Children in need

2.1 Systems to strengthen identification of risks to unborn babies have been consolidated. Learning from serious case reviews has promoted improvements in taking social histories and recording the identification of others living in the home or who attend appointments with women. Women are routinely asked if they have experienced domestic abuse as their pregnancy progresses and this is clearly recorded. Local arrangements for the management of domestic abuse including notifications and feedback from multi agency risk assessment meetings (MARAC) are working well. Frontline health professionals are appropriately informed about incidents of domestic abuse and make follow up checks to ensure the safety of children.

2.2 The community midwifery service has good systems for tracking women who move into or out of area. Community midwives receive a written report following attendance of pregnant women at the Urgent Care Centre or A and E Department. They value this feedback in enabling them to monitor the progress of the pregnancy and risk. They would welcome stronger links with GPs and sharing of information in relation to the progress of the pregnancy. (Recommendation 1.3).

2.3 Children's social care staff are now working to a 20 week gestation period for initiating assessments of unborn children. In most cases, maternity staff are kept informed of the future plans for the baby and multi-agency planning informs discharge arrangements from hospital. A new Family Nurse Partnership (FNP) programme is being established and will be fully operational in Rochdale by the end of the year. This should positively complement the work currently being undertaken by the young person's midwife and the young parents' worker employed by the council.

2.4 The range of specialist midwifery roles provided by Pennine Acute Hospital Trust in Rochdale is less well developed compared to other areas where the Trust operates. Rochdale has a community midwife for women with mental health needs and ensures their rapid access to specialist mental health services. However, the area does not have a midwife with lead responsibility for substance misuse. Workers from the substance misuse team are helping to bridge the gap by attending community midwifery appointments with service users. NHS commissioners are undertaking further review of local midwifery services to ensure equity of experience and continuous improvement in outcomes for Rochdale women and their babies. (Recommendation 4.1).

2.5 The last inspection highlighted the need to strengthen access to contraception and sexual health services and reduce teenage pregnancy rates. A range of actions, including joint review of the contract specification and further training of sexual health staff has been undertaken. School Nurses provide good support with personal relationships and sexual health needs as part of core service they provide in school drop in and clinic sessions. Positively, young people of school age not attending school remain on the caseloads of school nurses. However, young people continue to experience difficulties in accessing free emergency contraception both in and out of office hours. Teenage conception rates in the area are reducing. There is insufficient data about specific groups who are more vulnerable to unplanned pregnancies, including children who are cared for or care leavers. Improved understanding of need in this area is recognised as a priority in scoping the work of the new FNP programme. (Recommendation 1.4).

2.6 A young people's sexual health support service staffed by young people's workers is managed by a service leader within PCFT children's services. Its members receive safeguarding supervision from the trust's named nurse. The service is accessed by referral from other agencies or self-referral. The service provides targeted 1:1 and group work in schools. However, the current location of the service means access is difficult for young people. This has led to a significant reduction in young people dropping in for advice or support. (Recommendation 1.4).

2.7 The young people's sexual health support service operates an assertive outreach model of support centred in developing open and trusting relationships with young people and their families. Team members persistently follow up young people about whom there are concerns, including when they move between council areas. Team members work closely with the Sunrise and school nurse team in helping to prevent escalation of risk and supporting young people over a long period of time until risk reduces to safe levels. The assessment of risk on cases seen was well managed through regular multi-agency child in need meetings. Individual assessments are comprehensive, with evidence of clear actions to help deliver improved outcomes as highlighted in this case.

C. is a 15 year old person living at home who has been exposed to sexual exploitation. A range of health assessments have been used to develop a holistic understanding of her wishes, needs and risks. This included screening for general health, drugs and alcohol misuse, mental health, emotional wellbeing and sexual health. Work has been sensitively scoped with C. and her mother to reduce risk, including building understanding of areas of vulnerability and agreeing shared strategies to keep C. safe.

Evidence of improved outcomes to date include C. has returned to school, her mother has effectively engaged and is a protective factor for her, her use of social media sites is closely monitored and is within safe limits, and she has received appropriate medical treatment.

