

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

Children Looked After and Safeguarding The role of health services in Oldham

Date of review:	1 st August – 5 th August 2016
Date of publication:	8 th September 2016
Name(s) of CQC inspector:	Sue Talbot Jan Clark Elaine Croll Deepa Kholia-Mehta
Provider services included:	The Pennine Acute Hospitals NHS Trust Bridgewater Community Healthcare NHS Foundation Trust Pennine Care NHS Foundation Trust Brook Sexual Health Service Virgin Integrated Care One Recovery Oldham- (ADS)
CCGs included:	NHS Oldham
NHS England area:	North Regional team
CQC region:	North
CQC Deputy Chief Inspector, Primary Medical Services and Integrated Care:	Alison Holbourn

Contents

Summary of the review	4
About the review	4
How we carried out the review	5
Context of the review	5
The report	7
What people told us	7
The child's journey	9
Early help	9
Children in need	15
Child protection	23
Looked after children	27
Management	31
Leadership & management	31
Governance	35
Training and supervision	38
Recommendations	40
Next steps	43

Summary of the review

This report records the findings of the review of health services in safeguarding and looked after children services in Oldham. 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 NHS Oldham CCG and the NHS England North Area Team.

Where the findings relate to children and families in local authority areas other than Oldham, 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 Director of Public Health 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 112 children and young people.

Context of the review

Oldham's population is diverse. The area is characterised by pockets of affluence and poverty, with almost one in four local children now living in poverty. The local population is growing, and is currently estimated at 225,000 people. Children and young people (0-19 years) comprise 27.7% of the total population, which is relatively high compared to other areas of England. Children from black and minority ethnic (BME) groups make up a growing proportion of the school-aged population; 41.2% compared to 27.8% nationally. Oldham has well-established Pakistani and Bangladeshi communities, and in recent years, has become home to people of East European and Roma heritage.

The health and well-being of children in Oldham is generally poorer than the England average. Infant mortality and birth weight rates are worse. Mortality and morbidity rates are higher.

Oldham has very good performance in ensuring children and young people, including children looked after, are immunised to help protect them from disease. However, the rates of hospital attendance and the incidence of dental caries in children under five years of age is the second worst in England. The causes of dental decay are linked to low levels of breast feeding and poor family nutrition, which contribute to increasing concerns about childhood obesity in the area.

Rates of under- age conceptions and teenage mothers were previously very high in Oldham. Recent data indicates a significant reduction in teenage pregnancies. Hospital admissions due to alcohol misuse are relatively high. Emergency department (ED) attendances for 0-25 year olds and hospital admissions of young people for mental health conditions and self-harm are significantly higher than other areas in England.

Levels of children looked after in Oldham are higher than the average for England. Strengths and Difficulties questionnaire scores are comparable to other areas. At this time of this inspection, 429 children were looked after, 132 of whom were placed out of area. In addition, 226 children were placed by other local authorities in Oldham.

NHS Oldham CCG is responsible for commissioning acute health care and child and adolescent health services (CAMHS tier 3) in Oldham. The local provider of acute hospital provision is The Pennine Acute Hospitals NHS Trust. We visited its emergency departments, children's wards and maternity services at Royal Oldham hospital as part of this inspection. Child and adolescent mental health services, known as Healthy Young Minds are provided by Pennine Care NHS Foundation Trust. Adult mental health services are also provided by Pennine Care NHS Foundation Trust.

Oldham Council's Director of Public Health is responsible for commissioning health visiting and school nursing services. Bridgewater Community Healthcare NHS Foundation Trust has been commissioned to provide these services since April 2016. The Director of Public Health also commissions young people's contraception and sexual health services (CASH) and substance misuse services. Young people's sexual health services are provided via 'Positive Steps' a third sector provider in partnership with Brook. Virgin Integrated Care provides 'all age' CASH and genito-urinary (GUM) services. 'Positive Steps' provides the young person's substance misuse services OASIS. The Director of Public Health also commissions adult substance misuse services. These are provided by 'One Recovery Oldham'.

Commissioning arrangements for looked-after children's health are the responsibility of NHS Oldham CCG. The CCG employs an Associate Designated Nurse for Looked After Children to provide strategic oversight of this work. The looked-after children's health team are provided by Pennine Care NHS Foundation Trust.

The previous safeguarding and looked after children inspection published in January 2012 rated the contribution of health agencies to keeping children and young people safe as good, and health outcomes for children looked after as outstanding. Progress against the previous report's recommendations has been considered 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

A young mother supported by the Family Nurse Partnership programme told us:

"My family nurse is fantastic- she is always there for me. She has helped me a lot, and is always there for advice. If I think anything is going wrong, I will check it out with her. We have a trusting relationship, and she regularly sees me and my baby".

A foster carer told us:

"The GP has been lovely; ready to listen and understand the situation and how it is affecting the child."

"The children see the school nurse at the health clinic for their health reviews every year, but I have never been invited to be part of the assessment or give my views about any of the children. Even the little ones are seen all on their own for the whole appointment. I don't think that's right; that I'm not seen at all. I get a copy of the health plan a few weeks later."

Another foster carer told us about her experience of working with a number of health professionals:

"We got a lot of help with everything from social care and health; OT was involved, physio for hydrotherapy. She got a special wheelchair and all the equipment she needed."

"I took her to my GP and he was very good. We got a good specialist and regular dental support at the Integrated Care Centre."

"The health visitor was excellent. She was lovely and came to visit every month to see how we were getting on; but it did take ages to get her taken up by the school nurses. She was a lot better by then but still needed the support as well as the reassurance that she was on the right track."

Another foster carer told us:

“The Vent team are fab and great, coming in every night to give us a break. We do have problems sometimes when they can’t send anyone as they haven’t got enough staff. When that happens we don’t get a break as he needs someone with him all the time.”

“From hospital to home was horrendous. There were so many people involved, but everything is now falling into place. The Team Around the Child (TAC) is really helping everybody to work together.”

“He has an Open Access letter. If anything is wrong I just have to phone the hospital and they get all the right doctors in place and I bring him straight in. He is fast-tracked.”

“Everyone- health and social care, have always treated me and the children I have looked after with care and respect. I’ve been very lucky.”

A care leaver told us:

“Health staff and GPs don’t understand looked-after children; that we have particular needs. When you tell them you are a care leaver, they don’t always ‘get it’. I’m lucky, my GP knows me and my health needs well, and I get fast-tracked if I need to make an appointment to see him”

“I didn’t get any letter or record of my immunisations or anything else about my health when I left care. I had to get that information myself from my GP. Getting a health history when you leave care is so important.”

“If young people have left care and need to get help for physical health needs, we don’t always have people who can support us and act as our advocate.”

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 Oldham Council had implemented a new approach to the delivery of early help to replace the Common Assessment Framework. The new model spanned a range of interventions tailored to individual children and their family's needs. This included provision of community-based support, low intensity support, medium term engagement work, and intensive support over a longer period to help prevent escalation of risk and support 'step-down' from statutory work. Access was via the multi-agency safeguarding hub (MASH), with early help work undertaken on a single or joint agency basis.
- 1.2 The single point of entry and partnership work underpinning the approach was working well with evidence of strong child/young person-centred team working between health, social care and other professionals. For example, One Recovery Oldham had seconded staff into the Early Help team to enable a stronger focus on families where substance misuse was a concern. The post holders provided training to the wider Early Help team to help strengthen the impact of preventative work.
- 1.3 The single point of access to the Healthy Young Minds service had also recently been integrated into local MASH operations. The new pathway promoted a timely and streamlined response to young people and their families. This meant a joined-up early help response at the first point of contact was now possible, with flexibility to 'step-up' or 'step-down' interventions as required. Although the new approach was only a week in operation at the time of our visit; it had the potential to significantly transform the engagement and provision of early help to children and young people.

