This report relates to the recent integrated inspection of safeguarding and services for looked after children which took place in the above Authority recently.

It provides more detailed evidence and feedback on the findings from the Care Quality Commission’s (CQC) component of the inspection, and links these to the outcomes requirements as set out in the Essential Standards for Quality and Safety.

Thank you for your contribution to the inspection and for accommodating the requests for interviews and focus groups with your staff and those of partner agencies at relatively short notice.

The team provided feedback to your local Director of Children’s Services at the end of fieldwork and the joint inspection report to the authority is now published on the Ofsted website and can be accessed via this link: The joint inspection report.
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This report includes findings from the overall inspection report, and provides greater detail about what we found, mapped where relevant to the Essential Standards, in order that your organisation can consider and act upon the specific issues raised.

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

*In respect of the recommendations in the report, please complete an action plan detailing how they will be addressed and submit this to CQC and your SHA Chief Executive within 20 working days of receipt of the final report.*
The Inspection Process

This inspection was conducted alongside the Ofsted-led programme of children’s services inspections. These focus on safeguarding and the care of looked after children within a specific local authority. The two-week inspection process comprises a range of methods for gathering information – document reviews, interviews, focus groups and visits – in order to develop a corroborated set of evidence which contributes to the overall framework for the integrated inspection.

CQC contributes to the inspection team and assesses the contribution of health services to safeguarding and the care of Looked after children relating to that authority. Our findings from the inspection contribute to the joint report published by Ofsted and also enrich the information we use to assess providers against the Essential Standards of Quality and Safety. This report sets out specifically the evidence we obtained in relation to these standards and extracts from the published report are included and identified.

CQC used a range of documentary evidence in advance of and during this inspection, and interviewed individuals and focus groups of selected staff and, where possible, children and young people, their parents and carers in order to provide a robust basis for the findings and recommendations.

This document sets out the findings in relation to the organisations listed above, but includes some areas which apply to one or more other NHS bodies where pertinent.
Context:

Health and wellbeing in Oldham has been improving for many years, this is demonstrated in the steadily increasing life expectancy. Infant mortality, another key indicator of a population’s health, also improved from the mid 1980s and showed an improving picture of health which was sustained until the mid 1990s. However, persistent deprivation is a constant challenge to improving health and wellbeing. The health of the Oldham population is poor, relative to others in comparison with the national average. Oldham has a higher proportion of people aged 15 or under and lower proportions of the population aged 65 or over, 18 per cent of the population are from Black and Minority Ethnic (BME) groups. Within the 0-15 age group, 29 per cent of the Oldham population are from BME groups.

Since 2001, NHS Oldham covers the same area as Oldham Council which has a resident population of approximately 219,600. For a number of years NHS Oldham and Oldham Council have had effective joint commissioning arrangements in place with aligned budgets were possible to allow service developments were there have previously been gaps, examples include the well established Local Strategic Partnership arrangements in place with child and adolescent mental health services (CAMHS) and with teenage pregnancy, the complex cases panel operates within a shared protocol agreement that allows tripartite funding to be agreed when a placement is required out of the local area.

NHS Oldham, the Council and the community services provider, Oldham Community Health Services (OCHS) have worked in partnership to reconfigure health visiting and school health services to be delivered within a defined geographical area that aligns with the council’s locality delivery model- neighbourhood working. The council’s Associate Assistant Director for Family and Youth Support Services is working one day a week in NHS Oldham within Children’s Commissioning reviewing the health visiting service, it will include a new contract specification to meet local need and improve outcomes for children and their families. Positive Steps Oldham is commissioned by the Council to offer ‘one stop’ shop services for all young people from a universal setting (i.e. with other agencies such as social care, housing and connexions) and also offers targeted support services to young offenders, young people misusing drugs and alcohol and teenage parents.