Feedback is regularly sought from C and her parent.
In C.'s words: *'Things are pretty good now'*

2.8 Frontline staff working with young people at risk of sexual exploitation told us they would benefit from further training to strengthen their awareness and capacity to support young people with a diverse range of needs and family circumstances. This includes young people from minority ethnic communities and those with specific learning difficulties. (Recommendation 1.5).

2.9 Children and young people with emotional and behavioural needs generally receive a timely response from child and adolescent mental health services (CAMHS). Care is taken to ensure young people are not placed on adult mental health wards and there have been no recorded incidents of this happening. However on a few occasions, lack of access to local specialist in patient (tier 4) facilities has meant young people are placed out of area or on paediatric wards. Young peoples' vulnerability in these circumstances is well understood. Action is promptly taken to ensure children from Rochdale are discharged home or moved to a more appropriate environment.

2.10 CAMHS waiting times and outcomes for children are closely monitored. Waiting list pressures and the need for enhanced support for children with autistic spectrum disorders (ASD) are being addressed. Recent changes in commissioning have been effective in significantly reducing waiting times and expanding the level and range of services available to parents and their children. Tangible evidence of progress includes waiting time reduction from 18 months to 18-20 weeks. Action has also been taken to strengthen support to young people aged 16-18 years. The CAMHS transitions team provides ongoing support to young people aged 16-18 who require additional help whose needs fall below the threshold for specialist adult mental health services. This provides an important safeguard to young people in what can be the most challenging years of their lives.

2.11 Staff at the Urgent Care Centre report a prompt response in most cases when young people require a mental health assessment. However, they said that there can be delays in response when young people 16-18 years present out of hours. For young people over 16 years, the response is provided by the adult mental health on call service. Risks in this area are clearly recognised and planned service developments include strengthening the CAMHS and adult mental health on call systems in A and E and UCC.

2.12 We saw some examples of sensitive casework by CAMHS practitioners in offering support to young people from minority ethnic communities, including recognising the importance of gender and location in planning their work. However, further work is required to reach and strengthen local approaches to the delivery of culturally appropriate services to promote and sustain the involvement of young people and their families (Recommendation 1.5).

2.13 Community health staff, adult mental health and substance misuse staff are appropriately engaged in and supportive of child in need assessment and care planning arrangements on most cases seen. Appropriate use is made of escalation processes to raise concerns where there is evidence that outcomes for children are not improving as evidenced in this case.

D. is a 5 year old girl previously on child protection plan for neglect. Following a child protection review conference this was stepped down to a child in need plan. The school nurse continued to monitor her progress and that of her siblings, including undertaking regular home visits with school staff. Prompt identification of further concerns led to the re-instigation of the child protection plan. A range of safeguards and checks are now in place to closely track risks to D. and her siblings.

3. Child protection

3.1 Multi- agency, NHS commissioning and provider safeguarding children policies and procedures have been reviewed and strengthened to promote clearer accountabilities and timely information sharing in handling concerns about the safety and wellbeing of children. All health staff we spoke to were aware of their responsibilities for reporting concerns to safeguarding leads within their agencies and to children's social care.

3.2 Good local systems are now in place in community health services such as the introduction of a dedicated handover day where health visitors ensure detailed information is exchanged about children at risk of harm when they are transferring to school nurse caseloads. We saw evidence of health professionals initiating contact with children's social care to ensure they are included in child protection conferences or looked after children statutory reviews. The young people's sexual health support service provided good advocacy support to young people to enable their voice to be heard.

3.3 Our previous inspection in 2010 highlighted the need for improvement in arrangements in unscheduled care settings for identifying children and young people at risk of being harmed. Most records seen of young people presenting at the Urgent Care Centre or the A and E Department at Royal Oldham hospital noted whether any safeguarding concerns had been identified. We saw an example of good practice and recording of the voice and experience of a young person by the advanced nurse practitioner, with sensitive recognition of her wish to end her life. The number of previous attendances is automatically generated on a Trust wide basis. From cases seen, where concerns had been identified by the examining doctor or nurse, contact was usually made with children's social care before the child was discharged home.

