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](#).
### NHS Bury

#### Safeguarding Inspection Outcome

<table>
<thead>
<tr>
<th>Findings</th>
<th>Aggregated inspection finding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall effectiveness of the safeguarding services</td>
<td>Adequate</td>
</tr>
<tr>
<td>Capacity for improvement</td>
<td>Adequate</td>
</tr>
<tr>
<td>Contribution of health agencies to keeping children and young people safe</td>
<td>Good</td>
</tr>
</tbody>
</table>

#### Looked After children Inspection Outcome

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<tr>
<td>Overall effectiveness of services for looked after children and young people</td>
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</tr>
<tr>
<td>Capacity for improvement of the council and its partners</td>
<td>Good</td>
</tr>
<tr>
<td>Being healthy</td>
<td>Outstanding</td>
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</tbody>
</table>

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 deputy director - North and Head of Operational Improvement 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 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:

Commissioning and planning of child and young peoples’ health services and primary care are undertaken by NHS Bury. Services for children and families are commissioned by NHS Bury in partnership with NHS Greater Manchester and the local authority. A Clinical Commissioning Lead for children and families has been appointed and work is under way on four priority service areas. Areas for joint commissioning are considered through the Bury Children’s Trust Board.

Primary Care services are provided through Children and Young People Improving Access to Psychological Therapies (IAPT), Child and Family Bereavement Service and through the 33 general practitioner services, 40 pharmacies or 30 NHS dental practices. Secondary care and emergency care services are provided through Pennine Acute Hospital NHS Trust (PAHT). Tertiary Care is provided by Central Manchester and Manchester Children’s Hospital Trust.

Maternity Services for 60% of women are zoned to North Manchester General Hospital (PAHT) and 40% are zoned to Bolton Hospital Foundation NHS Trust. Neonatal Services at Level 2 are provided at PAHT and Bolton Foundation NHS Trust. Level 3 services are through specialist commissioning arrangements provided at Bolton Foundation NHS Trust, or PAHT and Central Manchester Foundation NHS Trust.
Pennine Care Foundation NHS Trust (PCFT) provides community services including: Speech and Language Therapy, Occupational Therapy, Children’s Community Nursing Team, Safeguarding and Vulnerable Children’s Team, Learning Disability Team, Cambeck Close - short break services, child and adolescent mental health services (CAMHS) and contraception and sexual health services, specialist mental health services including both the Hope and Horizon Units (inpatient services). Other providers include The Central Manchester and Manchester Children’s Foundation Trust (Galaxy House) and through specialised commissioning, Greater Manchester West Mental Health Foundation Trust (McGuiness Unit). Services for children with learning disabilities and difficulties and who have complex health needs services are provided by PCFT.

Walk in centres including a centre at Prestwich in the south of the Bury and the Urgent Treatment Centre/minor injury centres at Moorgate Primary Care Centre in Bury town centre.

In 2010, the resident population in Bury was estimated to be 183,800, with approximately 22%, aged under 18 years. The population is projected to increase by approximately 5.5% between 2012 and 2022. The 2010 Index of Multiple Deprivation (IMD) ranked Bury PCT 84th out of 151 primary care trusts, where 1 is the most deprived. Levels of child poverty are particularly high in the wards Moorside (31%), East (32%), Radcliffe West (27%) and Besses (29%). In total, the proportion of children in poverty in 2009 was 18.5% for Bury, which is lower than the national average of 21%.

Bury has a predominately white population (91.2%), with certain areas of Bury having a higher concentration of people from minority ethnic backgrounds. Approximately 20% of school age children are from an ethnic background. Births in Bury have shown a steady increase: 2322 children were born in 2006 and this has risen in 2010 to 2592 births. Infant mortality rates in Bury are lower than regional and national averages. For the period 2008 to 2010 the infant mortality rate at less than 1 year of age, was 3.0 per 1,000 live births, compared to 4.9 and 4.6 per 1,000 live births for the North West and England respectively.
General – leadership and management

1. Health organisations have a shared vision with partner agencies for safeguarding and for the improvement of life chances for children and young people. There is a well disseminated joint strategic needs assessment, which is well incorporated into the children and young people plan.