The approach to integrated commissioning in Oldham is through the development of an integrated commissioning hub with identified priority areas, this approach is supported by Oldham’s Clinical Commissioning Group (CCG) who are working closely with the Council. The CCG and integrated commissioning hub have a specific focus on pathway redesign and maximising quality and value for money, with a clear focus will be on further developing preventative services at community and primary level with the aim of reducing dependence on secondary care and specialist services. Recent work with the CCG has agreed a number of joint priorities: public health, children’s services, carers, and sexual health services.
Commissioning and planning of child and young peoples’ health services and primary care are undertaken by NHS Oldham. Universal services such as health visiting, school nursing, and paediatric therapies are provided primarily by Oldham Community Health Services (OCHS), part of Pennine Care Foundation NHS Trust. The acute hospital providing accident and emergency services for children is the Royal Oldham Hospital, part of Pennine Acute Hospitals NHS Trust. Maternity and newborn services are also provided by Pennine Acute Hospitals NHS Trust. Children and families can access primary care services through one of the forty eight GP Practices (one which provides primary care for an un registered population), thirty five dental practices, thirty one optician’s premises, fifty four pharmacies, an urgent care walk-in facility at the integrated care centre, with an out of hours general practice and an out of hours emergency dental provider. NHS Oldham is the lead Commissioner for the Christie Hospital NHS Foundation Trust, provider of services for those suffering with cancer.

Child and adolescent mental health services (CAMHS) are provided by Reflexions (CAMHS Unit) as part of Pennine Care Foundation NHS Trust, based on the Royal Oldham Hospital site. For children with learning disabilities and difficulties and who have complex health needs, services are provided by Oldham Community Health Services. Safeguarding Children and Looked after Children (LAC) health services are commissioned through NHS Oldham and delivered by OCHS. The LAC school health advisor works alongside the specialist health team based at Positive Steps Oldham and provides access to health care for all looked after children and those that are vulnerable and on the edge of care and care leavers. NHS Oldham has a Designated Nurse for safeguarding, a named board lead for safeguarding and a named GP. During transition accountability for the NHS safeguarding children and adults functions has transferred from the ten locality areas to NHS Greater Manchester (the primary care trust cluster). NHS Greater Manchester is in the process of developing a Greater Manchester Safeguarding Service that incorporates the roles and functions of the designated professionals across the ten localities of Greater Manchester whilst maintaining their local focus and responsiveness. The service will focus on safeguarding adults and children.
1. Health organisations have good, mature leadership and partnerships with all agencies from executive level to front line workers. There are exceptional levels of collaboration between organisations and individual practitioners with the focus remaining on the child’s needs; this is also seen in a number of joint commissioner posts. Services for children remain a priority, with funding being protected for health organisations and the local authority, despite all the organisations undergoing significant changes. There is clear demonstrable evidence of and in some instances ambitious targets and challenges for, improvements to safeguarding services to ensure that children and young people are safe in Oldham.

2. There are high levels of challenge and scrutiny from Children Trust Board, the local safeguarding children board (LSCB) and the LSCB sub groups (some of which are chaired by health managers) trust boards, and the child death overview panel. The Children Trust Board is seen as the key driver for change and influence, with good governance structures and process being effectively led by the Acting Director of Children Service. All actions identified in the last joint area review (JAR) have been addressed by both the Children Trust Board and the newly formed Health and Well-Being Board which has good links and reporting structures with the LSCB. The Director of Public Health is now a core independent member on these boards, providing another level of challenge and scrutiny. The specialist nurse for looked after children has recently become a member of the Corporate Parenting Board, with the aim of improving service design and delivery as well as improving information sharing.

3. All the health organisations’ annual reports for safeguarding children and looked after children comply with statutory guidance and are subject to good levels of scrutiny; action plans and their outcomes are effectively monitored. There are good governance structures and processes effectively monitoring the ‘RAG’ (red, amber and green risks) rated concerns, including those identified within the section 11 safeguarding audits and/or the North West Safeguarding Standards audits used within the main health provider organisations. The North West Safeguarding Standards were, at the time of the inspection, being implemented across primary care. All safeguarding policies are up to date and are aligned to all the LSCB policies, in which the health providers operate, (some health organisations cover four or more LSCBs). The well performing LSCB has addressed earlier concerns over poor attendance and functioning of sub-groups and is influential in improving service design and delivery. Learning from the serious case review has been thorough and is embedded.

4. The Local Strategic Partnership (LSP) has been reformed to the Public Services Board (PSB) with good representation from all public sectors in Oldham. Key themes are identified and communicated through to the Health and Well-Being Board and reported to the LSCB and Children Trust Board. Through effective partnership working issues such as the need for review transitions for young people to adult services has resulted in the formation of a Transition Forum, which aims to address issues in a contemporaneous manner, aiming to improve access to services. However, the autistic spectrum disorders transition to adult service pathway is yet to be realised.
5. There is good use made of the children and young people plan (CYPP) and joint strategic needs analysis (JSNA) with the highly effective use of the commissioning and quality innovations (CQUIN) which are viewed as being key drivers for change. Recent positive changes, as a result of CQUINs, have included the increased use of common assessment framework (CAF) and Family CAF, and ensuring that the ‘voice of the child’ is being heard and influencing decision making at all levels within and across organisations. The JSNA clearly identifies the diverse needs of Oldham’s communities with an increasing black and ethnic minority (BME) population, high levels of deprivation, long term chronic illness and high levels of unemployment.