- 1.4 The future model of community health services and its fit with the early help offer had yet to be fully implemented following the recent transition of community health services to Bridgewater Community Healthcare NHS Foundation Trust. Given continued growth in the area's child population combined with high levels of deprivation and need in some localities; demands on local community health services were high. Particular capacity challenges were evident in the school nursing service. Whilst the service continued to demonstrate good coverage of childhood immunisations; the availability of school 'drop-ins' in primary and secondary schools had been reduced; with long waits for enuresis clinics. **(Recommendation 3.1)**. *This was also brought to the attention of the Director of Public Health as the commissioner of school nursing services.*
- 1.5 All children and young people under 18 years of age attending the emergency department at Royal Oldham Hospital were booked in at reception, before they were directed to the dedicated paediatric waiting area. A range of demographic information was collected, as well as details about the adult accompanying the child/young person. Emergency department staff were aware of the Trust's 'Left Before Being Seen' protocol and flagged such incidents as part of their routine sharing of information with community health staff. We saw one such form submitted to the MASH about an assault on an 11 year old boy. This provided limited information about the injury, and further contact had not been made by the emergency department with the family for a follow up check of his wellbeing. The ED matron advised the inspector of her actions to promote learning from this. **(Recommendation 8.1)**
- 1.6 The oversight of all paediatric attendances was completed by ED senior nursing staff. Community health professionals were routinely informed of all attendances of children at ED. They also received further information about those children where ED staff had concerns through an information-sharing form. The information sharing form included a 'recommendation' section which informed community health staff about whether ED staff felt the case required follow up or whether no action was required. Community health professionals, in turn, exercised their professional judgement about the level of follow up action required in the light of the information they held about a particular child or family.
- 1.7 All GP practices were advised of children's emergency department attendances, and had a named health visitor and school nurse linked to their practice. However, levels of contact and joint working were still relatively under-developed in most localities. The role and contribution of GPs in partnership with other health professionals in supporting Oldham's Early Help offer required further consideration. **(Recommendation 3.1)** *This was also brought to the attention of the Director of Public Health as the commissioner of health visiting and school nursing services.*

- 1.8 Oldham women had good access to maternity services when they were pregnant. The work of midwives was visible in local children's centres and strongly promoted within local communities. Whilst midwives identified women that would benefit from early help, this work was often completed by children's centre staff. A programme of development work was in progress to enable midwives to more clearly evidence their contribution to the area's early help offer. (**Recommendation 3.1**)
- 1.9 Late booking and concealed pregnancies had been recognised as areas of concern in relation to maternity booking patterns in Oldham. The CCG, health providers and local authority partners were actively seeking to encourage early booking so that all women and their babies could benefit from health promotion at an early stage. The new early help arrangements aimed to encourage women to notify health services at around 10 weeks of pregnancy. A lead health visitor was appointed to work with women at the 24 week antenatal gestation point.
- 1.10 Information-sharing between midwives and health visitors was generally appropriately managed and complied with practice guidance on case records seen. An incident reporting system provided good management oversight of any gaps in information sharing. Reporting of such incidents had reduced, and evidenced joint recognition of the importance of routinely sharing information of concern to assist the smooth handover from maternity to health visiting services.
- 1.11 Midwives promptly informed GPs and health visitors when they were notified that a woman was pregnant following her booking appointment. Current arrangements invited GPs to share information about women's health histories and social circumstances. However, such information was not routinely shared with midwives by GPs. Midwives did not access GP records unless they saw the woman at the GP surgery. Regular communication and information sharing between primary care and midwifery services is essential in promoting shared awareness about vulnerable woman to strengthen the early help offer. (**Recommendation 2.1 and 3.1**)
- 1.12 The current arrangements for registering children at the two GP practices we visited could be strengthened. Staff registering children either permanently or temporarily did not make routine enquiries about agencies working with the family, or if they had a social worker. This was a missed opportunity to consider risks and any additional needs right from the start and ensure relevant other agencies were kept informed about areas of concern. Both GP safeguarding leads expected clinicians to record the name and relationship of adults that accompanied children and young people to all appointments. However, they were not able to provide any assurance of the quality of practice in this area. (**Recommendation 2.1**)

- 1.13 All GPs in Oldham had received a financial incentive to provide same day appointments for children under the age of five years. This aimed to reduce the high levels of presentation of young children at the local emergency department. The CCG reported good performance by all GP practices in meeting same day target requirements. Improved outcomes were evident in the reduction in admissions to hospital for children with asthma.
- 1.14 Health visitors and school nurses had good joint working relationships which had been strengthened through co-location in all, except one locality; with clear pathways and guidance to support handover of the care of school-aged children. A transfer summary was completed by health visitors, and a verbal handover/joint visit was undertaken of vulnerable children and families. We also saw examples where health visitors proactively sought information from school nurses about what was known about older children when they were advised by midwives about vulnerable women. This indicated good progress was being made in embedding learning from a previous serious case review.
- 1.15 A biographical data sheet, which supported community health professionals to gather information about all aspects of children's identity and social circumstances, including faith and ethnicity, was expected to be completed for all children and young people on their caseload. However, in records sampled, we found that the data sheet was not fully completed and did not support holistic recognition of the identity of each child.
(Recommendation 6.1). This was also brought to the attention of the Director of Public Health as the commissioner of school nursing services.
- 1.16 A number of developments were in progress to expand the local early help offer to school aged children. Oldham had a specialist mental health school nurse who led on work to strengthen the emotional support and wellbeing offer within local schools. Action was being taken to progress local arrangements for meeting Healthy Child Programme targets for older school-aged children; with plans to extend school entry questionnaires to include transition to secondary schools. Other development work included ensuring all schools had an annual health plan. These initiatives should enable improved screening of health risks and enable better targeting of support to local children.

- 1.17 The school nursing focus on children not in education/missing from school and young people aged 16-19 attending college was good; with support provided by two specialist nurses. This helped ensure the provision of early help was positively promoted to all young people throughout their childhood/young adulthood. We saw an example of good casework and inter-agency working in relation to an eight year old girl missing school, whose parents reported a number of serious health conditions. The school nurse had devised appropriate health management plans whilst further checks were made about parenting capacity.
- 1.18 School nurses worked closely with OASIS (young peoples' substance misuse service) and the contraception and sexual health services provided by Brook and Virgin Care. Partnership working promoted shared recognition of young people's needs and enabled easy access to additional support they required. The work of 'Positive Steps' was highly valued by young people and enabled a wide range of local professionals, including health professionals, to reach and support young people who may be reluctant to access help in school or health settings. This was helping to foster a strong team around the child approach.
- 1.19 Young people in Oldham had good access to a widening range of contraception, sexual health and GUM services provided by Virgin Integrated Care and Brook. Virgin had recently expanded its offer to include a young person only drop-in clinic in response to increased levels of demand in the area. The two providers operated in a complementary and mutually co-operative manner. We saw a number of case examples where young people had positively benefited from their sharing of information and joint working. Young people were routinely seen alone, enabling them to safely disclose any areas of possible abuse or risk.
- 1.20 One Recovery Oldham was making good progress towards the establishment of a 'Think Family' model of service delivery. New assessment documentation had recently been introduced to strengthen the capture of information about children. Home visits to clients where there were known to be children aged up to 16 years of age were undertaken, and a comprehensive home environment assessment was carried out. This represented a strengthening of practice as previously this was only routinely undertaken in households where there was a child of under the age of five. One Recovery Oldham was recruiting to vacant posts at the time of our visit which should enable the service to re-launch the previously successful 'Partners in Parenting' and domestic abuse programmes.

- 1.21 The recent appointment of a genetics counsellor and outreach worker was helping to widen awareness within communities and amongst health professionals about a range of family illnesses and disabilities. Two support groups had been developed for families where there was a child affected by a genetics-related condition. The support provided was valued in helping to build shared understanding of risks and the needs of children with specific conditions. This work arose from the Local Children's Safeguarding Board's (LSCB) concerns about child death trends and the increased incidence of children born in the area with complex health needs and disabilities. Oldham was working closely with Blackburn and Darwen to share lessons from their programme of co-sanguinity related work.
- 1.22 A 'link' health visitor was attached to the Child Development Centre to enable a prompt response to newly diagnosed children with disabilities and complex health needs. The link health visitor liaised closely with locality-based health visitors and the children's community nursing team in shared work to build parents' confidence, knowledge and skills. This included promoting safe use of equipment and medication within the home and attendance at clinic appointments.

