

# **Review of Health Services for Children Looked After and Safeguarding in Bury**

## Children Looked After and Safeguarding The role of health services in Bury

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<b>Provider services included:</b>	Pennine Acute Hospitals NHS Trust Pennine Care NHS Foundation Trust Virgin Care Services Limited One Recovery (ADS) Bardoc (Prestwich Walk in Centre)
<b>CCGs included:</b>	NHS Bury Clinical Commissioning Group
<b>NHS England area:</b>	North region- Greater Manchester
<b>CQC region:</b>	North
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## Summary of the review

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This report records the findings of the review of health services in safeguarding and looked after children services in Bury. It focuses on the experiences and outcomes for children within the geographical boundaries of the local authority area and reports on the performance of health providers serving the area including the Clinical Commissioning Group (CCG) and Local Area Team (NHS England).

Where the findings relate to children and families in local authority areas other than Bury, cross-boundary arrangements have been considered and commented on. Arrangements for the health-related needs and risks for children placed out of area are also included.

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## About the review

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The review was conducted under Section 48 of the Health and Social Care Act 2008 which permits CQC to review the provision of healthcare and the exercise of functions of NHS England and Clinical Commissioning Groups.

- The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.
- The focus was on the experiences of looked after children and children and their families who receive safeguarding services.
- We looked at:
  - the role of healthcare providers and commissioners.
  - the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
  - the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.
- We also checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, Working Together to Safeguard Children 2018.
- Where we found areas for improvement in services provided by NHS but commissioned by the local authority then we will bring these issues to the attention of the local public health team in a separate letter.

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## How we carried out the review

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We used a range of methods to gather information before and during the visit. This included document reviews, interviews and visits. Where possible we met and spoke with children and young people. This approach provided us with evidence that could be checked and confirmed in several ways.

We tracked individual cases where there had been safeguarding concerns about children. This included some cases where children were recently referred to social care and others where children and families had not been referred, but were assessed as needing early help from health services. We also sampled a spread of other such cases spanning universal and specialist health provision.

Our tracking and sampling also followed the experiences of looked after children to explore the effectiveness of health services in promoting their well-being.

In total, we considered the experiences of 108 children and young people.

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## Context of the review

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Bury Council area consists of 6 towns including Bury, Prestwich, Radcliffe, Ramsbottom, Tottington and Whitefield. The council has a total population of 189,600 residents with approximately 44,900 children and young people aged 0-18 (comprising 24 per cent of the total population). Approximately 18 per cent of the population are from a black or minority ethnic population; mostly of British Asian heritage. Other minority groups living in the local area include a long-established Jewish Orthodox community and well as more recent arrivals including refugees.

Bury is ranked 83 out of 152 Local Authorities in England on overall indices of deprivation. Infant mortality rates in Bury are comparable to the rest of England. Teenage conception rates have been continually declining and are in line with national rates. Levels of low birth weight babies (a risk factor for neonatal deaths) are in line with national levels. Breastfeeding rates in Bury however, are much lower than England levels. Childhood vaccination coverage is significantly better for most immunisations that are offered. The average number of decayed, missing and filled teeth in children however, is much higher than national rates. Performance data in relation to children achieving a good level of development at the end of reception, although improving, remains below the average for England.

The rate of hospital admissions caused by unintentional and deliberate injuries to children aged 0-14 years is higher than the average for England. Bury has a higher rate of young person admissions to hospital for reasons of mental health compared to national and regional levels. Hospital admissions due to substance misuse is also significantly higher in Bury when compared to national rates.

Commissioning and planning of most health services for children is carried out by NHS Bury Clinical Commissioning Group (CCG) and Public Health Bury.

Commissioning arrangements for looked-after children's health are the responsibility of the Clinical Commissioning Group. The looked-after children's health team is provided by Pennine Care NHS Foundation Trust. Medical examinations are undertaken by Pennine Acute Hospitals Trust (PAHT) paediatric doctors.

The local emergency department (ED) is located at Fairfield General Hospital in Bury. Pennine Acute Hospitals Trust also provides maternity services to pregnant women in the area. Some Bury women also deliver their babies at Royal Bolton Hospital, but we have not included this provider within the review.

Health visitor and school nursing services are commissioned by Public Health Bury and provided by Pennine Care NHS Foundation Trust.

Healthy Young Minds (HYM), the child and adolescent mental health service and adult mental health services are provided by Pennine Care NHS Foundation Trust.

Contraception and sexual health services (CASH) are commissioned by Public Health Bury and provided by Virgin Care Services Limited.

Child substance misuse services are commissioned by Public Health Bury and provided by Early Break. Adult substance misuse services are commissioned by Public Health Bury and provided by One Recovery (ADS).