2. The shadow clinical commissioning group (CCG) has prioritised child safeguarding, and appointed a dedicated paediatric lead with safeguarding responsibilities. Priority work streams and associated audits have been identified which include looked after children and parental responsibility for consent, and the notification to primary care health services of other authority out of area placed children and young people within Bury.

3. The role of designated nurse for looked after children complies with statutory guidance. The looked after children health annual report is shortly due to be submitted to the corporate parenting board. The annual report (and previous annual and exception reports) are submitted to the health providers’ trust boards. There is good engagement and partnership working with the Independent Reviewing Officers (IROs), with good notification and attendance at the looked after children reviews, leading to creative individualised health plans.

4. All health organisations have concurrent safeguarding policies including safeguarding supervision policies which are becoming fully embedded in practice, despite the recent organisational changes. Pennine Acute Hospitals Trust (PAHT) reviewed their safeguarding training policy following previous inspections of its safeguarding children services and subsequent requirements resulting in slow but consistent improvement in training compliance rates, although, at the time of this inspection, the trust wide rates still remain inadequate. PAHT is on target to achieve the trajectory rate of 80% compliance by August 2012. Progress is being robustly monitored by the trust board.

5. There is good active engagement and contribution from the designated safeguarding nurse, all other safeguarding health staff and executive safeguarding leads with the Local Safeguarding Children Board (LSCB) and the subgroups. Robust and embedded governance and health based scrutiny systems are present in all health organisations, providing good levels of challenge to both the annual and quarterly safeguarding reports, exception reports and also the serious case review action plans.

6. The designated safeguarding nurse is the health representative and regular attendee at the multi agency public protection arrangement (MAPPA) meetings.
Outcome 1 Involving Users

7. There is effective service user participation with the children in care council, which is ensuring an increasing appropriate range of venues for looked after children health assessments and range of choice in service provision. Leaving care information is being enhanced still further, through the use of the new ‘blue book’, designed by young people, which at the time of the inspection. Health promotion and education are fully embedded within health assessments and health reviews. Plans are well developed, in conjunction with members of the children in care council, to improve the health information and activities provided.

8. The CAMH in patient service have gained the You’re Welcome Quality Criteria for Young People Friendly Health Services accreditation.

9. Good consideration is given to cultural and faith health needs. There is very effective working (and some dedicated posts) with the local Jewish, Asian and travelling families communities, which is improving engagement with health services. This successful engagement has led to health visitors, the infant feeding practitioner and midwives being invited to attend meetings with faith and community leaders, resulting in an improved shared understanding. There is good access for community practitioners to interpreters and translation services, with some staff who are able to speak a number of different languages complimenting this service.

Outcome 2 Consent

10. Looked after children have access to a specialist orthodontic services, although processes for ascertaining parental consent are not fully embedded.

11. The ascertaining of parental responsibility in accident and emergency (A&E) has been subject to a small scale audit. Results showed good rates of compliance. However, cases selected were where staff had already identified concerns; consequently this does not give a true reflection of practice for all children and young people using the department. There are no ‘flagging’ systems in place within the A&E department to identify those children and young people known to social care, but increasingly robust systems are becoming embedded which ensure that all children and young peoples’ potential vulnerabilities are fully assessed.
Outcome 4 Care and welfare of people who use services

12. The Being Healthy outcome is judged as outstanding. All health assessments and health reviews seen during the inspection were comprehensive, with some health files containing the strength and difficulties questionnaires (SDQ) and outcome scores. Good use is made of the SDQ processes, involving SDQs completed by foster carers and young people over 11 years old, which inform health assessments and referrals to mental health services. There is good access to interpreter services and same gender health staff for health appointments. The current ‘Being Healthy’ outcome data shows that immunisation rates are 99%, the dental assessment rate is 93% and the health assessment/review rate is 93%, all of which are above England averages. The authority wide SDQ score is 13.7 and has decreased since the previous year, and is now lower than England rates (England 13.9).

13. Care leavers are very well supported by the service provided by the designated looked after children nurse up to the age of 21 years. This service includes a ‘drop-in’ clinic as well as individual appointments which are accessed when the young person reaches 18 years old and the statutory health assessments have ceased. This choice of provision for care leavers has improved their access to, and use of, universal health provision. Care leavers are given a copy of their health histories, including birth information, immunisation status and their NHS number. There is good support for those care leavers living in the supported housing, with a dedicated school nurse for those who are still engaged with education services. It has been recognised by childrens’ social care that some care leavers are not well prepared to, for example, cook for themselves. In response to this unmet need the looked after childrens’ designated nurse has provided a successful cookery and nutrition courses along with personal advisors.