3.4 Some gaps remain in PAHT's systems for information sharing and routinely checking risks in relation children on a child protection plan and children who are looked after in unscheduled care settings. Clinicians operate a system of flagging child health records, at their discretion, where a child is highlighted as a 'special case patient'. This applies to any child about whom they have a concern that they feel should be highlighted. This approach however, carries significant risk that some vulnerable children and young people where risks are already known may not be appropriately identified and followed up. In one case seen where a young person's looked after status was known, information sharing and follow up support was poor. Recent audits of safeguarding arrangements in PAHT have highlighted that the required standards of practice in identifying children's social circumstances or those with caring responsibilities for them are not consistently undertaken. (Recommendations 1.6 and 5.1).

3.5 Given the high number of looked after children placed in the area, additional safeguards are required to ensure their vulnerability and legal status is fully recognised. Frontline health professionals at the UCC highlighted the challenges they face in not having good information about local children's homes or the young people they look after. This can result in medical and nursing staff having to undertake a number of follow up checks to assess the level of safeguarding concerns. This was evident on the day we visited when a young person from a children's home presented for treatment two days following his injury, and left without being seen by medical staff. (Recommendations 1.6 and 5.1).

3.6 Senior managers in PAHT have now begun to take action to implement a comprehensive alert system in all four of its hospital sites that will identify children and young people attending its unscheduled care settings who are subject to a child protection plan or are looked after. This is an important interim measure before the roll out of the national electronic alert system.

3.7 PAHT has recently piloted and is in the process of introducing a new pathway for identifying and managing concerns about children and young people under the age of 16 who present to their A and E or urgent care centres. The new arrangements incorporate learning from serious case reviews and support tighter scrutiny of risks to children under the age of 1 year who present with bruising or injuries. New assessment paperwork is being introduced to encourage a higher level of vigilance and consistency of response in managing safeguarding concerns in all locations operated by the Trust.

3.8 PAHT has reviewed its arrangements for the management of child protection medical examinations and generally examinations take place in a timely manner. Children from Rochdale borough are seen at the bespoke consultant led clinic at Fairfield General Hospital, Bury which is one of the 4 sites in the PAHT footprint used by Rochdale residents. Requests for medical examinations are higher in Rochdale compared to other areas covered by PAHT. The designated doctor is working with PAHT to further develop a service for section 47 medicals to enhance the quality of service for children and families.

3.9 Case records seen in relation to young people at risk of sexual exploitation were generally well managed. The team in conjunction with children's social care staff have a robust system for assessing and monitoring risk to individual young people. We saw a number of examples of sensitive and thoughtful work with young people and their wider family or support networks. A high level of multi-agency and multi-disciplinary work underpins local arrangements co-ordinated through the work of the Sunrise team. A holistic focus on young peoples' health and personal safety is secured through effective partnership working with a range of agencies including substance misuse, CAMHS, the young people's sexual health support service and PACE- a voluntary organisation supporting parents whose children are at risk of sexual exploitation. This ensures a clear shared focus on their safety, health and wellbeing.

3.10 A 'Think Family' approach drives and underpins the work of adult mental health and substance misuse services alongside other partner agencies in safeguarding children. Adult mental health staff pay attention to identifying children and young people in families who may benefit from young carers support. The service is working to continuously strengthen awareness of the impact of parental mental health issues on children and young people living in the household. Records seen provide good information about children and young people and of risks to their wellbeing or safety.

3.11 Most health staff are fully engaged in child protection work including attending child protection meetings, with good use made of their expertise to inform decision making. GP engagement in child protection work is slowly improving, but local arrangements overall currently do not meet the required standards of practice. Safeguarding work seen in one GP practice was young person centred. Recording of concerns and analysis of risk was clear and comprehensive. The alert system was in place and it helped inform GP consultation and follow up support offered to young people and their families. However, further work is required to promote better understanding of their role and accountabilities for safeguarding children. This includes work to strengthen partnership working and embed management information systems including use of coding for identifying and keeping up to date key information about the needs of vulnerable children living in the area. (Recommendation 2.1).