The latest published data indicates there were 227 children on a children protection plan during 2016/17. Of these, 52 children (22.9 per cent) were subject of a plan for a second or subsequent time. A total of 56 per cent of children were on plans for neglect and 35 per cent for emotional abuse.

A total of 350 children were looked after by the local authority at the end of March 2017 (a rate of 82 per 10,000 children compared to 62 in 10,000 nationally). Approximately 10 per cent were placed more than 20 miles away from the local area.

Relevant findings from CQC's previous inspections including regulatory inspections and the Special Educational Needs and Disability (SEND) inspection that took place in 2017 are referenced within the report.

At the time of the inspection visit the local area (in common with other local authorities in the Greater Manchester region) was undergoing significant organisational change to integrate the statutory powers of the CCG and local authority as a single body to form One Commissioning Organisation.

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## The report

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This report follows the child's journey reflecting the experiences of children and young people or parents/carers to whom we spoke, or whose experiences we tracked or checked. Recommendations for improvement are made at the end of the report.

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## What people told us

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*The school nurse is amazing. She believed in my daughter and really listened to her. The nurse does not tell my daughter what she should do, she just supports her with the things she needs. Parent.*

*They listened and took time to explain all the information. She didn't drag out long-winded questions. I remember she got straight to the point. I liked that, it was less painful. She didn't make me feel uncomfortable. I could speak to her any time I needed, so helpful. Care leaver telling us about their experience of using the looked after children (LAC) health service.*

*I found it difficult at first to get the help I needed. I think Healthy Young Minds (HYM) should offer to make meetings friendlier, in the home, rather than in an office environment. Care leaver telling us about their experience of using HYM.*

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## The child's journey

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This section records children's experiences of health services in relation to safeguarding, child protection and being looked after.

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### 1. Early help

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1.1 The paediatric emergency department (ED) at Fairfield General Hospital in Bury supports children and young people up to 16 years of age. Those over the age of 16 are generally seen in the adult emergency department unless they are already known to the service such as young people with long term conditions or disabilities. If a child or young person requires admission to hospital they are transferred via ambulance to another location as Fairfield hospital does not have any in-patient paediatric facilities.

1.2 Paediatric medical and nursing cover is not available on all ED shifts. This means that children and young people may not have staff caring for them with the appropriate paediatric competences. Pennine Acute Hospitals Trust-wide (PAHT) improvement plan gave top priority to ensuring its workforce had the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. Gaps in paediatric capacity and skills had not been fully addressed at the time of this recent inspection. (**Recommendation 11.1**)

1.3 Children are booked in via the main reception desk (a shared booking point for all patients), and are asked to wait in the main waiting room for triage. After triage, they are transferred to the dedicated children's waiting room. The waiting room does not allow direct observation of the children and young people who are waiting, and is away from the main nurse station. Observation of this area by ED staff is intermittent. This limits the ability of the ED team to check on the condition of a deteriorating child or monitor interactions between children and those accompanying them. This risk was identified in our previous inspection of Fairfield ED in October 2017. Estate plans have now been drawn up with approval granted to proceed with building alterations.



1.4 Whilst there is an electronic system of information-sharing from ED to GPs about attendances, communication to community health professionals is not supported by a timely and streamlined process. The ED does not have a dedicated paediatric liaison role. Paper ED discharge forms are shared via internal post leading to significant delays in health visitors receiving important information required to safeguard children effectively. In one case, a delay of three weeks was evident following attendance for head injury. Further delay can occur whilst health visitors pass on relevant information about older children to the school nursing team. Where ED staff identify a safeguarding concern, this is shared with PAHT's safeguarding team who forward this on to the relevant health visiting or school nursing team. Whilst PAHT's improvement plan clearly recognises the need to have information technology infrastructures that are fit for purpose, the timescale for completion is still some time away (March 2020). (**Recommendation 2.1**) *This was also brought to the attention of the Director of Public Health as commissioner of health visiting and school nursing services.*

1.5 Bury and Prestwich walk-in centres use a single assessment form that covers both children and adult issues. The form does not contain any prompts to encourage identification and wider exploration of risks to children, including for example, risks from domestic abuse. Wider enquiry about the safety and wellbeing of children and recognition of their need for early help was reliant on the professional curiosity of individual practitioners. The approach taken did not support the delivery of child-centred practice. (**Recommendation 5.1**)

1.6 Most Bury pregnant women self-refer and choose maternity services provided by Pennine Acute Hospitals Trust or Royal Bolton hospital. The Fairfield Hospital site does not have maternity delivery facilities; but offers antenatal clinics and is the base for community midwives working in the area. Whilst there is no standard offer of a universal home visit, community midwives work flexibly to engage women in their care and offer choice where they can be seen, including at children's centres or in GP practices.