14. Looked after children and young people have good access to Early Break, the young person substance misuse service. Data shows that not all looked after children who are known to be substance misusers are accessing services. There is a current work programme to ascertain the reasons for this and to improve engagement and take up of services.

15. The youth offending specialist nurse provides a highly valued health education and sexual health programme for those ‘hard to reach’ young people, and for those who are not attending education, which may include looked after young people.

16. Over the past year there has been good dedicated six week personal health and sexual relationship education programmes for unaccompanied asylum seeking children and young people provided by the looked after children health team. These programmes were all positively evaluated.
17. There is good dedicated provision for all pregnant teenage women and their partners, including support for those who wish to terminate their pregnancy. However, the rates of teenage conception continue to fluctuate too much and currently are above England averages at 41.1/1000. There is an above average use of the termination of pregnancy services with reported rates at 59%, reasons for this are not well understood (England averages are 49% for the same period). The teenage pregnancy midwife and the teenage parent specialist practitioner work collaboratively to ensure teenagers are well supported and can make informed choices regarding their pregnancy. Young women who conceal their pregnancy from their parents are encouraged and well supported by maternity staff to disclose. Good use is made of texting services to ensure that young women remain engaged with maternity and health visiting services and continue to attend appointments. All pregnant teenager’s maternity ‘booking appointments’ are held at their own home allowing for a full risk assessment to be undertaken. This practice is now becoming commonplace for all pregnant women. Contraceptive advice to prevent unplanned second conceptions is well embedded, with processes well embedded across both maternity, sexual health and the contracted termination of pregnancy services. Unqualified data is showing a decline in unplanned second conceptions.

18. Those looked after pregnant young women are well supported by the dedicated teenage pregnancy midwife and dedicated teenage parent specialist practitioner - health visitor. There is good joint working with the young woman’s personal advisor and other key health professionals. Sexual health services for looked after young people are well provided through universal services. There is good joint working with youth offending services and personal advisors who both provide C-card scheme (condom distribution) and Chlamydia testing for looked after young people. There is good support provided to those young women (and their partners) who chose to terminate their pregnancy, with on going bereavement support provided through the emotional health and well being services and the IAPT service.

19. There is an effective multi-agency early intervention ‘drop-in’ service for families including teenage parents, which provides good ongoing ‘wrap around’ care mainly provided by health, youth services and connexions.

20. Unborn baby safeguarding referrals are not accepted by childrens social care until 28 weeks gestation, which prevents and limits effective multi agency pre-planning and early intervention work. This is a missed opportunity. For some more vulnerable mothers to be, such as those misusing substances, as babies are frequently born before their gestation date, there are no fully agreed robust multi agency birth plans in place. To mitigate this risk, the named nurse at PAHT will develop a plan to be used at the time of the birth, which is shared with social care. Post birth plans are however not always available. The general lack of timeliness within pre birth planning, and post birth plans frequently results in prolonged hospital stays in too many cases, when the average length of stay is up to six hours, which may cause further distress for the birth mother, their relatives, other mothers and health staff.
21. There are a number of weaning and young mother groups which are attempting to effect cultural change and promote good weaning and nutritional habits, with some evidence of impact starting to happen within some communities. These groups also discuss and promote good sexual health practices and provide contraception advice including well promoted delay messages.

Outcome 6 Co-operating with others

22. There is good coordination of both initial health assessments (IHA) and the review health assessments (RHA) for looked after children and young people, although it is recognised that the IHA process could be enhanced further. The IHAs completed within timescale is only 80%, attributed to delays by social care not providing correct consent information. The social care ‘change of placement’ notification process is not robust, restricting the accurate ‘flagging’ on the health information and patient record management systems of looked after children and the subsequent production of the health record ‘alert’ notices. General practitioners report that they are not always notified in a timely manner by childrens social care or by child health services of another authority looked after children being placed in Bury. Frequently they find out when the foster carer attends the practice to register the child/young person. GPs do receive copies of both the IHAs and RHAs and any required action points, these are appropriately actioned.