3.12 A new information sharing protocol has been introduced that provides clear guidance to GPs on how to make a referral if they are concerned about the safety or wellbeing of a child. Further training has been provided and is ongoing to raise their awareness about child sexual exploitation, domestic abuse and neglect. The number of referrals from GPs to children's social care is now increasing. However, there remain gaps in the contribution of GPs to child protection work, including attendance and provision of reports to child protection conferences. Although lead GPs are in place in all practices, systems to monitor ongoing risks to children including audit and review of children on child protection plans or who are looked after are still at an early stage of development. (Recommendation 2.1).

4. Children Looked After

4.1 Consent to statutory health assessment activity was clearly sought and provided in a timely manner on most cases seen. Consent is appropriately requested and recorded from young people who are of age and are able to make decisions about their health needs and treatment choices. Overall we found improvements in partnership working with children's social care including timely information sharing and communication about children who have moved into or out of care or whose care placement has changed.

4.2 The designated nurse for Cared for Children has begun to strengthen links with all independent providers operating in the area and is working to ensure information held on children placed in the area is accurate and up to date. This is an important safeguard given the number and turnover of placement changes. However, Responsible Commissioner² arrangements require further development to ensure the council and its health partners are informed in a timely manner about children being placed in Rochdale, the likely duration of their placement, and their current health needs or risks to their wellbeing. (Recommendation 1.2).

4.3 Action is being taken to improve the quality and timeliness of initial health assessments (IHAs). Recent IHAs and health care plans overall provide an adequate level of information about the health needs and risks to children in care. However, the quality of the work seen is variable, with some records providing insufficient information about risks to children. In one case, the impact of domestic abuse on a young child was not sufficiently explored or used to inform their future support needs. In another case, we saw good analysis of the potential risks on the future development of the child from parental alcohol misuse. However, the paediatrician did not have access to birth parents' medical notes at the time of completing the assessment for adoption. Health risks had not been sufficiently explored in the first assessment undertaken 3 months earlier. Work is now taking place to align and streamline IHA and adoption medical processes. (Recommendation 3.1).

4.4 Current performance indicates that 90% of Review Health Assessments (RHAs) are undertaken in line with statutory timescales. We saw examples of some good quality, child centred assessments and health care plans. Health visitors maintained regular contact with babies and young children in care and provided appropriate advice and support to foster carers. Assessments provided a clear overview of young children's health, development and self- caring skills. Positive practice was seen in one case where the same health visitor who was previously involved in child protection work provided ongoing support following the child's move to live with foster carers in another locality. However, GPs are not being routinely contacted to help inform the child's RHA or support plan. (Recommendation 1.3).

² Department of Health Guidance in relation to paying for secondary care

4.5 Although GP's routinely receive copies of children's health assessments and care plans, further work is required to ensure the information provided is easy to read, and provides specific detail about risks, with clear direction as to whether any follow up work is required by them. For example in one case seen, Strengths and Difficulties³ were referred to as high. The GP was not clear what this meant. or what, if any action, they needed to take. (Recommendation 1.3).

4.6 Detailed attention has been paid to strengthening systems and access to support for young people who are at risk of being groomed, bullied or exploited. However, further thought needs to be given to how sensitive personal information in relation to sexual exploitation risks is shared. In one case seen of a vulnerable looked after young person, appropriate medical treatment was given by the GP in response to the presenting need, but given they were not aware of her history of previous risks and of the complexity of her needs, no follow up checks were made. (Recommendation 1.3).

4.7 Practice in identifying and addressing health inequalities experienced by young people has been strengthened. Screening is routinely undertaken of young people's emotional and mental wellbeing and misuse of drugs and alcohol. Levels of risk and patterns of harm are increasingly being used to inform the young person's health assessment and frequency of support. This denotes positive progress since the last inspection. However, further work is required to ensure planned actions are always clear and focused on outcomes that can be effectively tracked over time. (Recommendation 3.1).

