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.
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 head of national Inspections, who has overall responsibility for this inspection programme.

The Inspection Process

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

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

Tameside has a resident population of approximately 53,800 children and young people aged 0 – 19, representing 24.8% of the total population of the area. Boys (27,500) slightly outnumber girls (26,300). Approximately 9% of the population of children and young people are classified as belonging to an ethnic group other than White British. Bangladeshi (2.2%), Pakistani (2.0%) and Indian (1.4%) are the most commonly recorded minority ethnic groups. There are 60 different languages spoken by children in schools in Tameside. Apart from English the most commonly spoken are Bengali, Urdu, Polish, Gujarati and Panjabi.

Commissioning and planning of children and young people’s health services was undertaken by NHS Tameside and Glossop. From 1st April 2012 the shadow Tameside & Glossop Clinical Commissioning Group will assume responsibility. Universal services such as health visiting, school nursing, maternity and sexual health are delivered by Tameside and Glossop Community Healthcare Business Group, which is part of Stockport NHS Foundation Trust. The acute hospital providing Accident and Emergency services for children is Tameside and Glossop NHS Foundation Trust. Children and families access primary care services through one of 42 GP practices and walk in centers, including “Go to Doc” based at Ashton Primary Care Centre. Child and adolescent mental health services (CAMHS) are provided by Pennine Care NHS Foundation Trust.
1. General – leadership and management

The contribution of health agencies to keeping children and young people safe is Outstanding.

1.1 There is a strong safeguarding ethos throughout the commissioner’s NHS Tameside and Glossop and the provider organisations. This is embedded in front line practice, providing coherence in respect of safeguarding provision across the health economy.

1.2 A well established children’s commissioning framework is in place, with some joint funded commissioning for key areas, such as early attachment and early intervention. NHS Tameside and Glossop has shown commitment and sustained investment in safeguarding and this has agreement to be carried forward into the future Clinical Commissioning Group agenda. Excellent quality assurance and performance monitoring is in place, with safeguarding specifications in all commissioning contracts.

1.3 Tameside has had a strategic children and young people’s partnership board in place since 2003, which formally became the Tameside Children’s Trust Board in 2010. The Board is supported by a range of partners including the voluntary, community and faith sector. Health is an effective partner.

2 Outcome 1 Involving Users

2.1 User engagement is excellent across CAMHS. The implementation of the Young Person’s Mental Health team was done after consultation with young people who were already receiving a service in CAMHS, along with other young members of the public. “Your Opinion Matters” and experience of service user surveys actively seek comments and feedback from young people, parents and carers. Examination of surveys returned demonstrated a very high level of satisfaction with all aspects of the service, with particular reference to the speed of referral into the service and individual care and treatments delivered.

2.2 Young people who are receiving a service from CAMHS are part of staff recruitment. They sit on separate panels during interviews and are fully engaged with recruitment decisions. They receive appropriate training and are reimbursed for any expenses accrued. The website and handbook for young people was edited by service users and a DVD has been produced giving information about the service and environment within the Spring Lee day unit.

2.3 There is good engagement from young people involved with the sexual health service. The sexual health team conducted a sexual health needs survey and findings from that influenced the current service delivery model. Sessions held reflect the times that the young people wanted clinics to be held, in the evenings after school and on Saturdays. Some young people have also been seen prior to the start of sessions to ensure that they are engaged and seen. Clinics are always well attended.
3  **Outcome 2 Consent**

3.1 Within both the acute and mental health providers there are appropriate policies and procedures in place that ensure consent is taken prior to any treatment of children and young people. Consent is gained from parents and carers and is appropriately documented. The Fraser competency of young people is fully assessed within all services but particularly within sexual health.

3.2 Consent to undertake health assessments are obtained, in accordance with the Department of Health’s Guidance, by the Looked After Children’s (LAC) health team. Consent is also obtained to the share the summary and health recommendations with social care and GP’s.

4  **Outcome 4 Care and welfare of people who use services**

4.1 Within health visiting corporate caseloads are RAG assessed according to areas of deprivation and vulnerability of families. Teams are locality based and linked to GP practices. Health visitors (HV) confirmed that caseloads are high and that capacity is frequently an issue. The Tameside Agreement, which reflects the principles of the Lewisham Agreement, has been implemented following learning from a serious case review. This has seen markedly improved liaison with GP’s and other key agencies to target early intervention and raise awareness of risks.