Outcome 1 Involving Users

6. There are effective communication structures in place with children and young people to express their views within services provided by Pennine Care Foundation NHS Trust (PCFT), the substance misuse service, complex needs services and the sexual health services which include the Brook organisation (independent provider of sexual health services) the latter of which have gained the ‘You’re Welcome’ standard accreditation. CAMH services are implementing, at the time of the inspection, a young person engagement strategy as a result of, and in conjunction with, the effective use of results from the service evaluation questionnaire. The current evaluation shows the CQUIN relating to the ‘voice of the child is heard’ in influences services, is making good progress. There is a high level of engagement with service users involved with the range of substance misuse services to evaluate their experiences, and the impact and changes that have been made to their health and well being. Evaluation outcomes demonstrates that the services are seen as confidential, anonymous, and with a range of accessible settings where treatments and interventions sessions are held which young people report is having a long term positive impact on their health.

7. The New Horizons/Hope Centre, (intensive [tier4] inpatient mental health unit) inpatient information has been developed by service users and has been used successfully in the prevention of stigma felt by service users, related to the use of mental health services.

8. Health histories are inconsistently given to care leavers. However, personal health information is added into the pathway plans, albeit in a limited number of cases; this was being addressed with care leavers at the time of the inspection. There is limited health education information given to all care leavers. Health promotion leaflets are currently being developed along with the Children in Care Council to ensure that they will address the needs of the looked after young people and care leavers.

9. Dental staff have worked with various faith groups and produced a range of health promotion materials such as ‘smile with the prophet’ to improve dental hygiene, however, the effectiveness has yet to be evaluated.
10. All health staff reported good timely access to interpretation services. Substance misuse services make good use of the national FRANK materials, which are, as required, translated into different languages. There is effective monitoring of trends in substance misuse, which show high use of cannabis and alcohol, and increasing trends in the use of anabolic steroids. This is resulting in joint health education and harm reduction programmes being delivered including, in the case of anabolic steroids delivery taking place in the local gyms. The impact of which is yet to be realised. There has been dedicated work with the Imams and Madrasahs to raise awareness of the risk of substance misuse within the local communities, resulting in a range of dedicated health promotion materials being produced.

11. Parental information leaflets have been produced regarding ritual circumcisions, following a serious case review in another authority. However, evidence of the use and impact has not yet been undertaken.

12. The speech and language therapy services have employed bilingual workers who have assisted with the improved assessment of a child’s speech, language or swallowing needs.

Outcome 2 Consent

13. Consent is gained before a looked after children health assessment or review is undertaken; however, this is not always recorded on the British Adoption and Fostering Form (BAFF) which gives the appearance that consent was not sought.

Outcome 4 Care and welfare of people who use services

14. There are highly accessible and well used sexual health services. Although the rate of teenage conceptions remains above comparators, the rate of decline has been significant and better than comparators. There is good collaboration and complimentary services provided for young people, including those from different cultures and genders who are well supported when they access the contraception and sexual health (CASH) and other services, including screening and termination of pregnancy services. There are effective pathways in place, including in accident and emergency services, for the referral to the local sexual assault referral centre.
15. There is strong evidence of good multi-disciplinary practice at strategic and operational levels, including with the voluntary sector. For example, the Messenger Partnership, a sexual exploitation and missing children project, although the effectiveness of Messenger in protecting all young people is less evident and remains a concern for some community health practitioners. Whilst the main focus of Messenger is to identify and deal with the perpetrator, some health staff who spoke to inspectors remained concerned that proactive and preventive work is not always having a direct impact on the behaviour or changing the behaviour pattern of the young person being exploited. Front line community and substance misuse staff interviewed state that prevention strategies and approaches require frequent review to ensure that they are meeting the current/changing cultural and societal needs, which is not currently the case. The OCHS named nurse has recently been appointed as the health member of the Messenger Partnership, with a remit to identify children at risk and the health response for these children and young people, which aims to address some of the front line staff concerns.