2. Children in need

- 2.1 Royal Oldham Hospital emergency department used the 'Manchester Triage' tool to support decision-making about the urgency and level of care a child or adult required. This did not include a formal safeguarding risk assessment tool. Senior managers and safeguarding leaders in the Trust recognised the need to strengthen local arrangements for safeguarding, clinical assessment and recording practice. New 'paediatric attendance illness and injury' documentation had been piloted in one of its hospitals, with plans to introduce it to Oldham. The new approach aimed to strengthen further enquiry about others within the household, whether the family had a social worker, who had parental responsibility, and whether the child had any caring responsibilities. This work should help to complement the Child Protection Information Sharing system (CP-IS) now well established within the Trust.
- 2.2 Pennine Acute Hospitals Trust reported a significant increase (24%) in the number of information sharing forms or referrals made in 2015-16 compared to the previous year. This denoted increased awareness of professional accountabilities. A safeguarding children 'Trigger List' guided frontline professionals in making decisions about the circumstances where they needed to share information with community health professionals or when a referral should be made to children's social care. Such notifications were reviewed by a member of the safeguarding or nursing management team prior to being submitted to the MASH. Information-sharing/referral forms generally provided sufficient information about the presenting issues, but the voice of the child and analysis and articulation of risk could have been more explicit on some records seen. (**Recommendation 3.3**)
- 2.3 Good attention was paid by emergency department staff to exploring the vulnerabilities of all non-mobile babies, children and young people. All non-ambulant babies under a year old with burns, head injuries, bruises or fractures were seen by a paediatric registrar or a paediatric consultant. This promoted effective review of the causes and impact of such injuries and of further action required to safeguard the child/young person.

- 2.4 We found adult emergency department practitioners were not sufficiently mindful in their approach to identifying safeguarding risks to children where adults attended the department following an incident of domestic abuse, self-harm, mental health or substance misuse. In cases sampled, we saw information about young people and children within such households was not routinely collected. Safeguarding practice was monitored by the Trust in its weekly auditing of emergency department activity. All adult practitioners had been briefed on the safeguarding children standards expected through staff meetings and a lessons learned bulletin, with a strong emphasis on ensuring timely reporting of incidents of domestic abuse. However, further work was required to secure a high level of vigilance to all 'toxic trio' issues with effective recognition of the potential harms to children within these households. (**Recommendation 8.1**)
- 2.5 A young person drugs and alcohol worker attended the emergency department weekly and ensured routine follow-up of young people by substance misuse, contraception and sexual health staff. A bespoke assessment tool had been developed for use within the emergency department to strengthen follow up support to all young people presenting under the influence of alcohol or drugs. Joint working in this area helped promote comprehensive assessment of risks to young people who may be vulnerable to a range of harms. We saw the process worked well in relation to a 12 year old boy living in a children's home, found by care staff in an intoxicated state and brought to the emergency department. Appropriate action was taken alongside the police, OASIS and by children's social care to protect him.
- 2.6 The Pennine Acute Hospitals midwifery team comprised a number of specialist roles to support vulnerable women including a young person's, substance misuse, bereavement, HIV, domestic abuse and mental health midwife. Vulnerable pregnant women were routinely visited at home to enable holistic assessment of their home environment. Midwives made routine enquiries about female genital mutilation (FGM) and shared information of concern with children's social care. The specialist midwife for substance misuse made a weekly visit to the substance misuse service to review pregnant women and provided ongoing assessment and support to them as required.
- 2.7 Although we saw examples of good co-operative working between adult mental health and the perinatal mental health midwife and an obstetrician with an interest in mental health, Oldham was not compliant with Department of Health guidance in the provision of a specialist perinatal mental health service under the lead of a specialist consultant psychiatrist. This was a recognised area for development, and was being addressed within a business case to the CCG at the time of this inspection. It was clear from records seen that women were well-supported by the specialist mental health midwife with close tracking of changes in maternal mental health and assessment of the impact for the unborn or new born baby.

- 2.8 We saw a good standard of safeguarding children practice in the work of some adult mental health practitioners in the community mental health team (CMHT). This included a referral to MASH that provided clear analysis of the areas of concern, risks to children and of the required actions to effectively protect them. However this high standard was not consistently seen on other referrals which detracted from a 'Think Family' approach. **(Recommendation 3.3)**
- 2.9 Some adult mental health practitioners were proactive in initiating engagement with other professionals where there were known risks to children or unborn babies, including liaison by e-mail and telephone on a regular basis in line with best practice. However, we also found adult mental health professionals were not actively sharing information with relevant child health professionals to inform them of significant changes or escalating risks. For example, in one case where a mother and baby had been placed in a specialist mother and baby unit, where there were increasing concerns about the mother's capacity to nurture her baby, the health visitor had not been invited to the discharge planning meeting. **(Recommendation 3.2)**
- 2.10 In another case where there was a history of poor engagement and disguised compliance, a mental health appointment was cancelled where there were growing concerns about both the infant and mother's safety. The impact of this in relation to risks to a young child did not appear to have been effectively risk assessed. Care Programme Approach (CPA) operating procedures included a 'Did Not Attend' protocol. Whilst it made reference to the organisation's safeguarding policy, it did not explicitly include a focus on children and young people who may be at an increased risk of harm as a consequence of parents not attending appointments. Pennine Care acknowledged the need to further strengthen practice in this area and took immediate action to address this.
- 2.11 We found some adult mental health practitioners were passive in their approach to ensuring that child in need and child protection plans were obtained and appropriately entered on the Trust's electronic case management system PARIS. Operational practice required strengthening in some cases to ensure adult care plans were actively informed by child in need and child safeguarding plans thereby maximising the contribution of adult mental health to multi-agency meetings. **(Recommendation 9.1)**

- 2.12 Practitioners and managers within One Recovery Oldham liaised closely and well with probation and children's social care, with joint visits made as appropriate. Service managers acknowledged that liaison and communication with some other services such as adult mental health, health visitors and midwifery was not as strong as it could be. It was not common or routine practice for adult substance misuse practitioners to have direct communication with these practitioners outside of formal meetings such as child in need meetings, core groups or child protection case conferences. Relapse indicators were not shared with other key professionals such as health visitors who may also be regularly visiting the home. There were few regular meetings between services to increase mutual understanding of each other's roles and responsibilities and explore ways in which each service could best support the work of the other to strengthen 'Team around the Family' working. (**Recommendation 3.2**)
- 2.13 GP referrals to children's social care seen were of a variable standard with one that was entirely descriptive with no analysis of risk, whilst the other set out risks more clearly, but the impact for the child could have been stronger to reflect the level of concern the GP had. Neither referral had been followed up by the practices to clarify the outcomes. (**Recommendation 3.3**)
- 2.14 Both GP practices we visited used standard read codes for child safeguarding contacts. Where alerts were in place, these were clearly visible on the child's record. However, children linked to adults where domestic abuse, substance misuse or mental health related issues were identified as concerns had not been consistently flagged to promote their visibility to practice staff. Joint care planning for pregnant women with mild to moderate mental health problems managed at a primary care level were not easy to identify to support early recognition of any emerging child or adult safeguarding risks. (**Recommendation 2.2**)
- 2.15 The Family Nurse Partnership (FNP) programme has been established in Oldham since 2014 and delivered a comprehensive package of support to help build the resilience and capacity of young first time mothers. Case examples seen demonstrated family nurses effectively challenged and supported young mothers, sensitively working with them to address their own, often poor experiences of childhood, to enable them to bond with their baby.

Case example: A 16 year old care leaver was referred to the family nurse at an early point in her pregnancy. She had witnessed a high level of domestic abuse as a child and had low self-esteem and anger issues. She had not attended school for some time. During her pregnancy she moved between living with her mother and boyfriend at his family home. When her baby was born, she was made the subject of a child in need plan.

There were allegations that her boyfriend was controlling and two incidents of domestic abuse were reported. The young person then moved back home to live with her mother though continued to have contact with her boyfriend. The family nurse maintained strong oversight of her parenting capacity and effectively challenged her in relation to her responsibilities for her baby and the need to keep her safe. The family nurse had picked up early signs that the baby was not making eye contact with the young person and helped her understand the impact of conflict on the emotional wellbeing of young babies.

The young mother has come to realise that she needs to put her baby first, not only in practical ways through ensuring she is well cared for physically which she managed well; but the importance of her baby experiencing safe, nurturing relationships. In recent months, she has grown in confidence and her baby is thriving. Although a number of challenges remain including her housing and economic situation, she is keen to ensure her baby has the best possible start in life. She has valued and taken on board the advice and guidance of the family nurse and now proactively seeks this out. The plan is for her baby's care to be stepped down to early help with the continued engagement of the family nurse in supporting the move to toddler-hood.