4.8 The Cared for Children nurses provide targeted support to young people who otherwise may have difficulties getting to or fail to attend their health appointments. The regular weekly drop-ins undertaken by them in the council run child homes are valued by young people and the staff that support them. CAMHS are proactive in providing ongoing support to children and foster carers and to staff working in the council run children's homes. '*The Den*' a targeted youth service with input from CAMHS, offers a supportive environment including social and leisure activities for young people who are looked after. Positive outcomes include growth in social skills and self- esteem, and strengthening of young people's emotional wellbeing and resilience. Each young person is provided with clear feedback on the things they do well and on the behaviours they need to work on.

4.9 Further work is required to strengthen information sharing to ensure children not attending school have good access to CAMHS, including Rochdale children placed out of area. (Recommendation 1.2).

³ Strengths and Difficulties questionnaire used nationally to inform the emotional wellbeing of children looked after

E. is a 12 year old child with significant and long term emotional and behavioural difficulties. He is not attending school. Despite a number of appointments being offered by CAMHS over the past two years, a lack of flexibility around appointments has meant that this young person has not received the help he needs. Inadequate communication between health professionals in the two council areas has led to assumptions that the young person is accessing support. His needs and risks to the sustainability of his current foster placement have continued to increase.

4.10 Whilst faith, language and cultural needs are generally briefly recorded, IHA and RHAs do not sufficiently explore equality and diversity in relation to children's identity and support needs. Casework with children with disabilities, including those with autism, also requires further development to make better use of assistive technologies and adapted communication. (Recommendation 1.5).

4.11 The Cared for Children nurses provide a high level of support to young people aged 16-18 years old. This includes targeted work with young people placed out of area who on leaving care, will be returning to live in Rochdale. We saw examples of good outcomes from work with some young people with long term conditions to ensure they regularly attended medical reviews, understood the need for medication, and took it responsibly. The increase in capacity in the team has meant the Cared for Children's nurses can provide the level and intensity of support some young people need when they move out of area or leave care as highlighted in this case.

F. is a 16 year old young pregnant woman placed out of area. The Cared for Children's nurse has continued to maintain regular contact with her and with relevant health professionals including through a further move of care placement. The Cared for Children's nurse attended the pre-birth and hospital discharge planning meetings and facilitated the young person's access to the Family Nurse Partnership programme in the area she moved to. The nurse has proactively contributed to wider assessments and care planning for F. and her unborn baby. This included sharing her analysis of risks and support F. requires to help strengthen her parenting capacity.

F. has experienced the Cared for Children's nurse as a consistent and trusted person in her life, helping her to cope with changes and making sure everyone works well together to ensure her safety and that of her baby's. This has reduced the need for F. to have to repeat her story and 'start again' with new professionals. F. and her baby are now making good progress in a mother and baby foster placement.

4.12 However, local arrangements to provide a case summary/health passport for young people leaving care are not yet in place. The model has been agreed, but has yet to be implemented. Our review of the final health support plans for young people leaving care indicated the need to be more specific about transition arrangements. This includes ensuring the final review health care plan provides specific details of handover arrangements and of the roles and accountabilities of key health and social care professionals and agencies available to work with them. (Recommendation 3.2).

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 Strong senior leadership and support from health professionals is helping to underpin local improvements and promote more innovative ways of working. Senior health managers are well-informed about practice on the ground and ensure frontline staff are appropriately supported to deliver the required changes. Senior managers are actively engaged in and supportive of the work of the Rochdale Borough Safeguarding Children Board (RBSCB) and its sub-groups. Development work in areas such as the Early Years Strategy and Excellence in Practice is helping to cement a shared culture and operating systems to support the delivery of future plans.

5.1.2 Although the overall numbers of children on child protection plans and those who are looked after remains high, we saw cases where parents, who had children previously removed from their care, were able to safely care for subsequent children. We also tracked some cases where effective identification and provision of early help by health professionals had reduced the need for statutory intervention. Organisational strategies are increasingly focused on learning and working together across agencies to strengthen the sustainability of such arrangements.