16. A recent increase in the number of young men accessing sexual health services has been achieved. The vulnerable and high risk young women and men who are referred to sexual health services are given a good level of ongoing support. Further, work has commenced with unaccompanied asylum seeking children and especially young men who have received little to no sexual health information, to ensure that risk taking behaviour is reduced through sexual health education. This group includes ‘failed asylum seekers’, the impact of this work is yet to be evaluated.

17. There is good partnership working with contraception and sexual health (CASH), dental and substance misuse services offering range of interventions and approaches, including one to one and group work for health promotion activities, and recent joint work with fire brigade, which was rated highly by young people (including looked after young people) in promoting safe environments.

18. Substance misuse services have been a focus of attention due to a local priority to reduce the number of children intoxicated by alcohol, with new posts such as the A&E liaison nurse being appointed. Flexibility of service delivery has resulted in good engagement of the ‘hard to reach’ groups, and those that frequently are known to ‘fail to engage’ with services and programmes of interventions. Young people, through the joint care planning approach, are enabled to take ownership and responsibility for their own treatment, which is extended to those accessing services through the courts, the pupil referral unit, and for looked after young people, which has improved treatment compliance. There are dedicated projects within the black and ethnic minority communities to reduce the barriers in accessing treatments for substance misuse services; resulting in an increase in referrals from these communities.
19. There is an increasingly cohesive approach ensuring that those young people deemed to be of high risk are accessing services through the good partnership arrangements with CAMHs, the CAMHs young offender service mental health workers, (which includes the OASIS service), accident and emergency (A&E) services and for pregnant young women, the community specialist midwife for substance misuse. These partnerships have resulted in effective joint management of substance misuse cases with co-located services improving levels of compliance with treatments. There is good support through a young carers and sibling group of substance misusers ‘COSMO’ with close working arrangements in place and joint home visits with the Family Intervention Project (FIP) workers, resulting in positive outcomes for the young person. There are a range of dedicated educational materials and structures in place to support younger siblings from the age of seven years old, increasing their resilience and preventing them from misusing substances.

20. There is good support for those children, young people with disabilities and/or life limiting conditions and their families. The robust single point of access and referral using the family common assessment framework (CAF) approach is proving to be successful in improving access to services. Services are based on meeting the needs of the child/young persons first; with good family engagement and involvement. The complex needs service staff (health and social care service) are co-located, which has improved information and communication. The service design has enabled flexible approaches to providing services based on individual needs and are not constrained by service structures or the employing authority, this embedded approach to referral, assessment and ongoing treatment intervention encompasses all health and social care services, as well as including therapists and educational staff. This effective use of resources has enabled waiting lists to be reduced and more children and young people to have timely access to services and equipment.

21. There is good access to universal health provision, via a ‘drop-in’ service, ‘Positive Steps Oldham’, which is also used by some care leavers. The service is located in the same building as the social care after care team, which improves access to timely health and well being advice for care leavers up to the age of twenty-one years. The advanced nurse practitioner is able to provide a wide range of health treatments/interventions for all young people and compliments school based services, including sexual health services, emergency contraception and condom distribution or support and advice for a young women should they choose to terminate their pregnancy.

22. There is a well established infant feeding service with dedicated staff for those who are classified as ‘hard to reach’. Oldham is one of only two towns in the country to be awarded baby friendly status. There are a range of well accessed breast feeding groups and peer support with latest data shows that initiation rates have now improved to 68%, which includes an increase in teenagers now breastfeeding. There are now personal health and sexual education (PHSE) dedicated sessions for Asian young women and this now includes breast feeding with the aim of improved initiation rates in the future for this group.

23. There is increasing use of children centres to deliver antenatal sessions and provide support for young fathers, as well as play and stay schemes, aimed at building resilience within new families, however, evaluation shows attendance rates of fathers remains low.
Outcome 6 Co-operating with others

24. The ‘Being Healthy’ judgement is graded as ‘outstanding’. The mature partnership working between looked after children team (LAC) and the social care teams including, the ‘Life Chances’ and ‘Positive Step Oldham’ teams has improved communication regarding looked after children and their access to health services. There is very good communication with the looked after children social care teams, (with some staff being co-located) and the specialist nurse, with weekly updates received regarding the changes in the looked after children population, including those out of area. The specialist nurse and the LAC administrator have direct access to the social care database, which ensures that all ‘changes in circumstances’ are addressed promptly and further ensures a good timely process for all new health assessments, which meet the 28 day requirement, as well as timely ongoing health reviews. The health team manages all the health assessment/review processes, rather than traditionally through social care, which has improved the compliance rates and improved the flexibility of the service being provided for the looked after person and carer.