- 2.16 The consultation provided by the clinical psychologist in infant emotional health was used effectively by family nurses including to support young mothers experiencing anxiety and depression. The performance of the FNP programme was effectively monitored and compared well with other programmes nationally.
- 2.17 Children and young people under the age of 16 attending the paediatric emergency department at Royal Oldham Hospital with self-harming or mental health needs had their physical health needs assessed before they were transferred to the paediatric ward to await a mental health assessment. They were promptly followed up by a Healthy Young Minds worker to ensure they were not kept on the ward for lengthy periods of time when they were medically fit for discharge. Hospital discharge was generally timely with prompt follow up by the Healthy Young Minds team and sharing of their assessments and care plans to promote the delivery of holistic care.

- 2.18 When children and young people with self-harming behaviours/mental health needs were admitted to the paediatric ward senior managers expected a risk assessment to be undertaken. However, at the time of our visit, such arrangements were still in development. The Trust was working to implement a new risk assessment model and associated documentation having recognised that the lack of consistent approach presented organisational risk. Other development work in progress at the time of our visit included a new learning and development programme for paediatric staff to enhance their awareness of risks and of care interventions to enable the delivery of holistic care.
- 2.19 We found the Healthy Young Minds service met a diverse range of emotional, mental health and behavioural needs of children and young people well. Young people with complex needs were effectively managed on cases seen, with improved outcomes for many young people and their parents and carers. The service was responsive to urgent needs, with evidence of steady and continuous improvement in its timescales for routine assessments, now six weeks on average, which indicated good performance nationally. Case work seen promoted an individually tailored and co-productive approach to help achieve shared understanding of concerns and strengthen protective factors. We saw examples of creative use being made of therapeutic tools adapted to children's/young people's ages, individual needs and family circumstances. Transition arrangements for young people who required ongoing support from adult mental health services were carefully considered and planned for on cases seen.
- 2.20 Children and young people were highly visible in the practice and recording of Healthy Young Minds clinical staff. Good attention was paid to portraying the feelings, wishes and risks posed to children and young people. We saw a number of examples where staff were positive champions for children and young people and ensured their voice was heard in relation to their wishes and feelings. This included a young person who no longer wanted contact with their parents, a young person who felt they were the wrong gender, a young person who was at risk of forced marriage, and a young person seeking asylum. In these cases, work was sensitively undertaken with young people and their carers to understand the experience of the young person, to weigh options and risks, and to work closely with a range of partner agencies to help improve outcomes. Safeguarding and information sharing was well- managed; with practitioners providing strong input into a range of child protection and team around the child meetings.

- 2.21 Oldham's Phoenix team (specialist multi-agency child sexual exploitation team) did not have a health practitioner as a core member. This was not felt to be needed by senior managers we spoke to given well-established working relationships with a number of health professionals who provided additional support with health needs when required. Team members had recently benefited from consultation provided by the clinical psychologist within the Healthy Young Minds team. This support was valued by Phoenix team members in strengthening their reflection on work undertaken with young people who were at high risk of being harmed and who had often experienced high levels of loss and trauma in their lives.
- 2.22 Both Virgin and Brook had robust risk assessment proformas which supported practitioners well in gathering information about the young people, their sexual history and behaviours to help inform a comprehensive assessment of overall risk. For example on one case seen we saw that the 'professional curiosity' sensitively undertaken by the Brook worker revealed the adult 'cousin' presenting with a 13 year old asking for condoms, was someone who may have been starting to groom a vulnerable young person to engage in sexual activity. The contradictory information provided by the young girl was thoroughly checked out given her age and vulnerability. In another case, sexual health reception staff identified intimate behaviour between a 13 year old girl and a 21 year old male waiting to be seen separately. Although both denied a sexual relationship, the police and children's social care were informed, and further action was taken to safeguard the young girl in the light of further investigation.
- 2.23 Child sexual exploitation (CSE) assessment tools such as *'Spotting The Signs'* were embedded and routinely used with all under 18s in sexual health services. All women and female young people were asked about FGM as part of the routine assessment; and risks to other female children within the family were considered. Sexual health services were fully aware of the FGM pathway and used it to signpost women and girls who had been victims of FGM or who may at be at risk of being harmed in this way. Targeted work had commenced with some local schools where FGM risks had been identified. The practices of these providers had been positively informed by a local charity that worked with victims of FGM. Although all school nurses have received CSE training, their work with young people at risk of sexual exploitation was not yet supported through use of a CSE assessment tool. (**Recommendation 6.3**)
- 2.24 Managers in both Brook and Virgin monitored the safeguarding referral process closely through their electronic incident reporting system, but did not monitor quality and content of the referrals. Operational oversight and governance of the quality of referrals made to MASH was an area for development for both sexual health providers. (**Recommendation 10.1**) *This was also brought to the attention of the Director of Public Health as the commissioner of sexual health services.*

- 2.25 Children and young people that visited their GP for contraceptive or sexual health advice and support however, were not routinely assessed for the risk of child sexual exploitation. Neither GP practice was using the suggested Greater Manchester CSE tool to aid assessment of risks to young people who were sexually active. Further work was needed to help develop the role of GPs in supporting the identification of children and young people at risk of child sexual exploitation. (**Recommendation 2.3**)

3. Child protection

- 3.1 Pathways into MASH were flexible and sought to promote a 'No Wrong Door' approach. Safeguarding health professionals located in the MASH provided good oversight of local safeguarding arrangements within health. They were effectively engaged in strategy discussions alongside partner agencies, and quickly co-ordinated a range of health information to inform decision-making. They ensured frontline health professionals were kept well-informed about new and emerging risks to children and young people.
- 3.2 The Pennine Acute Hospitals NHS Trust was an early adopter of the child protection information sharing system (CP-IS). Hospital staff were able to easily identify and shared information with relevant others about children attending its hospitals on child protection plans or who were looked after. Work in progress to include children and young people placed in the area and cared for by independent sector providers should further strengthen safeguarding arrangements for looked after children. Children and young people identified as children in need or at risk of CSE were not yet flagged on CP-IS.
- 3.3 Midwives were expected to see pregnant women on their own and ask about domestic abuse as part of routine enquiry about their safety and that of their unborn baby. Midwives were expected to clearly record the woman's response and acknowledge completion of routine enquiries on the ante natal summary record. However, our review of maternity records indicated midwives were not routinely enquiring and/or recording the outcomes of such enquiry in line with NICE guidance. (**Recommendation 8.2**)
- 3.4 Midwives had received training and recognised their professional accountabilities for reporting FGM. New guidelines recently published by the Greater Manchester Safeguarding Partnership were being implemented within the Trust. Data seen identified indicated a steady increase in the numbers being reported with increased understanding of risk to women and young girls within the local community. Arrangements were in place to ensure women received appropriate clinical care and treatment.
- 3.5 Midwives were able to refer women for pre-birth assessment by children's social care at any stage of a woman's pregnancy. This flexibility was positive, as up to recently, arrangements did not allow sufficient time for a comprehensive assessment of women and their partners; or for an agreed multi- agency birth plan to be put in place prior to the baby's delivery. This had been an area for improvement identified in our last inspection in Oldham.