4.2 Specialist HV posts in youth and family teams and the early attachment service, is ensuring joint agency working and a better understanding of thresholds. The service in Tameside has already reviewed and is applying the principles of the DOH “Call to Action” Implementation plan for HV. Better interagency working and partnership is already seeing that referrals to, and interventions by, specialised health professionals are being made earlier and more effectively.

4.3 School Nurses have an excellent understanding of safeguarding, which is clearly embedded into everyday practice and there is good evidence of multiagency working. Most feel that there is better communication across health, and feel able to refer to other health professional’s including the sexual health team and CAMHS. Vulnerable children are usually well known, as school nurses work in primary as well as the feeder secondary schools. School nurses are not directly involved with PHSCE or SRE curriculums; however partnership working with education is reported as good.

4.4 There is excellent comprehensive CAMHS provision. A range of specialist teams are commissioned, including core CAMHS, early intervention, LAC and a 16-19 team. Tier 2-4 services are delivered by Pennine Care NHS Foundation Trust. Waiting times for referral into the service is slightly better than national average, currently at 4-5 weeks. There is fast track access for LAC within 24 hrs and following assessments for other children and young people, dependant on individual need, within 24-48hrs.
4.5 CAMHS outreach services are provided when a young person presents via the Accident and Emergency department, in the local acute provider trust, with substance misuse or self-harm. Any person that does not attend a CAMHS appointment after discharge, is followed up quickly, with liaison with social services and if applicable, the LAC health team. The in reach/outreach team carries out assessments and acts as the gate keeper to access to inpatient services. Tier 4 services are provided within two units. The Hope unit provides acute short stay averaging up to 6 weeks. The Horizon unit provides longer more complex treatments and support.

4.6 There is excellent evidence of multiagency/multi professional early intervention work within CAMHS. The early intervention team work closely and in consultation with, the Early Attachment service, HV, School Nurses, Midwives and Social care. There is a comprehensive Parent Infant Mental Health Pathway in place. This gives health professionals guidance to assessment and referral protocols to ensure access to the most appropriate professional. CAMHS also work with the cognitive behaviour team and co work cases with the Integrated Services for Children with Additional Needs (ISCAN). The Clinical Psychiatrist and Physiologist works across both teams. There is an effective case management approach.

4.7 Integrated Services for Children with Additional Needs (ISCAN) is delivering an excellent, comprehensive service that includes complex nursing needs, dietician, SALT, Occupational therapy and cognitive behaviour therapists. The head of the service is a jointly funded post between health and social care. The co-located team has frequent case management meetings that ensure timely and effective interventions. There is good partnership working across agencies, which include housing and social services. The adaptation service provides suitable accommodation for the children and young people, both within mainstream schools and within the home. Good provision is in place for respite and short breaks which are well evaluated by both the children and parents.

4.8 Within the Midwifery service the Named Midwife is also the lead for vulnerable women, substance misuse and domestic violence. The Parent and Infant Mental Health Care Pathway is ensuring effective multi professional involvement and early intervention to reduce risks. There is excellent evidence of safeguarding being an integral part of all antenatal care, right from the booking stage, with detailed recording of social assessments that include mental health needs and recording of domestic violence risks. Hand held notes contain emergency contact details for a number of health, social and voluntary agencies.

4.9 Three children’s centre Midwives, work in areas of highest deprivation. This has resulted in early and effective intervention with women who could have been at risk at not engaging in timely manner with health services. Flexible contact with the Midwives has greatly reduced risks within this vulnerable group of women. Currently there are 5 young girls who are pregnant. None of these girls are looked after but two of the dads to be are in care system. Care is lead by dedicated teenage pregnancy midwife who works closely with school nurses and CAMHS.
4.10 The Named Midwife has close links with the women’s refuge, which currently has women resident who are pregnant, being supported there. A monthly drop in to the refuge is to commence from April. Midwives also work closely with the young mums unit who have young women with complex social and educational issues.