25. Health assessments/reviews seen during the inspection were of good quality, with very good use made of the strength and difficulties questionnaire (SDQ) and analysis of the scores. However, action plans seen were too frequently not written in SMART terms, i.e. with measureable outcomes. Health files contained copies of the independent reviewing officer (IRO) review reports, conference notes, child protection and other health information, A&E attendances, and CAMHS contacts, providing staff with a very comprehensive information base for which to provide care to the child/young person. There had been, until recently, some delay with out of area health assessments being undertaken, however, since the very recently introduced payment protocols this is improving; all out of areas assessments are well monitored to ensure health needs are met. All initial health assessments are undertaken by a medical practitioner.

26. There is a good range of valued training, including attachment training, for foster carers, residential care home staff and social workers, as part of the dedicated ‘healthy care training’ programme. LAC CAMHS staff are not directly involved with provision of training for new adoptive parents; however, they do provide a well evaluated general emotional well being training. The designated doctor for looked after children provides individual health condition related training/information based on the potential adopters/adoptees needs. This approach has help to ensure suitable matches and that adoptive parents are fully aware of the life long commitment that they are making.

27. The speech and language services provide a range of dedicated services which include those for looked after children, and within schools that specialise in emotional and behavioural difficulties, resulting in timely comprehensive assessments, once the referral has been accepted, the waiting list although reduced to 15 weeks, still remains too long.
28. There is good access to the child and adolescent mental health services (CAMHS) dedicated LAC team, with most referrals being seen for consultations and even some starting interventions within a couple of weeks. The average CAMHS waiting time is 12 weeks, with high risk cases seen within seven days. There is also good access to the dedicated children with complex needs CAMHS team, which is further enhanced by co-location with the complex care team. The team around the child ethos and CAFs are well employed, starting at consultation, and prevent LAC from unnecessary referral to mental health services and becoming stigmatised.

29. There is good governance through the multi-agency Domestic Violence Partnership with regular reporting to the LSCB. Strategic changes achieved include the reduction of the age criteria for receipt of services from eighteen to sixteen years in response to the trend in referrals, and this has prompted health agencies to re-write their domestic abuse procedures in order to align them. The multi-agency referral and assessment conference (MARAC) and the multi-agency public protection arrangements (MAPPA) are both well established, with regularly held meetings with MARAC. The use of the domestic violence notices which do not meet the MARAC thresholds are effectively followed up by community, and maternity practitioners. Maternity staff ensure that pregnant women are asked alone if they have any concerns including if they are being subject to domestic violence. School nurses will ensure that the needs of children who have witnessed domestic violence are also supported.

30. The common assessment framework (CAF) is widely used and understood. The CAF is used effectively for the ‘step-up’ and ‘step-down’ from child protection plans and child in need cases, with appropriate learning leading to developments into Family CAF and Family Plus.

31. Safeguarding Strategy meetings are held promptly and sited to ensure the fullest attendance of key professional staff to enable good decision making i.e. many are now held in hospitals to ensure attendance of paediatricians. There is good involvement of GPs with production of case conference reports, although the time of the conferences in most cases prohibits their attendance due to clinical commitments. There is good timely distribution of the notes of case conferences, with handwritten records produced and circulated prior to the meeting closing. This is allowing for prompt action and communication of information for all those involved with the child and/or family.

32. Following previous concerns related to concealed pregnancies, there are effective systems and processes in place to ensure that all women who claimed to have had a miscarriage or a termination of pregnancy are followed up to ensure that they are supported and that there are no concealed pregnancies.

Outcome 7 Safeguarding

33. The contribution of health agencies to keeping children and young people safe is good.
34. Safeguarding referral thresholds are high and well understood, with health thresholds aligned to social care which has improved the rate of referral acceptance. There is very good monitoring and quality assurance of referrals undertaken by all named practitioners, ensuring that all cases receive the appropriate level of intervention and referrers receive feedback on the referral. ‘Cause for concern’ forms are used effectively and can, through the robust reporting/monitoring structures, identify issues and trends within families which may lead to a safeguarding referral being made. The ‘cause for concern’ notices are communicated effectively to community and primary care practitioners, who may follow-up the family, or provide further evidence for low level concerns which trigger a safeguarding referral. Notifications of attendance at accident and emergency settings are also mapped by the safeguarding health teams to ‘cause for concern’ forms, including the frequent attendee information, to identify and address any safeguarding or health concerns. These are sent to primary and community health staff and issues are followed up to ensure the child is protected from harm.