- 3.6 Midwives routinely contributed to the completion of pre-birth assessments alongside other relevant professionals. They told us however that the completed plan was not always shared with them by children's social care. Midwifery records seen generally provided a clear outline of actions required to protect women and their babies during their stay in hospital and reflected decisions that had been taken about the baby's future care arrangements.
- 3.7 Child health professionals including midwives, health visitors and school nurses regularly attended and actively contributed to child protection meetings. They routinely provided written reports to conferences outlining their concerns. Frontline health professionals were aware of the LSCB escalation policy and used it appropriately to flag any key points of professional difference of opinion in relation to the safety of children. Most child protection reports seen, whilst they provided good detail about levels of contact and activity; did not sufficiently develop analysis of risks and protective factors or explore children's views and experiences. Such reports would benefit from a more succinct analysis of the impact for children; with greater attention paid to promoting the voice of the child/young person as an integral part in helping to inform their professional opinion. **(Recommendation 3.4)**
- 3.8 The caseloads held by school nurses in Oldham were significantly higher than recommended levels. School nurses were expected to complete a comprehensive health assessment for all children that were made subject to a child protection plan. However, we found limited evidence of such health assessments being completed in line with local guidance. The role and contribution of school nurses in child protection meetings was the subject of further discussions with the LSCB. Given some of Oldham's families had a relatively large number of children; getting the right level of health representation was important. **(Recommendation 6.2)**
- 3.9 GPs contributed to child protection case conferences verbally if timescales were limited, or in writing by completing a report. Reports seen demonstrated that the templates used did not provide sufficient direction, with no requirement for GPs to identify and analyse safeguarding risks and protective factors for children. There were no routine quality assurance processes in place to analyse the contents shared. **(Recommendation 3.4)**

- 3.10 Although chronologies were in place on most health visiting and school nurse records seen; they were of a variable standard and were not kept up to date in some cases. Community health professionals had received training in the use of genograms and were expected to use this as a tool for identifying all household and wider family members who had contact with children. Whilst we saw it being effectively used by a safeguarding health professional at a strategy meeting, its use was not yet fully embedded in practice. In another case we tracked, the absence of a genogram in the work of a health visitor may have contributed to insufficient consideration of the role of the father and whether they were likely to pose risks or to be a protective factor for children. On a few case records we also saw a neglect tool had been used to good effect. However, further work was required to ensure these approaches routinely informed the practice of all frontline community health professionals. (**Recommendation 6.3**)
- 3.11 Sexual health practitioners demonstrated prompt and effective liaison with children's social care when they identified concerns in relation to a young person's age, consent or safety. The Brook sexual health service was vigilant to risks to young people presenting with sexually transmitted infections (STI's). In one case we tracked of a 19 year old young woman, a check of previous presentations within the Greater Manchester area revealed her ongoing vulnerability given a high number of previous STI's which had been identified from an early age.

Case example A 15 year old young person was recently seen by the Positive Steps Alcohol Liaison Nurse who worked for the Integrated Substance Misuse and Sexual Health Service. She said she had unprotected sex with a male aged 17 in a park. She was a looked after child and was also being supported by the young person's substance misuse service OASIS. The young person was deemed to be Fraser competent. She advised that the care home staff were not aware of this event. The Brook worker encouraged her to give her consent for this information to be shared with the care home. The young person had been referred to the Phoenix team the previous week.

She attended Positive Steps again just a month after first visit and reported unprotected sex with a different partner aged 24 years. All relevant professionals were informed with action promptly taken to safeguard her.

- 3.12 Since April 2015, Positive Steps and Brook sexual health service received a list of young people known to be at risk of CSE on a weekly basis from the Phoenix CSE Unit. This was helping to support effective risk assessment within the service as a range of "cautions" or flags were routinely added to young people's sexual health case record alerting practitioners to have heightened vigilance if the young person presented for sexual health advice and support.

- 3.13 Virgin Integrated Care however did not receive information from Phoenix about young people known to be at risk of CSE. It was not clear why this information was not shared with this provider to inform their risk assessment as Virgin Care services was also accessed by large numbers of young people, some of whom may also be accessing Brook. *This was brought to the attention of the Director of Public Health as commissioner of sexual health services.*
- 3.14 In One Recovery Oldham, there was good use of flags on the client record system to immediately alert practitioners and managers that there were known safeguarding concerns in the case. However, copies of safeguarding referrals were not retained. Operational supervisors and managers were therefore not able to quality assure referrals being made to the MASH. **(Recommendation 3.3)**
- 3.15 One Recovery Oldham was actively engaged with multi agency risk assessment conference (MARAC) arrangements and routinely attended multi-agency meetings. There was a clear management expectation that practitioners attended core groups and child protection conferences and we saw case evidence supporting this. However, written reports to case conferences were only submitted if the practitioner was unable to attend and this is not in line with best practice. **(Recommendation 3.4)** *This was brought to the attention of the Director of Public Health as commissioner of adult substance misuse services.*

4. Looked after children

- 4.1 Partnership working between local health services and children's social care was generally good. Health visitors were involved in social care led statutory reviews for looked-after children which enabled them to be well-informed of any changes to the care arrangements of children looked after, including plans for adoption. We identified an issue in relation to information-sharing between the Council and the looked after children (LAC) specialist health team which had drifted for some time. This was resolved during our visit. Further work was required by the specialist LAC health team to develop a robust and efficient management information system to enable key information about their care status and health needs to be effectively managed. (**Recommendation 4.6**)
- 4.2 Initial health assessments (IHAs) were routinely undertaken by a speciality doctor paediatrics, the named doctor, in Pennine Care, with oversight by the designated looked-after children doctor. Where there had been repeated failure to attend appointments, initial health assessments were undertaken by a Specialist Nurse. On a few occasions, from cases seen of IHAs undertaken by specialist nurses, the records did not clearly evidence if IHAs had been initially offered by the paediatrician; or what had led to the decision for these to be carried out by nurse practitioners given statutory guidance expects this work to be undertaken by a registered medical practitioner. Performance data did not provide a clear picture about the extent of this practice. (**Recommendation 4.2**)
- 4.3 At the time of our visit, the specialist looked after children nurse was absent from work, which led to a gap in management oversight of the quality of review health assessments (RHAs) for Oldham children placed out of area. Local practice within the LAC health team had been that after sharing full documentation with children's social care; photocopies of Parts A and B of the assessment record were destroyed, retaining only Part C, the child's health care plan. This meant that the child's health record was incomplete, and did not comply with record-keeping standards. In addition, health managers could not be assured that a comprehensive assessment of the child's health needs had been carried out, that the assessment was child-centred, and that the health plan had been sufficiently tailored to meet the child's ongoing health needs. Destroying the record significantly hindered further review of young people's health and wellbeing through time and placement changes to clearly evidence risks and whether health outcomes for looked after children and care leavers were improving. Since the inspection visit, the full child health record, including photocopies have been retained. (**Recommendation 4.4**)

- 4.4 Senior leaders from health and social care recognised further work was needed to better understand the health care needs of children placed by other councils within Oldham. This included their access to and impact on the capacity of local health services. The capacity of the specialist health team to provide targeted work with children living in residential homes (local authority and independent sector provision) was limited and this had been identified by the Designated Nurse as an area to strengthen. **(Recommendation 4.7)**
- 4.5 Although the capacity of paediatricians working in Oldham was stretched, priority was given to looked after children's health work, with most IHAs completed within the required timescales. Performance reports indicated a good level of compliance overall for initial and review health assessments completed within statutory timescales.
- 4.6 We found inconsistencies in practice in the recording the consent of those with parental responsibilities and of the child/young person themselves. In a few cases, it was evident that the young person was able to give consent, and this was clearly visible; in others however, only verbal consent appeared to have been given, including by those with parental responsibility. **(Recommendation 4.1)**
- 4.7 Casework seen indicated sensitive and creative approaches underpinned the work of school nurses in engaging children and young people. However, most looked after children health records did not provide a holistic picture of the young person's needs and the things that mattered most to them. The words of the young people were not routinely captured in IHAs or RHAs to help strengthen the voice of the child. **(Recommendation 4.5)**
- 4.8 We found some key gaps in the quality of and quality assurance of initial and review health assessments. Whilst good attention was paid to children's physical health needs; records did not sufficiently provide details of family history or children's emotional health and mental wellbeing. Practitioners completing assessments did not routinely include the ethnicity or religion of birth parents or of the children themselves. In one case seen of an unaccompanied asylum seeker, significant improvement was needed to provide a clear picture of their identity and needs. Health professionals required further development to ensure holistic assessments were undertaken that reflected the diverse backgrounds, needs and experiences of children looked after. **(Recommendation 4.5)**
- 4.9 There was a clear expectation that the child's GP would be invited to contribute to the IHA but this was not seen on case records we checked. Although GPs were routinely sent a copy of the child's health care plan (Part C), they did not receive a copy of the child's complete health assessment. As the GP potentially holds important information about the health of a young person and or/their wider family, not sharing the comprehensive record limited their awareness of the health needs and vulnerabilities of looked after children. **(Recommendation 4.3)**

- 4.10 Most health plans had loose timescales and mainly contained a task-focused list of actions rather than measurable objectives. They required further development to promote holistic care and secure a consistently SMART approach in relation to identifying outcomes, accountabilities, timescales and expected impact. Gaps in this area detracted from the effectiveness of any follow up review and monitoring activity undertaken. **(Recommendation 4.5)**
- 4.11 Young people who were looked-after with emotional, mental health and behavioural needs had good access to a Healthy Young Minds consultation service. Casework seen indicated good support for foster carers at an individual level or through attending a comprehensive therapeutic training programme. This approach positively promoted the voice of the child and helped carers strengthen their awareness, understanding, and coping capacity.