4.11 Alerts are maintained on Central Delivery Suite at the local hospital, so that staff have current safeguarding details of any vulnerable woman who goes into labour. There are three assistant practitioners who support the midwives mainly on the post delivery ward. They have input into promoting breast feeding and early attachment support. There is an escalation policy in place for any safeguarding issue and this is seen as empowering staff to act earlier on risks to implement appropriate intervention.

4.12 There is a well established sexual health team providing a fully integrated sexual health service. Targeted outreach centres are identified most deprived areas, which provides a One Stop service at Tier 2, with Tier 3 at the clinic hub. 48 hr target for access to GU is consistently achieved. There is a very good rate of Chlamydia screening. Insertion of long-acting reversible contraception (LARC) has risen by 33% in under 18’s. The team has proactive targeting of social events to promote sexual health and safeguarding. This allows opportunistic screening at youth clubs, collages and cinema complexes.

4.13 Inspectors were informed that the team is very over stretched. There are concerns that working at this level will not be sustainable, due to long term sickness and an increase in capacity by 40%. Pressures on capacity have meant that attendance at key partnership groups recently has been limited. The community trust is aware of the issues.

4.14 The health of looked after children is good. Initial health assessments are comprehensive, have been undertaken within statutory timescales and are completed by a paediatrician. In spite of disorganised health files, review health assessments are robust and completed as required. Health action plans are always implemented. There is evidence that actions from previous plans have been completed and when children and young people do not attend appointments, there is good evidence that these are followed up effectively.

4.15 Significant improvements have taken place in completing immunisations. These were at a low base but are now at 98%. All looked after children and care leavers are registered with GPs and Dentists.

4.16 Following a service redesign the looked after children health team is now part of the Young People’s Health Team, This includes looked after children health, the leaving care team (16-18) and the Youth Offending Team. The young people’s health team is managed by the community provider trust.
4.17 When looked after children leave school, they are transferred to the specialist looked after children service for 16-18 year olds which is linked into Tameside’s leaving care service. The Young People’s Health team provide weekly health drop in services, immunisation sessions and personal health advice and support, including sexual health advice. Health assessments are always completed when a young person leaves care to ensure that their assessments and health needs are up to date.

4.18 The Lead Nurse for looked after children is currently covering the looked after children nurses caseload and whilst this provides for continuity, there is an issue with sustainability and the impact on the capacity within the team.

5 Outcome 6 Co-operating with others

5.1 There is strong membership from both commissioning and provider health organisations on the Tameside Safeguarding Children Board. Across health there is strong representation and robust participation on its sub groups. It is clear that the dissemination of learning from serious case reviews and serious untoward incidents across health has resulted in improvements in the safeguarding of children and young people.

5.2 NHS Tameside and Glossop is working closely with dental practices across the area, to raise the awareness of safeguarding issues. There has been a significant increase in the number of dentists undertaking training in safeguarding. Protected learning sessions have been held, with training carried out by the designated doctor and nurse. The lead dentist confirmed that awareness of safeguarding has increased within practices due to contact with the designated safeguarding leads and better communication via secure emails and newsletters from the TSCB. There was a good response by dental practices to a safeguarding audit conducted by the designated nurse. This has demonstrated the increased awareness and increased attendance at training.

5.3 Health visitors are generating CAF’s and are lead professionals when appropriate. The implementation of CAF’s is now monitored as part of key performance indicators (KPI) quality assurance. Health visitors report strong multiagency and partnership work

5.4 Within CAMHS the transition into adult services is well managed by the 16-19 team, with effective interagency work on going with LA, housing, connexions and other voluntary groups such as Branching out (substance misuse) and 42nd Street (counselling). Branching Out in particular provides effective support for young people and is appointing key workers for looked after children and CAMHS, to further strengthen partnership work. There are well established transition arrangements in place with adult services, which is provided by the same organisation.
5.5 CAMHS participates in multiagency training and also provides training opportunities and support for foster carers. This assists in early recognition of emotional and mental health issues, which results in earlier interventions. Good example of impact of the service was demonstrated, when placement stability was at risk of breakdown.