35. The Children Act section 47\(^1\) medical protocols and systems have been recently streamlined with a new Oldham and Rochdale approach being taken to improve the availability of the consultant paediatrician and more timely access to assessments for children and young people. Early findings show that this new approach has been realised.

36. The capacity of the designated nurse for safeguarding to maintain a visible presence, to lead safeguarding across all providers and drive forward safeguarding changes is limited. This is due to the joint function of the post as the associate director for quality and clinical governance and a perception by other health staff of limited capacity in the role in driving forward safeguarding changes. Examples of this include the lack of evidence of monitoring the impact of changes to Royal Oldham Hospital A&E services for children, and the poor safeguarding level two training rates at Pennine Acute Hospitals Trust. However, there has been good demonstrable change brought about from the use of the CQUINs that this joint role has been able to influence. Whilst there is good evidence of supportive supervision for primary care and community practitioners in ensuring that children and young people’s needs are being identified and met, the role of the designated nurse in providing leadership and supervision for all named and lead professional is less apparent and reported that it becomes merged and compromised with the governance role as a commissioner. There is good use made of peer support throughout the safeguarding health team.

37. There are mature and robust partnership arrangements with co-located staff, with joint appointments between health and social care which are reducing the gaps in services, promoting early identification and sharing of safeguarding concerns and ensuring that children and young people are protected from harm. There is good access to the safeguarding health ‘hot line’ and the highly visible and valued safeguarding designated and named professionals. There is good use made of the local safeguarding arrangements within the commissioned dental services to protect service users from harm.

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\(^1\) Section 47 Enquiry (Child Protection Enquiry) in accordance to the Children Act 1989 Enquiries are directed at determining whether the authority should take any action to safeguard or promote a child’s welfare.
38. Royal Oldham Hospital accident and emergency services (A&E), part of Pennine Acute Hospital NHS Trust, has insufficient numbers of qualified registered children nurses, resulting in a lack of available ‘children expertise’ throughout all shifts. All staff have received training in children pain management and receive paediatric life support training to try and mitigate this risk. There is a good rate of safeguarding training compliance in the A&E department, including the foundation year(s) doctors. Whilst there is no ‘flagging’ of children known to social care on the information management systems within the department, other strategies are effectively employed to ensure that all children are identified and protected from harm.

39. However, the identification of the adult with parental responsibility, especially for looked after children, is less well developed. Audits of parental consent only used the sample group where children where already identified through the ‘cause for concern’ process only. The most recent sample in January 2012 only identified six children, which showed staff followed the hospital policy when ascertaining parental responsibility. There was no evidence to show how parental responsibility is ascertained for all children and young people who attend Royal Oldham Hospital A&E or where there is not already a ‘cause for concern’ form generated. There is good access and timely response to safeguarding enquiries from the social care duty teams at all times. There are good systems in place which ensure that all primary and community staff receive information on A&E attendances of all children and young people, as well as attendances by pregnant women which are also sent to midwives. The primary and community staff take any required action to ensure that the child and or family are protected from harm and are accessing appropriate health care services.

40. The annual child death overview panel (CDOP) report is well scrutinised through a range of governance structures and the LSCB. Cognisance is paid to other local CDOP concerns and issues and these are mapped to the needs of Oldham. Themes identified from child deaths including those from other local CDOP, are also shared and reviewed locally to ensure that any lessons that can be learnt are realised. However, communication of information from both LSCB and CDOP is not robust within primary care; with those GPs interviewed were not aware of the CDOP campaigns, with the exception of some GPS with regard to the recently commenced programme of work considering consanguinity. The consanguinity programme of work has been agreed with the local faith leaders, MPs and Imams, all of whom are well engaged in the finding ways to resolve concerns. Further, there are good links established with the Health and Well-Being Board as part of the infant mortality strategy to ensure that there is consistency in approaches to deal with consanguinity concerns. There is good information sharing between CDOP and maternity services in monitor and reduce infant mortality rates. The revised child health record ‘red book’ now contains the latest ‘back to sleep’ information as well as shaking baby and baby crying information. However, the information for other carers e.g. grandparents, not just the parents of a child, is not consistently communicated. CDOP have supported dedicated programmes for young fathers to improve their knowledge especially related to crying babies, such as the ‘Dads Behaving Dadly’ programme, although attendance rates have been low.
41. There is good access to internal complex mental health (tier 4) in patient beds through the New Horizons/Hope Centre. Repatriation for those young people placed out of area, including looked after young people, is improving, however, there remains some challenges with the older young people who have both a mental health and learning difficulty where there is no adult service.