5.1.3 The high number, systemic nature and diversity of issues emerging from historical and current serious case reviews have significantly challenged the capacity of local organisations, particularly designated and named safeguarding professionals. NHS leaders have managed these additional pressures well and provide a supportive and challenging environment to help deliver higher standards of safeguarding practice.

5.1.4 Serious case reviews highlighted a number of historical resource pressures and high caseloads in some agencies. Health staff reported that although they were busy, they had sufficient time and support to undertake priority work. Although the capacity and workloads of school nurses are high, smarter working and strong partnerships with local health visitors is enabling targeted support to all the children in the family. Community midwives reported their workloads are manageable with high priority given to the delivery of continuity of care.

5.1.5 Gaps remain in safeguarding leadership in primary care and the area does not yet have a named GP. As highlighted in an earlier section of this report, safeguarding arrangements in primary care do not fully meet the required standards of practice. In the interim, the designated professionals and a senior CCG Trust representative have provided additional training and support to GPs. NHS HMR CCG and the GM area team are working together to explore future options that provide the level of support and flexibility required on a local and Greater Manchester basis. PAHT does not currently have a named midwife in post. The Trust is working to address this. (Recommendation 1.7).

5.1.6 Rochdale health and social care managers and frontline professionals continue to take extremely seriously past failures to recognise and effectively support young people at risk of sexual exploitation. Concerted efforts are being made across partnerships to address the underlying causes of such incidents, with a stronger focus on work to improve early identification of neglect and domestic abuse.

5.1.7 The investment in additional specialist Cared for Children nurses and administration capacity has enabled a more structured and responsive service, with additional capacity to provide intensive support to young people with the most complex and enduring health needs and vulnerabilities. The designated nurse for Cared for Children has actively driven a range of improvements in local operating systems and practice development. However, further review of their role is required as the strategic and lead commissioning aspects of the role are under-developed. Priorities to be addressed include comprehensive analysis of health inequalities and reporting of child health outcomes. (Recommendation 1.8).

5.2 Governance

5.2.1 NHS HMR CCG is working closely and effectively with Council partners and with the NHS England Area Team to continuously strengthen local governance and accountability arrangements. Senior health managers in all organisations have given high priority to learning from serious case reviews. Most actions from published serious case reviews are on track for completion in line with agreed timescales. PCFT has adopted a 'Team Investigation Report' (TIR) process to help promote organisational learning about serious incidents that fall below the threshold for undertaking a serious care review. This denotes increased organisational vigilance in promoting learning from safeguarding practice.

5.2.2 Our previous inspection found that commissioning arrangements and performance management frameworks focused too heavily on quantitative data rather than the quality of practice or understanding of the child's journey through services and outcomes achieved. Recent work undertaken with users of substance misuse and CAMHS services demonstrates good practice in this area. Overall, we found the voice and experience of young people and their families in shaping the development of local health services is still relatively limited. Further work is required to ensure feedback from children, young people and their families is routinely gathered about their experience of the quality and impact of help provided. (Recommendation 1.9).

5.2.3 The GM Area Team has clear governance arrangements that support enhanced scrutiny of safeguarding arrangements and incident reporting across the wider health economy. The Area Team has a strong focus on safeguarding and the reporting of serious incidents by NHS providers. Recent work evidences a high level of challenge of providers where reporting levels have been historically low. Additional training has been provided, and since April, levels of reporting are increasing in line with expected levels in relation to PAHT. Designated safeguarding professionals play an active role in strengthening reporting and promoting learning from such incidents.

5.2.4 NHS HMR CCG Governing Board seeks assurance on a regular basis to inform its understanding of progress being made in strengthening safeguarding systems and review of areas for further improvement. High priority is given to improving awareness and understanding of the experience of children exposed to multiple harms including sexual exploitation or domestic abuse. Current health contract monitoring arrangements do not provide a sufficiently robust focus on the experience of vulnerable children and families or of outcomes for them. Health commissioners recognise the need to undertake more detailed analysis of the effectiveness of provider safeguarding arrangements and to undertake regular checks of frontline service delivery. Positively, health and other partner agencies are now more confident to challenge and escalate concerns to promote wider learning and continuously strengthen joint working arrangements. (Recommendation 1.9).