23. There is limited training, although highly valued, provided to foster carers and new and potential adoptive parents. Training includes attachment training and bespoke training for individual foster carer/adoptive parent, provided by the designated nurse for looked after children and the dedicated mental health looked after children service. Training is provided to maintain placement resilience and prevent breakdown. A number of parents and foster carers have successfully gained accreditation after completing the ‘Speakeasy’ course.

24. There is a dedicated looked after child and mental health service (CAMHS) outreach service. This service is co-located with childrens social care which enables good communication and information transfer, as well as swifter referrals from social care. Waiting times for urgent appointments vary and can be up to two weeks, which can be too long for some patients; a routine appointment may take up to sixteen weeks, waiting list cases however, are subject to regular review and in line with national targets.

25. Since the end of the highly valued targeted mental health provision in schools programme, some provision is delivered for dedicated areas of work, such as cyber bullying. Where it has been assessed as appropriate, there is good use made of the voluntary sector provision, such as Streetwise. Streetwise provide a crisis service for young people who require advice regarding housing and/or benefits, as well as emotional support. Emotional health and well being services provided by the Children’s Society are also being used to support families.
26. The PCFT CAMHS Pennine Assessment Document, ‘PAD’, has improved care planning and the quality of the letters sent to patients. There are pre-planned structured reviews in place of assessments, ensuring that the patient receives the agreed planned care, by the most appropriate person. Audit cycles have yet to be fully completed before full impact can be measured.

27. There are good partnerships and joint working in place with the full health multi-disciplinary team and CAMHS staff, supporting young people and preventing hospital admissions. The Improving Access to Psychological Therapies (IAPT) service provides a range of brief interventions, with good identification of hidden harm risks and concerns. When concerns are identified these are appropriately and promptly assessed for their impact on children, with referrals made to childrens social care. The IAPT service also provides a highly rated bereavement and support service for young women who had had a miscarriage or a termination of pregnancy.

28. There a very few transitions between child and adult mental health services needed. There is a well embedded transition policy, which focuses on meeting the needs of the young person and well established joint working arrangements, which commence when the young person is 14 to 16 years old, depending on the young person’s needs. The transition pathways for young people with a learning disability or difficulties have recently been reviewed and processes are now aligned to the care programme approach. These pathways commence from the age of 14 years, when it becomes apparent that the young person will require adult learning disability services. There still remain some challenges in ensuring smooth transitions for those young people with Attention Deficit Hyperactivity Disorder who will require ongoing medication. Stakeholder and parent consultation groups are currently being used to review the current pathways.

29. Children and adult alcohol and substance misuse services are well integrated, with many examples of good joint working. There are effective multiagency substance misuse partnership arrangements in place. Through the development of ‘Holding Families’, alignment of adult and children’s appointments has facilitated better treatment interventions. This work has successfully enabled children to be ‘given a voice’ in front of their carers/parents, to explain to the adults the impact of the substance abuse on them. The Early Break service has been successful in identifying and working with children who are assessed as being at high risk of misusing substances. The prevention project has enabled children to remain with their carers, stay in, or return to, education and in some cases reduced the need for children to be placed on a child protection plan. This service has won international acclaim. There is an effective needle exchange scheme in place for young people, including those taking steroids, which is an area of increasing local concern. There is a range of health information projects related to the harm associated with substance misuse, although evaluation of these is less well developed. There is good use of data and trends analysis. For example, data analysis revealed increased attendance at health services of individuals with bladder problems caused by the misuse of Ketamine. This has prompted a health campaign, in conjunction with the local media, aimed at raising awareness of the health risks associated with Ketamine misuse.
30. Streetwise is commissioned, as a result of the identification of a gap in provision, to provide a transition service for young people between the ages of 16-24 years. This valued service has successfully prevented some young people from requiring a referral to adult services. Streetwise successfully works with young people identified as ‘hard to reach’, social excluded and those with learning disabilities and difficulties. There is emerging evidence showing that the ‘Health Trainers’ are effectively working with young offenders and those young people who are not on statutory orders reducing habit forming behaviours.

31. There are effective partnerships and multi agency working between substance misuse services, maternity services, social care and police. ‘Lock boxes’ for medication such as Methadone, are provided in homes where there are adult substance misusers and also children present. Home risk assessments are well embedded. Good use is made of contingency planning as result of the risk assessments in line with the child death overview panel (CDOP) campaign relating to the risks of co-sleeping and substance misuse.