Good Practice in the work of Healthy Young Minds

The work of the clinical psychologist in the Healthy Minds team provided a clear and sensitively tailored approach to hearing the voice of children. Children and young people were helped to reflect on their feelings and behaviours which included sharing some painful feelings about their relationships with their own parents and siblings, enabling them to have greater control over what they wanted to see happen. This included a young person being appropriately informed about and supported in making decisions about gender change.

Parents, foster carers and relevant others such as teaching staff were effectively engaged in building a shared understanding of the child's presentation in a range of settings to more clearly define the underlying causes of children's needs. For example an initial referral for attention deficit hyperactivity disorder (ADHD) was attributed to poor attachment and led to a review of the quality of care provided within a kinship care arrangement.

The Fostering Attachment Group training programme co-delivered by Healthy Young Minds and a children's social care team manager ensured good recognition of children's emotional and mental health and a strengthening of foster carers' awareness and capacity to deliver safe and nurturing care.

- 4.12 Access to specialist Healthy Young Minds support for those young people who required more intensive, individualised work was also good. However, our review of Healthy Young Minds case records demonstrated limited contact by the LAC specialist health team to promote their contribution to assessments and joint review of the planned outcomes for children. Strengths and Difficulties Questionnaires (SDQs) were seen on most looked after children health records, but these were not yet being purposefully used to evidence progress in promoting children's self-esteem and resilience. The need to strengthen awareness of looked after children using the Healthy Young Minds service had been flagged as an area for further development in the LAC annual report in January 2016. (**Recommendation 4.3**)
- 4.13 Positive Steps provided a valued space for looked after children and care leavers where they could access a wide range of information, advice and support. The health offer to care leavers in Oldham was still relatively under-developed at the time of this inspection. However, a significant programme of co-production work had taken place over the past three years to build the confidence of young people and ensure health and social care managers actively listened to and learned from young people's experiences. The development work was centred in 'bringing to life' promises in the Council's Pledge to young people in its care. Young people attending the Children in Care conference last year identified three key priorities for the development of local health services. These included mental health information and support, good access to support and advice on sexual health and to medical care once they left care.
- 4.14 Although this work has taken some time to come to fruition, it reflected the joint efforts being made to embed a new culture to transform the experience and outcomes for young people leaving care. An impressive new offer '*Passport to Independent Living*' was nearing completion which should provide a comprehensive young person-centred approach to promoting care leavers' health and wellbeing. It was envisaged that the new passport would be co-developed with the young person from age 14 onwards, with young people actively contributing to its contents. Positively the new approach also recognised the role primary care could play in supporting young people to maintain good mental and physical health. The leadership and championing of this work by young people was impressive and has been nationally recognised.

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 NHS Oldham CCG was strengthening and consolidating its safeguarding leadership and organisational capacity. A review of the CCG staffing establishment was carried out by the newly appointed Head of Quality & Safeguarding and agreed by the CCG in July 2015. This led to the appointment of the two associate designated nurse posts in early 2016, the Associate Designated Nurse for Looked After Children and the Associate Designated Nurse Safeguarding Adults. These posts provided important additional capacity to help drive improvement across the local health system and support wider partnership working. The safeguarding forum led by NHS England provided good support for designated professionals in the Greater Manchester region with evidence of sharing of capacity and expertise in supporting the implementation of new safeguarding agendas.
- 5.1.2 There remained some key gaps however, in the CCG's staffing establishment as set out in the NHS Assurance Framework and inter collegiate guidance that it was working to fulfil. These included the appointment of an Executive Nurse and Named GP to complement and support the leadership work undertaken by the Head of Quality and Safeguarding and the CCG executive lead GP for safeguarding. The capacity of designated and named doctors for safeguarding and looked after children was an area to further strengthen in line with inter collegiate specifications and recommendations from the review undertaken by the Royal College of Paediatric Child Health (RCPCH).
(Recommendation 1.1)
- 5.1.3 The new designated nurse post holders had taken forward a number of actions to strengthen strategic oversight and address recognised gaps in the quality of assessment and care planning for looked after children and care leavers. The Head of Quality and Safeguarding as chair of the LSCB Serious Case Review sub-group promoted shared recognition and ownership of the required improvements in safeguarding practice spanning acute, community health and primary care. The 7 minute 'lessons learned' serious case review briefings were commended by a number of frontline health professionals we met.

- 5.1.4 A local safeguarding forum was being developed to raise awareness and help improve the quality of safeguarding practice in primary care. The lead GPs we met demonstrated a strong commitment to improving child safeguarding practice. We saw that both practices had child safeguarding policies and guidance in place that were accessible to staff. All general practices were reported to have a lead GP. However, as the earlier sections of this report highlight, a significant programme of work was still required to promote wider awareness of the accountabilities of GPs and strengthen their contribution to local child safeguarding arrangements.
- 5.1.5 Named safeguarding leads in NHS provider trusts were actively engaged in a number of service development and training lead roles. Action recently taken to involve senior midwifery expertise in the work of the LSCB addressed a previous gap in local partnership arrangements. The strong leadership demonstrated by the safeguarding health professionals within the MASH was valued by frontline staff and partner agencies.
- 5.1.6 Oldham's performance against areas for improvement identified in the NHS England benchmarking activity for looked after children had significantly improved; with plans in place to address the remaining gaps. The recently established multi-agency Task and Finish group for looked after children aimed to promote further improvement in local operational arrangements. Given the size of the improvement agenda, further consideration needed to be given to the development of a longer term operationally focused multi-agency group to embed the development agenda across the wider partnership.
- 5.1.7 Oldham's locality plan provided a clear and ambitious framework for the delivery of its early help offer. However, as the early section of this report highlights, further work was required to clearly specify the role and contribution of all child and adult health professionals to help achieve the required levels of responsiveness and impact for children and their families; making best use of all available capacity, expertise and resources.
- 5.1.8 Oldham's first annual report of early help work (June 2016) indicated promising results. Data indicated 92% of families remained voluntarily engaged with the early help programme, with low re-referral rates of 3%. Positive outcomes included a decrease in levels of anxiety and depression, with evidence of some high level concerns being effectively de-escalated and managed safely at an early help level without the need for multi-agency statutory intervention. A recent marked reduction in the rates of teenage conceptions was to be commended given rates in Oldham previously were amongst the highest in England.
- 5.1.9 Oldham CCG worked closely with neighbouring CCGs to promote shared oversight of the performance, safety and quality of NHS providers in common. Oldham CCG was making good use of commissioning for quality and innovation (CQUIN's) and 'Boilerplate' initiatives to encourage service improvement.

- 5.1.10 Health commissioners and providers were increasingly listening to and seeking to learn from the experience of children and their families. We saw good practice in a number of areas where young people had been actively involved in shaping the development of local services. This included work to expand the young person's mental health offer; young person-centred work undertaken by Positive Steps; new developments in leaving care preparation and young advisors work at Royal Oldham Hospital to help promote a young person-centred environment and care delivery.
- 5.1.11 The recent transition of community health professionals to a new provider appeared to have been managed well with frontline staff pragmatically adjusting to the ongoing changes. However, prompt action was needed to appoint to posts in the school nursing service given current pressures and priorities yet to be delivered as highlighted in earlier sections of this report.
- 5.1.12 Positive Steps and the Brook sexual health services were effectively engaged in multi-agency CSE arrangements and were members of the sub-group of the LSCB and the operationally focused 'vulnerability' group. The vulnerability group positively used case examples to successfully identify and resolve blockages between services in information sharing and co-operative working. The group was working to strengthen its "Team around the Child" approach for young people who frequently accessed a range of different services; recognising they may not sustain their engagement well with any one service. Virgin Care was not a member of either leadership group. This warranted further consideration by partner agencies. *We brought this to the attention of the Director of Public Health as the commissioner of sexual health services.*
- 5.1.13 Operational managers in adult mental health services had good oversight of the cohort of children known to be vulnerable or subject to child in need and child protection arrangements through its weekly 'zoning' meetings. However, locality managers in child health services did not have this information easily available to help them recognise children and young people in their area who were at risk of abuse or looked after. This was essential to their being able to effectively deploy their workforce to meet local priorities and ensure a proactive response to changes in demand. **(Recommendation 6.4)** *We also brought this to the attention of the Director of Public Health as the commissioner of community health services.*
- 5.1.14 The named midwife was visible to frontline practitioners in Royal Oldham Hospital. The Trust 'walkabouts' by senior managers were interactive and enabled the safeguarding team to be aware of any current issues for midwives and to test out their practice. If common themes were identified, this led to the development of an action plan.