42. The dental service has introduced a flagging system to track and monitor families and children of concern but the effectiveness of this is yet to be audited. Those children who missed appointments are now referred to health visitors or school nursing services, who follow up these families, ensuring that the young child is protected from harm and their oral care and nutrition is not being neglected.

43. There still remains a challenge in ensuring that opticians are maintaining their safeguarding competency. There are plans in place to promote the Royal College of Optometrists safeguarding portfolio; however, the national contract does not require local optical providers to participate in such initiatives, which is viewed as a gap. This issue has been raised at the LSCB and is yet to be resolved.

44. Social care accept safeguarding referrals relating to unborn babies at 24-28 weeks. Some midwives are concerned that due to this ‘late date’, early prevention work with high risk women such as those misusing substances is not always effective as such women often deliver early before birth plans are in place or agreed. There has been a recent review of the ‘removal at birth or soon after birth’ processes which resulted in more robust guidelines and better documentation for recording of professional expectation. Early evaluation shows that this has resulted also in improved recording of the needs of fathers. Good use is made of the local, regional and national maternity alert systems, with further good communication with A&E services when there has been a pregnant women seen for treatment, to ensure that any risks to the unborn child are addressed. All pregnant young women aged sixteen years or under have a safeguarding referral made and safeguarding cause for concern form submitted to ensure that there are no unmet safeguarding concerns for either the young women or unborn child.

Outcome 11 Safety, availability and suitability of equipment

45. The accident and emergency service at Royal Oldham Hospital, does not have dedicated waiting areas or treatment rooms/areas for children or young people which may compromise their privacy and dignity and their safety and well being whilst in the department. There is one resuscitation room which is currently being used as a multi purpose treatment room. There are plans in place for a new building to commence shortly which will have a dedicated childrens area.

Outcome 12 Staffing recruitment

46. All health organisations follow the safer recruitment good practice guidance. Further, all other organisations actively review the criminal records bureau (CRB) clearance status of all employees every three years with the exception of Pennine Acute Hospitals NHS Trust where there is no policy or process in place, resulting in a lack of trust board assurance of the fitness of the employee to work/practice.
Outcome 13 Staffing numbers

47. There are a number of work streams in place which are reviewing the commissioning of the health visiting services, which includes the review of skill mix and staffing levels, in line with the review of children centres contract which are due to be implemented in April 2012. It is too early to judge the impact of the proposed changes. Of those community practitioners interviewed, the change to geographical working was viewed positively and had improved the working relationships.

Outcome 14 Staffing support

48. Compliance with safeguarding training is variable, with Pennine Acute Hospitals NHS trust, only achieving 33% of staff trained at level 2 at Royal Oldham Hospital, (40% trust wide) which is inadequate. Of those GPs interviewed, all were in date with their level 3 safeguarding training, with improved engagement across all practices. Monitoring and self reporting relating to the GP contracts for 2011/2012 showed that 61% of practices had received level 3 training in the last twelve months.

49. The role of the designated nurse in ensuring that training has had a positive impact on practice and that children are safeguarded is less apparent. The evaluation of the impact of training on practice by all designated and named practitioners, is not consistent across all health providers. There is good use of the ‘safeguarding walkabouts’ at Pennine Acute Trust, however, the sustained changes within the culture are not always well demonstrated. Safeguarding training at Pennine Care Foundation NHS Trust has a high rate of compliance with 96% of staff in date with level 2 training across the trust.

50. There is a waiting list for staff to access thematic training, such as the e-environment and the ‘hidden male’ and ‘hidden harm’ training and the impact of the adult who has mental health concerns on the children within the family, partially due to the large number of staff employed by the health trusts. Health staff reported that some of the multiagency level three training is repetitive and had not been updated from their previous attendance twelve months – three years ago. Whilst affirming knowledge and building confidence this has not led to further skill and competency development which is a missed opportunity.