32. All staff interviewed confirmed that they were ‘in date’ with their safeguarding training, at the level deemed necessary for their role. There are good opportunities afforded to practitioners to attend a range of safeguarding training, both single and multiagency, and thematic training events such as female genital mutilation and domestic violence. Training compliance rates are too variable within and across health providers, health economy wide at all levels rates are 43%- 96%, with the low compliance levels attributed to the slow implementation at PAHT of new safeguarding training strategies.

33. The safeguarding responsibilities of GPs has recently had an increased focus, resulting in an significant increase in training compliance rates, although still low, rates are now at 73% for level 2 training. There is some evidence that GPs are working towards level 3 training as required by Working Together. All safeguarding training includes lessons learnt from both serious case reviews and significant incidents. Following this increase in training compliance there has been more use made of the health safeguarding team to discuss cases of concern.

34. Health visitors and school nursing services are well integrated, which is promoting effective working from the age of 0-19 years as part of the child health surveillance and universal health provision. Nursery nurses employed within these community teams, delivering highly effective ‘packages of care’ as part of the healthy child programme, tailored to the individual child and family needs. The use of the common assessment framework (CAF) is inconsistent, and a recently revised document which includes referral requests for childrens’ social care is yet to be embedded. However, there were some good examples given by community practitioners where the use of the CAF had had positive outcomes for young people and families.

35. Community practitioners are well engaged with child protection case conferences. Effective dissemination processes for the outcomes from conferences, as well as strategy meetings, are in place between community practitioners.
36. There is good engagement by health staff with the multi agency referral and assessment conference (MARAC). The health safeguarding team effectively risk assess and communicate all the domestic violence notifications, including those that do not meet the MARAC threshold. Notifications are well documented in case file chronologies. There is effective use of the high risk dependency tool by community practitioners, which identifies those families of concern, with ‘alerts’ placed on the patient information management system for other practitioners. School nurses provide additional support to children and young people in schools when there are identified cases of domestic violence within the home.

37. The designated nurse for safeguarding is a member and active participant of the multiagency public protection arrangements meetings.

Outcome 7 Safeguarding

38. The designated doctor for looked after children also acts as the medical advisor to the adoption panel. There are well embedded processes in place and good support given to potential and new adoptive parents.

39. Unscheduled care notifications and ‘did not attend’ appointment notices are received by the looked after children designated nurse, who then ensures appropriate follow up action is taken. Primary care and community care staff receive and take appropriate action related to the unscheduled care attendance notifications, hospital and CAMHS appointment ‘did not attend’ notifications. CAMHS staff also follow up all ‘did not attend’ cases. Children and young people ‘of concern’ are reviewed at the multi-professional GP practice meetings, which includes both health visitors and school nurses, resulting in agreed and shared plans of action. Frequent attendees are also highlighted and ‘flags’ are placed on patient record systems, ensuring cases of concern are highlighted with appropriate follow up action taken. Young people who have attended the accident and emergency department as a result of self harming are also discussed at these meetings, although future care planning is inhibited by the slow feedback from CAMH services on the referral status.

40. There is a good dedicated work programme for those Bury ‘out of area’ placed looked after young people who go missing from home, which has enabled, through close monitoring of their situations and support, some of these young people to return to Bury and in some cases, return to their birth home in accordance with the young persons wishes.

41. Community children nurses who specialise in learning disabilities and difficulties provide good support to looked after children with complex needs and/or life limiting conditions. These services are well integrated with the social care disability staff. There is effective use of joint assessment processes including the common assessment framework.
42. Safeguarding thresholds are understood. GPs report that frequently when they contact the social care advice and assessment team, that their call is placed too long 'on hold', especially during the clinic times when an immediate assistance/response is required. Since the introduction of the mental health 'Standardised Assessment Tool', there has been an improvement in the identification of hidden harm related safeguarding concerns, and a subsequent increase in referrals. However, mental health service staff report that there has been variability in the application of safeguarding thresholds by social care staff and a lack of understanding of the needs of children with mental health issues or the level of neglect and the impact on the child’s emotional well-being when their adult carer has a mental health need. This delay in accepting referrals may exacerbated the negatively impact on the young person well-being. In these cases there has been good use made of the escalation policy, with staff being well supported by the named nurse.