5.2.5 Commissioning arrangements for children and young person's services have been strengthened with some examples of effective work taking place with young people and their families with long term and complex needs. New evidence based models of practice are being commissioned including a local FNP service to provide a higher level of targeted support to teenage parents. PCFT has strengthened the range of services it offers to children with emotional, behavioural and mental health needs.

5.2.6 PAHT is making good use of learning from audits to address gaps and inconsistencies in its current safeguarding arrangements. A culture of openness, accountability and learning is being strongly promoted, with an improving focus on children and young peoples' experiences as they access different parts of the organisation. PCFT has a programme of audit to inform review of progress made in strengthening the quality of its local services and has recently commissioned an independent review of safeguarding practice across the organisation.

5.2.7 The level of rigor and management oversight of the work of substance misuse practitioners is good. All cases that have had a formal review are checked to ensure relevant paperwork has been completed and that safeguarding children issues have been appropriately considered. Management oversight and quality assurance of the Cared for Children health team's work is still evolving. Learning from review of IHAs has not yet been formally evaluated. Some casework seen had become task rather than goal orientated, with insufficient analysis and reflection on the effectiveness of interventions and progress of the work in improving outcomes. (Recommendation 3.1).

5.2.8 Governance arrangements in all local health organisations include review of equality and diversity policies and commissioners are increasingly checking to make sure the expected quality and levels of take up of services are achieved. Action has been taken to address waiting times and low levels of take up of autism services by some community members where needs are known to be high. Further work is required by all local health organisations to ensure the role and purpose of local services is recognised by all members of its local communities and that there is appropriate recognition and support for their individual needs. (Recommendation 1.5).

5.3 Training and supervision

5.3.1 Serious case reviews highlighted significant historical gaps in training and support arrangements in local health services. Particular attention has been paid to developing new procedures and pathways of care to support work with adolescents who require help from a range of specialist services and agencies. New practice tools have been developed. Adult social care professionals have strengthened their links with children's social care and health services, working together to jointly develop vulnerable young person safeguarding arrangements for young people who are likely to remain at high risk of harm.

5.3.2 Our discussions with frontline staff and review of their casework indicate the required standards of practice are understood and becoming more embedded in practice. Frontline health professionals we met were open to learning and were striving to continuously improve the quality of their service and secure better outcomes for local children and their families. Priority has been given to strengthening supervision, professional support and challenge of practice.

5.3.3 Supervision systems for community health staff in PCFT are well managed and effective overall. However, supervision records were not consistently evident on the young person's case notes. In a few cases supervision records lacked detail, including analysis of risk or contingency planning. The named safeguarding professionals undertake the majority of safeguarding supervision in PCFT. Further work is required to strengthen the capacity of other senior health professionals to share the safeguarding supervision workload. Frontline health staff generally receive supervision at a frequency in line with intercollegiate requirements. The 'Monitor' database used by PCFT positively supports practitioners who are managing complex cases and those where risks to children are escalating. In these circumstances, there is further scrutiny of causes for concern with additional advice and support provided to help prevent further risk of harm to the child. Staff working in young peoples' sexual health services now receive good support.

5.3.4 Good supervision arrangements are in place in adult substance misuse and adult mental health services. The focus on risks to children is thoughtfully considered and recorded on supervision records seen. The adult mental health team operate 'a zoning board' to ensure ongoing vigilance of potential risks to children. All adults who have contact with children are automatically flagged and practitioners provide a weekly update to whole team on current status of case. This denotes good practice in safeguarding children. These approaches are effective in enabling frontline staff to reflect the child's experiences of family life, enables them to effectively engage in multi-agency safeguarding arrangements and to feel supported in undertaking complex work.

5.3.5 Peer supervision of GPs is slowly developing but it not yet sufficiently embedded in practice. Urgent and Emergency care staff have monthly discussions with consultants to promote learning from safeguarding incidents. Safeguarding is discussed as an integral part within midwifery supervision. The quality of safeguarding work is reviewed in the annual audit of midwifery records. Learning from serious incidents in PAHT is repeated on every shift change over 7 days to ensure all midwifery and unscheduled care staff hear the same messages to support shared understanding of expectations and the standards of practice required. Patient experience, for example, *Nathalie's Story* has been recorded to promote wider awareness of lessons learned.