51. The allocated social worker based within the CAMH service, is a valued role and has enabled improved liaison and training with the main social care teams. Training on self harm and attachment has been successfully delivered to other social care staff and has improved the success rate of these safeguarding referrals.

52. There is good access and use made of supervision by the dedicated looked after children staff and those staff who have a looked after child on their caseload, resulting in positive outcomes for both the staff member and service user. Strength and difficulties (SDQ) training is highly valued, resulting in good use of and improving CAMHS and school health service engagement with looked after children and ensuring that triggers for referrals are used effectively.
53. All staff interviewed reported good timely access to both safeguarding and looked after children supervision, with named and designated staff who are making good use of regional and national networks. Within some professional groups such as therapists, managerial supervision includes routine review of safeguarding issues, which staff report as being supportive. NHS Greater Manchester is progressing well the process of reviewing the Greater Manchester safeguarding service, which it is planned will incorporate the designated professional roles, from across the ten localities, whilst still maintaining their local focus and responsiveness and providing a core of supervisors.

Outcome 16 Audit and monitoring

54. Rates of health assessments for looked after children are above England and comparators. Latest data, December 2011; shows the compliance rates to be 93%, dental checks 90% and immunisation and vaccine rates 93.2%. Immunisation compliance rates are high due to the range of flexible approaches including immunisation clinics in care homes and foster carer homes. Health outcome rates are better than those seen within the child health indicators for the general population. The designated doctor for LAC is also the medical advisor to the adoption panel (although does not sit on foster carer panel). The designated doctor role is experiencing some challenges in maintaining the 28 day initial health assessment due to coordination of other health professionals in providing health history information in a timely manner. However, through focussed and dedicated work this target is being met, although future sustainability is uncertain. Plans are in place to address this. The designated doctor ensures that if there is the potential for a new looked after child who will be adopted straight away, that the initial LAC health assessment and the adoption medical are combined to reduce the stress and anxiety for the child/young person.

55. The Pennine Care Foundation NHS Trust and OCHS looked after children action plan for 2012, developed as a result of a record audit from December 2011, align with this inspection findings of the health records. The action plan aims to improve the robustness of the monitoring arrangements of health information, and through the attendance of the specialist nurse for LAC to attend the last review of a young person to ensure that all care leavers receive their health history information.

56. Whilst there is a training performance database/dashboard, there is limited evidence to show that timely action is being taken with those organisations that have low performance rates by the designated professionals. Following the mergers of health organisations a training passport system is to be implemented based on competencies to enhance compliance rates. NHS Oldham supervision audits, although limited, demonstrate that staff have valued supervision and the sessions have had a positive affect on safeguarding arrangements for a child/family.

57. The performance management sub group of the LSCB is chaired by the designated nurse, and has strengthened its approach to accountability from health providers with the aim of reducing slippage on action plans. Pennine Acute Hospitals NHS Trust non executive directors are actively involved in challenging the evidence base used to demonstrate compliance of action plan completion to ensure that this is robust and that changes are embedded.
Outcome 20 Notification of other incidents

58. The role of local authority designated officer (LADO) is widely understood and is used appropriately. Health staff make outstanding use of cause for concern and serious incident concern forms for reporting any safeguarding concerns, these are also used as referral forms to children’s social care safeguarding services.

Outcome 21 Records

59. Overall the quality of the looked after children health files reviewed during the inspection was good, with good collation of all documents providing staff with very comprehensive information base. Records seen did not contain the ‘example of signature for identification’ sheet as outlined in professional guidance.

Recommendations

(Those include from the joint report with OFSTED are in italics) –

Within 3 months

Pennine Acute Hospitals NHS Trust must ensure that there are robust systems in place to ensure that all employees, especially those working with and having contact with children and young people are fit to be continually employed/practice.

Pennine Acute Hospitals NHS Trust must ensure that all staff that require level 2 and 3 safeguarding training receive this and remain up to date with their training.

Pennine Acute Hospitals NHS Trust must ensure that all children and young people who use Royal Oldham A&E department are protected from harm that their privacy and dignity is maintained, and that nothing impedes the building of the dedicated children facility.

Next steps

An action plan is required from the commissioning PCT within 20 working days of receipt of this report. Please submit the action plan to your SHA copied to CQC through childrens-services-inspection@cqc.org.uk and it will be followed up through the regional team.