5.1.15 The routine management review of cases dealt with on the previous day within Brook sexual health service was a particular strength. This ensured that any safeguarding concerns about a young person were promptly identified and that actions taken were appropriate to protect the young person. Brook Oldham made good use of its national database of under 21 year olds known to be vulnerable; recording all visits, actions taken and outcomes. This supported strong vigilance of young people who may represent in different areas.

5.2 Governance

- 5.2.1 Serious case reviews were underpinned by a comprehensive improvement framework. We found good ownership by health leaders with clear accountabilities for delivering improvements in practice and ongoing review of progress. Lessons being learned included the need for greater vigilance to co-sleeping and the behaviours of adults misusing drugs and alcohol, strengthening the voice of the child, and engagement of GPs. As highlighted in earlier sections of this report; whilst good progress was being made in some areas in supporting partnership learning; joint working and recognition of the vulnerability of some children was not yet sufficiently secured within the practice of frontline child and adult health professionals.
- 5.2.2 The Section 11 audit work (required under the Children Act 2004) indicated most safeguarding standards were being met by local NHS bodies; with evidence of ongoing work to raise awareness about PREVENT amongst the local NHS workforce and promote early identification and support to children and families at risk of radicalisation. Section 11 audits positively also recently included representation from young people in reviewing the role and contribution of local health agencies to keeping children and young people safe. Young people were able to challenge CCG Board members about evidence of compliance and provided a helpful overview from a young person's perspective on the standards required.
- 5.2.3 The LSCB was taking further action to test the evidence submitted in Section 11 audits. Audits were increasingly used across the partnership and within agencies to provide a detailed picture of performance and of progress made in addressing the local safeguarding improvement agenda. These included reviews of the quality of practice spanning the use of thresholds, children with disabilities, domestic abuse, neglect, CSE and early help; with equality and diversity woven into each programme of work. A recent MASH audit provided good assurance that consent was being appropriately managed to support sharing of concerns.
- 5.2.4 The audit work based on the Greater Manchester safeguarding tool for GPs was nearing completion, and should enable further analysis and prioritisation of improvement work to strengthen the contribution of GPs to local safeguarding arrangements. The training strategy and performance dashboard being developed by the CCG in partnership with local GP practices should enable effective tracking of progress. However, the pace of change was likely to be dependent on securing additional capacity to support the development work. (**Recommendation 1.1**)

- 5.2.5 The gaps against the required standards in the quality of initial and review health assessments for looked after children had been identified in an audit of work; with priority attention given to the experience of Oldham's children placed out of area. Pennine Care's service specification was being reviewed at the time of our visit in recognition of the capacity challenges identified in the review undertaken by the Royal College of Paediatric Child Health (RCPCH).
- 5.2.6 We found a number of areas where the record keeping of community health professionals required improvement with stronger management oversight to ensure the required standards were achieved. Community health services were still using paper records, with some key gaps in quality as highlighted in the earlier sections of this report. Such records did not consistently provide a clear or up to date picture of risks to and of the needs of children. An audit had been undertaken by the previous provider in November 2015; but follow up actions had been put on hold given the significant programme of work required to transfer the workforce to a new provider. All children's records needed to be appropriately maintained to support transition to the new electronic case management system in 2017. (**Recommendation 6.5**)
- 5.2.7 Midwives completed special circumstances forms for the purpose of information sharing, and updated these when they identified new areas of concern that were then shared with children's social care. This required the midwife to RAG rate each form to indicate the level of priority. On the whole, we saw good use made of RAG rating within midwifery records that reflected escalating or de-escalating concerns. However, there were a couple of cases where the outcome of their referral had not been captured which in turn had not resulted in further review of the priority rating.
- 5.2.8 The quality and interface of IT systems detracted from efficient and in some cases, safe working practices. This related particularly to the PARIS system used within adult mental health services. Although the adult mental health electronic record system had the facility for alerts or flags to be put on individual client records, we were told that this was mainly done to alert for forensic risk or clinically focused risk. We did not see flags being used to alert staff and managers that there were vulnerable children or children subject to child in need or child protection arrangements in individual cases and this was a significant gap, given the other challenges presented by this recording system. (**Recommendation 7.1**)
- 5.2.9 MASH health arrangements would also benefit from greater connectivity across health and partner agencies to promote more efficient information sharing and tracking of outcomes. The Pennine Acute Hospitals community midwives had to make a visit to the hospital base to access the complete record that contained information such as child protection plans or special circumstances forms. The Trust advised that whilst community midwives visited the hospital daily as routine practice; having IT access to the complete midwifery record whilst in the community would support proactive oversight and monitoring of concerns. (**Recommendation 7.1**)

- 5.2.10 Information governance within primary care in relation to vulnerable children and their families required further development. Some documents such as health care plans and other correspondence sent to the surgery as an attachment were uploaded directly into the child's record, and may not have been reviewed by a GP. In one practice we visited, the safeguarding lead GP was not confident that correspondence received and managed in this way was being reviewed to the same standard as other correspondence dealt with using the document manager application. There was a recognised risk that such information was rendered invisible and would not inform any care planning or oversight of children's needs unless it was actively searched for. (**Recommendation 5.1**)
- 5.2.11 Vulnerable family meetings were not consistently held by GPs in Oldham. This approach was promoted in one of the two practices we visited with good engagement by the link health visitor. However, records made about ongoing child and family concerns were not placed on the child's record to inform follow up monitoring and review of outcomes. (**Recommendation 5.1**)

5.3 Training and supervision

- 5.3.1 Pennine Care NHS Foundation Trust had a comprehensive programme of training for its child and adolescent mental health staff with good coverage of training for staff working with children in line with intercollegiate requirements. However, we found adult mental health clinicians, in particular, would benefit from additional training to enable them to have a more up to date and fuller understanding of *Working Together* (2015) requirements. (**Recommendation 9.2**)
- 5.3.2 Supervision arrangements in Pennine Care were provided 1:1 on a monthly basis and promoted a strong focus on safeguarding children and of parental capacity. However, from cases seen of the work of clinicians, 'Think Family' considerations need to be strengthened. Records of supervision were included on child and adult patient records seen. The three monthly multi-disciplinary forum held by adult mental health and Healthy Young Minds, led by Pennine Care safeguarding team and the specialist perinatal mental health midwife provided a good opportunity for reinforcing the local safeguarding culture through sharing knowledge and learning together. These meetings were also well attended by health visitors.
- 5.3.3 Community health professionals, now managed by Bridgewater Community Health Care, had good and ongoing access to a wide range of safeguarding children training to support their continuous professional development. Preceptorship arrangements were well managed for newly qualified health visiting and school nursing staff. Our review of case records indicated the need for further development of community health staff in the areas of record keeping and delivery of LAC health work. (**Recommendation 6.5**)
- 5.3.4 Although Pennine Acute Hospitals NHS Trust safeguarding children training against intercollegiate standards at level 2 overall was good, coverage of level 3 in its Women and Children Division fell below expected levels of performance. Gaps in performance against Trust targets were monitored and there was an improvement plan in place to address this. Additional training sessions had been delivered for paediatric, maternity and neonatal staff in the last quarter.
- 5.3.5 Pennine Acute Hospital's safeguarding supervision guidelines outlined a number of ways frontline staff could be supported to reflect on their practice. Emergency department frontline staff reported good access to advice and support from senior colleagues and the Trust safeguarding team. Peer reviews were convened by the Head of Safeguarding in accordance with Royal College of Paediatric Child Health (RCPCH) requirements and were open to everyone within its emergency departments.