5.3.6 The Sunrise team continues to provide a number of child sexual exploitation awareness raising and training workshops for health professionals and partner agencies working in the area. PAHT has strengthened training for junior doctors, and reports compliance with Trust and CQC targets. Safeguarding training for locum doctors is recognised as an area for further development. PCFT training figures are slightly below the required targets. Not all GPs have yet completed level 3 training. Some training designated as level 3 is not multi-agency, and so therefore does not fully comply with intercollegiate requirements. (Recommendation 1.10).

5.3.7 PCFT HMR Safeguarding team has provided additional training and mentoring support for its staff involved in writing court reports. As a consequence, the standard of report writing by health professionals has significantly improved. Few health professionals are now required to attend court given the level and quality of information supplied.

Recommendations

1. **NHS England Greater Manchester Area team, NHS Heywood, Middleton and Rochdale CCG and Rochdale Metropolitan Borough Council together with Pennine Care NHS Foundation Trust and Pennine Acute Hospitals NHS Trust should:**
 - 1.1 Ensure all early help related activity is underpinned by effective and sustainable systems for the co-ordination, delivery and reporting of work undertaken by health professionals with children and their families.
 - 1.2 Ensure information sharing between agencies is child centred and provides a clear and up to date picture of their individual needs and risks.
 - 1.3 Secure stronger partnership working and good two way information sharing and communication between GPs, midwives, the young person's sexual health team and the Cared for Children health team.
 - 1.4 Address outstanding gaps in access to contraception and sexual health services for young people and improve management information in relation to the incidence of unplanned teenage pregnancies.
 - 1.5 Strengthen arrangements for the delivery of accessible and culturally appropriate services including support for children and families from minority ethnic communities and children with disabilities.
 - 1.6 Put in place a robust hospital liaison system for sharing concerns about children who attend unscheduled care settings.
 - 1.7 Ensure the capacity of named safeguarding professionals meets local demands and intercollegiate requirements.
 - 1.8 Strengthen the designated looked after children professional role and capacity to provide comprehensive analysis of the health needs and impact of work undertaken.
 - 1.9 Further strengthen local commissioning and performance management systems to embed learning from young people and their families, and provide a comprehensive picture of their experiences and of the quality of local health services.
 - 1.10 Ensure safeguarding training, supervision and peer review arrangements fully meet intercollegiate requirements.

2. NHS England Greater Manchester Area team, NHS Heywood, Middleton and Rochdale CCG and Rochdale Borough Children's Safeguarding Board should:

- 2.1 Ensure all GP's are clear about their roles and accountabilities for safeguarding and looked after children, are appropriately informed about and engaged in work with partner agencies, and have clear audit systems to evidence improvements in child health outcomes.

3. NHS Heywood, Middleton and Rochdale CCG and Rochdale Metropolitan Borough Council together with Pennine Care NHS Foundation Trust should:

- 3.1 Strengthen management oversight and quality assurance of initial and review health assessments and support plans to support effective monitoring and reporting of risk and promote continuous improvement in child health outcomes.
- 3.2 Ensure care leavers routinely receive a health care summary/health passport to actively support them in managing their transition from child to adult health and social care services.

4. NHS Heywood, Middleton and Rochdale CCG together with Pennine Acute Hospitals Trust should:

- 4.1 Ensure midwifery staffing levels and skill mix fully meets local needs and continuously improves outcomes for Rochdale women and their babies.

5. Pennine Acute Hospitals NHS Trust should:

- 5.1 Effectively use information about children on child protection plans and those who are looked after living in the area to inform its local safeguarding arrangements.
- 5.2 Enhance coverage of paediatric trained nursing staff working in the Rochdale Infirmary Urgent Care Centre and Royal Oldham hospital A and E department.

Next steps

An action plan addressing the recommendations above is required from NHS Heywood, Middleton and Rochdale 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.