5.6 There is excellent tracking of looked after children placed out of borough. A comprehensive data base is maintained and the administration team has been particularly tenacious in tracking those young people placed out of borough which ensures that their location and health status is current. A funding agreement with other Greater Manchester authorities has been secured which means that when young people are placed out of the borough they receive appropriate and timely health services.

5.7 The looked after children health team works well with foster carers. Support and advice is available with regards to all the health needs of looked after children. Work is ongoing with residential care homes in Tameside, to promote healthier lifestyles. Contact has been made with managers and children and young people have been invited to participate in work to ascertain future needs and continued links with the LAC health team.

5.8 Midwifery has good attendance and participation at MARAC where 10% of referrals made involve pregnant women. The Named midwife has a good relationship with social care and Police. Information sharing protocols are in place and information is shared in a timely manner.

5.9 The looked after children lead nurse is co-located one day per week within the Local Authority referral and assessment team. This has improved communication and partnership working. The looked after children lead nurse is repeatedly cited as being extremely influential in developing improved partnership working with social care and this is recognised and valued by social care staff.

5.10 The Early Attachment Service is a joint commissioned partnership with the Local Authority, Pennine Care NHS Foundation Trust and Tameside and Glossop Community Healthcare Business Group. This specialist service prevents family breakdown and promotes attachment in 0-3 yrs by targeted work and early intervention. The service also works alongside the universal HV service, providing specialised guidance. Due to the small team involved, the service has limited capacity, however direct work is ongoing with approximately 132 families currently.

5.11 The sexual health team work closely with the Greater Manchester Sexual Health network to reduce the rate of 2nd conceptions in young girls. There is a robust referral pathway that provides links with the teenage pregnancy midwife that starts in the ante natal period. The team work with Gynaecology services in the Acute Trust, when a young girl has undergone a termination of pregnancy has resulted in the current rate of 2nd conceptions reduced to less than 1%.
6 Outcome 7 Safeguarding

6.1 There is good evidence that safeguarding leads are enabled to have regular meetings with executive leads. This facilitates escalation of issues and a better understanding of current practice to trust board level, which provides appropriate challenge and accountability.

6.2 There is a well established safeguarding forum within the acute trust. Safeguarding training is seen as a priority within the trust. Safeguarding trainers are in post, along with safeguarding champions across directorates which include in A&E, midwifery, radiology and neonatal services. There are effective links with adult services. Named professionals are ensuring that safeguarding is clearly embedded into daily practice.

6.3 All cases where sexual abuse is suspected are referred to the sexual abuse referral centre (SARC) at St Mary’s, Manchester. The unit is a short distance away and has all the required equipment and expertise to deal with these cases. It was reported that there has been no issues with the transfer of children to this unit.

6.4 Within the mental health provider trust all safeguarding risks or incidents are treated as a serious untoward incident and are reported via a team incident report. This ensures that the incident has been correctly managed. All referrals into social services or other health professionals are received by the Child Safeguarding Lead.

6.5 Attendance at core groups and case conferences is generally good by health professionals. Notifications from social workers are reported to be received in a timely manner. Reports are always submitted if the health professional cannot attend.

6.6 There is an effective Child Death Overview Panel, with appropriate representation from the designated doctor. Recommendations from this panel clearly influence change to local policies and practice.

6.7 Translation services are available across health. Language line and “The Big Word” phrase book are accessed when dealing with children and young people and their parents and carer’s, when English is not there first language. All health professionals interviewed confirmed that family members and friends are not used to translate during any contact.
7. Outcome 11 Safety, availability and suitability of equipment

7.1 Emergency care for children and young people is delivered in a safe and dedicated children's accident and emergency department within Tameside General Hospital. An effective tracking system is in place that alerts staff to any child protection or safeguarding issue. All attendances are tracked by the paediatric health visitor liaison and copies of triage sheets are forwarded to HV, GP, school nurse and the safeguarding team within the hospital. All non attendances for follow up appointments are tracked by the HV and named nurse. The system has specific alert criteria which indentifies LAC, teenage pregnancy and safeguarding concerns with an unborn child. From arrival, through triage, examination and treatment, child protection and safeguarding prompts are required to be completed at every stage and the system will not allow practitioners to move until there is an acknowledgement to the alert.