43. All self harm referrals are assessed in a timely manner, and in line with national guidance. There is a robust out of hours’ child consultant psychiatric on call system in place. A seven day follow up appointment is offered to all young people who have self harmed, although there is a limited choice of appointment times.

44. Good referral pathways to core CAMH services are in place. There are effective weekly triage meetings of all referrals, although this has the potential to delay the urgent referrals from being seen for up to seven days. The daily review of all referrals is in place in an attempt to mitigate the risks of this process, although appointments can still take up to five days, which is too long.

45. Following an audit of the CAMHS referral processes and appointment notification letters to parents, parents now receive letters informing them of the child’s appointment date and what action to take if they have any concerns or the child’s condition deteriorates in an attempt to address the four months wait to be seen. Although the potential breach of confidentiality for older children and young people is not robustly risk assessed.

46. Since the recent closure of the inpatient children beds at Fairfield General Hospital, a review of the accident and emergency admission pathway for children and young people with mental illnesses is underway. Very early findings show that this is having a negative impact on the specialist inpatient provision, notably for young people with eating disorders who are physically ill, and requires specialist mental health provision, greater than that on a routine medical ward. Staff are well supported by the CAMHS in reach and outreach teams. There is good access to the highly specialist inpatient beds (tier 4) through the provision and both the Hope and Horizon Units. Good use is made of the care programme approach (CPA) to facilitate smooth discharges from these centres. Good post discharge and outreach follow up services are provided, resulting in shorter hospital stays.
47. Sexual abuse referral pathways to the regional sexual assault referral centre (SARC) are well understood by both primary care staff and accident and emergency staff. When there are concerns relating to gynaecological physical and/or potential growth and development concerns, pathways for referral and assessment are less clear. This has been recognised and early work supported by public health and the CCG has commenced to scope the care pathways and staff training requirements.

48. A new case conference report template has been introduced for GPS and is resulting in better quality information being submitted to the conference, although a formal audit is yet to be completed to ascertain the full extent of the perceived improvement to practice. Whilst there has been some improvement to the timing of case conferences to allow GPs to attend, there is still limited use of venues, such as the use of GP practices, to allow GPs to attend during busy clinics and at short notice. Standardisation of the clinical coding has just been introduced within the patient information management systems, to record when there is a case conference, a common assessment framework (CAF) being completed, children subject to a child protection plan, domestic violence and/or a change of status for a child e.g. when a child becomes looked after. GPs receive feedback on the status of referrals usually within forty-eight hours, with limited but successful use of escalation procedures.

49. The child death overview panel (CDOP) has effectively scrutinised and all child and infant deaths. Further there is good scrutiny and analysis of child death data, including data from serious case reviews. Lessons learnt are disseminated throughout the health services but staff within primary care and some community staff report not being aware of the learning from local cases. There is effective joint working with the coroner and registrar for deaths as well as other health staff and agencies to identify child deaths. Processes to review a child death are robust and well embedded. Support for staff at the time of a child death and during the child death review processes is readily available, with good use made of debriefing sessions. There is good bereavement support provided to siblings and families. The impact of recent teenage suicides in schools has resulted in additional support for schools, promoted through the use of internet sites, although it is too early to measure the impact. Issues relating to culture and faith practices such as co-sleeping and consanguinity have recently started to be addressed.

Outcome 11 Safety, availability and suitability of equipment

50. Accident and emergency (A&E) services at Fairfield General Hospital (part of PAHT) have identified priority access areas for children and young people within the adult provision. However, the privacy and dignity of services users may be compromised, especially at busy times when they are collated next to adults. Plans are in place for a new dedicated children’s A&E. There are appropriate skilled staff on duty, with good support at times of medical emergency provided from the children assessment and observation unit. Accident and emergency staff have good access to the social care advice and assessment team including the out of hours service, with feedback on referrals provided by the named nurse.
51. There is good use made of the shared equipment procurement processes for children with disabilities with professionals reporting no delays in obtaining equipment.