- 5.3.6 Specialist midwives had access to safeguarding children supervision on a quarterly basis. The named midwife, the supervisor of midwives or manager could be approached to offer support, however, uptake was reported to be variable. Caseload holding midwives did not benefit from regular access to safeguarding supervision. Supervision arrangements required strengthening to provide further assurance of the quality of safeguarding work.
(Recommendation 8.3)
- 5.3.7 Safeguarding professionals in the MASH had responsibility for the delivery of safeguarding children supervision to frontline community health professionals. In recent months however, one to one supervision had not been maintained due to a vacancy within the MASH health team that had been put on hold whilst the workforce transitioned from one employer to another. Group quarterly supervision was provided in the interim. At the time of this inspection, action was being taken to strengthen the model of safeguarding children supervision and to ensure all staff involved in delivering supervision received appropriate training. New supervision templates were being introduced which should help strengthen the focus on individual competencies and the impact of work to safeguard children- an area of recognised weakness in current arrangements.
- 5.3.8 The CCG recognised and promoted a range of safeguarding learning and development opportunities for GPs and their practice staff. All lead GPs had received training to level 3 against intercollegiate requirements. Over the past year, the Head of Quality and Safeguarding had facilitated a number of training events to raise awareness and strengthen compliance with information-sharing and reporting responsibilities. Arrangements to check the child safeguarding compliance and competence of locum staff used in primary care were not robust. Further development work was planned in the light of learning from the recent audit. Safeguarding supervision within primary care in Oldham was at a relatively early stage of development.
(Recommendation 5.2)
- 5.3.9 Practitioners in the adult substance misuse service received 1:1 supervision on a monthly basis. All cases held by the practitioner which had been rated and scored as having risks were reviewed in supervision. However, where cases were discussed in supervision, this was not noted on client records.
(Recommendation 11.1)
- 5.3.10 All Virgin Integrated Care clinical staff were trained to level 3 although this was single agency only. Service managers were aware that multi-agency training should be undertaken and were working with the lead commissioner for the local service (Rochdale) to address this. Both sexual health service providers were strengthening their safeguarding supervision arrangements. This was resulting in the provision of regular support to help practitioners in the discharge of their safeguarding responsibilities in what is an increasingly complex safeguarding landscape with highly vulnerable young people.

Recommendations

- 1. NHS England together with NHS Oldham CCG together with Pennine Care NHS Foundation Trust and local GPs should:**
 - 1.1 Address existing gaps within Oldham's designated and named doctors' workforce for safeguarding and looked after children; to provide additional capacity and expertise in meeting the needs of vulnerable children.

- 2. NHS England together with NHS Oldham CCG together and local GPs should:**
 - 2.1 Ensure comprehensive health and social circumstances information about children and families is gathered at the point of registration to inform ongoing review of the vulnerability of children and families.
 - 2.2 Consistently use read codes to strengthen identification of risks to children and young people living in households where mental health, substance misuse or incidents of domestic abuse are known.
 - 2.3 Ensure all general practice staff involved in contraception and sexual health work are fully aware of and use an appropriate assessment tools to identify children/young people at risk of child sexual exploitation.
 - 2.4 Ensure GPs are routinely contributing to child protection conferences using a template to support consistent practice in enabling good analysis and articulation of risk, with appropriate quality assurance to ensure the required standard is achieved.

- 3. NHS Oldham CCG together with local GPs, Pennine Acute Hospitals NHS Trust Bridgewater Community Healthcare NHS Foundation Trust, Pennine Care NHS Foundation Trust and One Recovery Oldham should:**
 - 3.1 Further review their role and contribution to the delivery of early help; enabling effective alignment of activity across the whole health system in partnership with other agencies to strengthen the impact of preventative work.
 - 3.2 Ensure regular and effective sharing of information about risks to children where parental mental health or substance misuse is impacting on their safety and wellbeing.

- 3.3 Ensure multi-agency referrals are underpinned by a clear analysis and articulation of safeguarding risks and of the voice of the child to support timely and effective decision-making and follow up; and that of the outcome of the referral is clearly recorded.
 - 3.4 Ensure reports to child protection conferences provide a succinct analysis of risk and the impact for children; with attention paid to promoting the voice of the child/young person as an integral part in helping to inform their professional opinion.
- 4. NHS Oldham CCG, together with Pennine Care NHS Foundation Trust should:**
- 4.1 Ensure consent is effectively managed and recorded to provide a clear audit trail of those with parental responsibility and recognition of the young person's capacity to consent.
 - 4.2 Ensure initial health assessments of looked after children are undertaken by a registered medical practitioner and provide a comprehensive picture of the child's health needs and their family history to enable effective recognition of their vulnerability with clear actions to address areas of risk.
 - 4.3 Ensure Healthy Young Minds and GPs are actively involved in statutory assessments to enable a comprehensive picture of young people's needs and to inform their role and contribution to the delivery of outcomes.
 - 4.4 Ensure health assessments for children out of area are consistently reviewed and that the full record is retained to provide good assurance that assessments are comprehensive, child/young person-centred and health care plan actions give due consideration to addressing areas of risk and promoting improved outcomes.
 - 4.5 Ensure the voice of the child/young person is clearly evidenced within looked after children health assessments and reviews; that the assessment of their needs is holistic; including in its recognition of the specific needs of unaccompanied asylum-seeking children; and that health care plans are SMART providing a clear picture of desired outcomes, accountabilities and timescales.
 - 4.6 Develop a robust and efficient management information system to enable key information about the care status of looked after children and their health needs to be robustly managed.
 - 4.7 Ensure children and young people living in care homes in the area benefit from targeted support to address areas of risk.

5. NHS Oldham CCG together with GPs should:

- 5.1 Ensure good standards of information governance in relation to the management of child protection and looked after children health records to ensure important information about their vulnerability is not missed.
- 5.2 Ensure all GPs and primary care staff receive ongoing training and supervision to help strengthen the quality of safeguarding practice.

6. Bridgewater Community Healthcare NHS Foundation Trust should:

- 6.1 Ensure its community health professionals routinely capture demographic details about children and their families' faith and ethnicity to support the provision of holistic person-centred care to all community members.
- 6.2 Provide a comprehensive health assessment for all children subject to child protection plans so that their health needs and progress can be closely monitored.
- 6.3 Ensure frontline community health professionals appropriately use chronologies, genograms, CSE and neglect tools to strengthen identification of risks and inform their safeguarding practice.
- 6.4 Strengthen management oversight of children in need, children on child protection plans and children who are looked after to support the effective deployment and review of local capacity.
- 6.5 Progress improvement work to raise the standard of record-keeping practice and ensure records are appropriately maintained in preparation for the transition to electronic records in 2017.

7. The Pennine Acute Hospitals NHS Trust and Pennine Care NHS Foundation Trust should:

- 7.1 Further develop their IT systems to ensure they are fit for purpose enabling ease of access to relevant information to enable them to remain vigilant to safeguarding children concerns.

8. The Pennine Acute Hospitals NHS Trust should:

- 8.1 Ensure further enquiries are routinely made about children who 'left without being seen' and that the parenting responsibilities of all adults with mental health, substance misuse or domestic abuse issues are clearly identified to inform risks to children.

8.2 Make routine enquiries about domestic abuse and ensure the outcome is clearly recorded in line with NICE guidance to enable women to share concerns about risks to them or their babies.

8.3 Ensure all midwives benefit from regular safeguarding children supervision to enable them to reflect on and continuously enhance their safeguarding practice.

9. Pennine Care NHS Foundation Trust should:

9.1 Further review its adult mental health policy and practice to ensure local care arrangements sufficiently recognise child safeguarding issues; and ensure mental health professionals are fully aware of and involved in relevant child in need and child protection activity to help embed its 'Think Family' approach.

9.2 Ensure its mental health clinicians have a good up to date awareness of Working Together (2015) requirements so that safeguarding children is effectively woven into clinical practice.

10. Brook and Virgin Integrated Care should:

10.1 Ensure multi-agency referrals are underpinned by a clear analysis and articulation of safeguarding risks and of the voice of the child to support timely and effective decision-making and follow up; and that such referrals are quality assured to promote a consistently high standard of practice.

11. One Recovery Oldham should:

11.1 Ensure a record of supervision discussion is placed on adult case records to promote a stronger focus on risks to children and young people and provide a clear reference point for management actions to protect children

Next steps

An action plan addressing the recommendations above is required from Oldham 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.