7.2 Additional emergency care is provided by “Go to Doc” within a primary care centre, which also houses a GP practice and an Out of Hours emergency service. There are appropriate safeguarding procedures throughout the centre. Alerts are flagged on the system of CP and safeguarding issues and multiple attendances are escalated to GP’s, social services or other appropriate health professionals. Notifications of attendances of children and young people are sent to GPs, health visitors and school nurses within 24hrs of attendance. There is a safeguarding lead, who is also the head of governance. The lead sits on the safeguarding forum in NHS Tameside and Glossop and has regular contact with the designated nurse.

7.3 There were no issues with equipment availability from the Integrated Services for Children with Additional Needs. Equipment was reported to be available, regularly serviced and replaced.

8. Outcome 12 Staffing recruitment

8.1 There are appropriate policies in place across health which ensures that staff are safely and effectively recruited. Criminal Records Bureau checks are undertaken before any designation of staff are employed.

9. Outcome 13 Staffing numbers

9.1 Some issues in regard to staffing establishments and capacity were raised during some interviews with health professionals. There are a number of vacancies within health visiting and school nursing but there is proactive recruitment on going. The capacity issues within the looked after children’s health team and within sexual health has been raised with managers and there are plans to address the problem.
10 Outcome 14 Staffing support

10.1 Training strategies are in place for safeguarding in both the commissioning and provider organisations. Performance monitoring of attendance at safeguarding training is effectively scrutinised.

10.2 Staff in NHS Tameside and Glossop, the Community trust and Pennine Care have good access to supervision, via a variety of forums, both individual, peer and group. A reviewed supervision policy has recently been agreed within the acute provider trust, to ensure a more formalised framework for supervision.

10.3 The designated nurse is a safer recruitment trainer and has delivered training to health partners. Supervision is also provided for the named professionals by the designated leads.

10.4 Child safeguarding champions and safeguarding trainers within the provider trusts, facilitate training and guidance for other staff. It is clear that learning from incidents and case management discussions are disseminated back to front line staff.

11 Outcome 16 Audit and monitoring

11.1 Strong, effective and rigorous leadership from the designated and named professionals is evident. This is supported by well established safeguarding assurance groups across health. Staff interviewed to date unanimously, have expressed confidence in escalating any safeguarding issues and are assured of the support from lead professionals.

11.2 Robust systems are in place within the mental health trust to give board and commissioner assurance on safeguarding children and young people. An effective integrated governance framework is in place across the trust. This includes child safeguarding champions within every speciality, including CAMHS and adult services. Safeguarding reports are fed into the trust wide safeguarding forum on which the named doctor and named nurse for the Tameside services sits.

11.3 A trust wide audit of safeguarding practice was published in 2011 and demonstrated effective practice across CAMHS and adult services. Staff had appropriate access to policy guidance and had received safeguarding training.

11.4 The Strategic Health Authority lead for children, young people and maternity reports good commitment and shared responsibility across the health economy in the promotion and performance of safeguarding. Section 11 audits are completed and these are appropriately monitored through designated safeguarding lead professional meetings.
12 Outcome 20 Notification of other incidents

12.1 There are satisfactory arrangements in place across the commissioning, acute and mental health trusts to ensure that appropriate and timely notifications are made in relation to the required alerts into the various agencies including NPSA and CQC.

13 Outcome 21 Records

13.1 Looked after children’s health cases files are not appropriately maintained and electronic records are not in use. Chronology of events was difficult to determine in most files. This makes reviewing the current status and the risk factors associated with any child or young person, very hard to ascertain. Out of the 12 case files reviewed only four had a completed chronology of events sheet.

13.2 All files examined indicated that looked after children are registered with GPs and dentists. Routine and emergency community dental care is also readily available, provided by Bridgewater Community Healthcare Trust. There is good evidence on file of communication to the LAC health team and social care when a child or young person attends A&E, urgent care or walk in centres and for any unscheduled attendance at drop in sessions.

Recommendations

Within 3 months

- Ensure a review of the health files of looked after children is undertaken.

- Ensure a review of the staffing establishment and capacity of the looked after children’s health team is undertaken.

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.