Outcome 12 Staffing recruitment

52. Most staff interviewed have had an enhanced criminal records bureau check (CRB) in the last three years with the exception of PAHT staff. The PAHT staff interviewed reported that only new employees have an enhanced CRB. Those staff who had been internal appointments, such as those promoted to new posts, reported not having a CRB check or an enhanced CRB check, in line with the *NHS Employment Check Standards and the CRB standard (January 2011)*. Information from human resources at PAHT showed that this practice is not in line with the trust policy. Evidence was not provided to show that internal appointments of clinical staff groups examined in this inspection were aligned to the trust policy. There are various strategies used by the trust, endorsed by senior managers, to mitigate the risks, including relying on the professionalism of staff to report or use the whistle blowing procedures.

53. There are outstanding induction processes for all new community staff which promote multiagency working within health and with other partners.

Outcome 13 Staffing numbers

54. There are very few health visitor vacancies. Community practitioners are effectively managing their capacity, through the increasing use of skill mixed teams.

55. Teenagers who use community services, including those who are pregnant, have successfully been involved in staff recruitment processes, such as the teenage parent specialist practitioner (health visitor) post.

56. Fairfield General Hospital does have anaesthetists with special interests in children, although these are not dedicated posts due to the low patient activity levels.

57. There is low staff turnover within all health services with staff reporting a positive open and transparent culture promoted through all staff daily working practices.
Outcome 14 Staffing support

58. Good use is made of safeguarding supervision to ensure that all staff are well supported and that child protection cases are progressing. Designated professionals and named staff have good access to external supervision, as well as both peer supervision and opportunities for networking and sharing good practice across the North West strategic health authority region. There are an increasing number of health providers supporting staff to have joint safeguarding ‘case based’ supervision with staff from other providers including social care staff and the young person’s sexual health service. Staff report that this has enabled them to clarify and ensure that safeguarding arrangements for children and young people are robust and that information and concerns are highlighted early and promptly shared. The recent revision of supervision policies has resulted in a standardised approach to recording of supervision sessions and outcomes. These documents are subject to regular review by the respective health organisation’s named nurse/doctor. All health staff reported feeling well supported and able to discuss any safeguarding concerns or worries that they might have.

59. Since January 2012, there has not been a named GP in post, following the previous post holder’s move to the shadow Clinical Commissioning Group, although the previous post holder is currently covering a majority of the named GP functions. All thirty-three GP practices have a designated safeguarding lead in place, with increasingly well used structures in place to gain support and advice.

Outcome 16 Audit and monitoring

60. All looked after children (LAC) placed in Bury health assessments/reviews are subject to good quantitative and qualitative review. Audit cycles of health assessments are well developed and are being enhanced further in relation to IHAs. Although there is similar rigour to the out of area placed children and young people the ability to affect improvements in these records is limited, as there is no regional quality schedule or agreement in place. Health assessment/review action plans seen were in operation, with all but one having objectives written in a measureable fashion.

61. Good use is made of treatment outcome measures within mental health services, which are reported quarterly and show positive outcomes for service users, and demonstrate flexibility in service delivery with staff consistency of practitioner being most highly rated.

62. There is effective use and monitoring, of the North West safeguarding standards equivalent to the Section 11 safeguarding audits, with good follow up of any action plans. The commissioners monitor progress through the quality visits and regular engagement and meetings with the designated nurse for safeguarding.
Outcome 20 Notification of other incidents

63. There has been effective use of the Local Authority Designated Officer (LADO) especially within the substance misuse services and PAHT. Health staff are aware of their organisation’s whistle blowing policy and some have used it effectively.

Outcome 21 Records

64. Health records are subject to rigorous audit to ensure information and genograms are appropriately recorded and that any identified health needs acted upon. Community practitioners report that this has had an immense positive impact on enhancing their working practice when promoting safeguarding.

Recommendations

Within 3 months

NHS Bury and Bury Metropolitan Council childrens social care must ensure that timelines for safeguarding referrals related to unborn babies does not impede unborn baby planning or delay the discharge of mothers.

NHS Bury and Pennine Acute Hospitals must ensure that nothing impedes the safeguarding training in order that a minimum of 80% of all staff groups are in date and have received the correct level of training, as deemed necessary for their post.

NHS Bury and Pennine Acute Hospitals must ensure that the trust complies with safer recruitment and the NHS Employment Check standards, especially in relation to criminal records bureau checks on commencing and changing job role.

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.