1.7 Health visitors reported they did not receive all PAHT antenatal notification slips which impacted on their performance in undertaking timely antenatal visits to all women on their caseload. On occasion, they did not find out about the pregnancy until after the baby was born. Given breastfeeding rates in Bury are also comparatively low, stronger joint working and handover arrangements could help improve the experience of mothers and their babies. (**Recommendation 10.1**) *This was also brought to the attention of the Director of Public Health as commissioner of health visiting services.*

1.8 Liaison and team working between health visiting, midwifery teams, and GP practices overall was variable and compounded by the lack of aligned or efficient case recording systems. Professionals who shared premises for clinics were generally more proactive and effective in alerting each other to new or emerging concerns about parents or their unborn or new born babies. The constraints of not having face to face contact to share sensitive information and promote shared recognition of risks were seen in one case record. Whilst the midwife wrote to the GP to request medication to help treat concerns about maternal mental health, wider emerging safeguarding concerns had not been shared. (**Recommendation 6.1**) *This was also brought to the attention of the Director of Public Health as commissioner of health visiting services.*

1.9 An increasing range of agencies provided in-reach support to schools to help strengthen the area's focus on early help. School nurses were actively engaged with other local teams such as Early Break, Healthy Young Minds (HYM) and Virgin sexual health services to promote a joined up and holistic response to children's needs. *'First Point,'* was available to children and families following diagnosis of autism or attention deficit disorders. The service promoted wider understanding and support for parents in their caring role through offering training, advice and information. The CCG had commissioned Early Break to deliver mindfulness and holistic therapies and a bereavement and loss counselling programme. Such approaches were helping to promote shared recognition of wider issues that impacted on children's health and wellbeing and helped strengthen 'team around the family' working.

1.10 The school 'link nurse' model in Bury worked well. School nurse provision is available in almost all high schools through drop in's. The offer included support to the pupil referral unit, post-sixteen provision and home-educated children and young people. The model aimed to ensure young people knew about and could easily access health services. In one setting, drop-in support was used well to help a child who was a refugee to understand how to access additional support so that gaps in meeting their needs could be addressed.

1.11 We saw examples of positive partnership working to address the needs of children and young people with long term conditions. School nurses were working closely with GPs and Pennine Acute Hospitals NHS Trust to identify and reduce risks to the safety and wellbeing of children and young people with asthma. Such approaches were helping improve the co-ordination of care and promote better experiences and outcomes for children.

1.12 Healthy Young Minds (HYM) had expanded its work alongside partner agencies to strengthen its offer of emotional, mental health and behavioural support to children and their families. The *'Time for Me'* course was valued by mothers with lower level mental health issues. Self-referral was encouraged. Such approaches encouraged earlier recognition of risks to mental health and of services available.

1.13 Priority had been given to promoting easy and equitable access to services in ways that recognised the area's diverse townships and population groups. Interpreting support was available for all families who needed it. HYM was working closely with the local Jewish Orthodox community to help strengthen awareness and promote better access to local provision.

1.14 The local Healthwatch team had received feedback from local people about challenges they experienced in accessing mental health services. At the time of this inspection, Healthwatch was planning a review of HYM services in Bury, Oldham and Rochdale. This should help provide further analysis of the impact of improvement actions taken to inform ongoing review of local transformation plans.

1.15 Virgin Care sexual health service was also expanding its early help offer and the flexibility and responsiveness of its service. This approach recognised the needs and personal circumstances of young people who may not be able to attend its centres for contraception and sexual health advice, care and treatment. Virgin has strengthened its 'on-line' offer to include screening for sexually transmitted diseases. The self-directed approach required completion of the '*Spotting the Signs*' form and encourages follow-up checks.

1.16 The sexual health team has been proactive in building links with children and young people who attended faith schools. Programme contents were shared with school leaders and adapted to make them more accessible. Virgin Care worked closely with school nurses or other professionals the young person was comfortable with, in a place they felt safe. The sexual health team also offered a monthly drop in at the mother and baby unit to support women who wanted to delay a further pregnancy.

1.17 One Recovery the adult substance misuse service worked closely with Early Break, the local organisation supporting young people who misused alcohol or drugs. For example, One Recovery co-facilitated the adult groups on the "Holding Families" scheme run by Early Break which encourages open discussion of the risk of hidden harm to children.

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## 2. Children in need

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2.1 Information-sharing between MASH and the health visiting and school nursing teams was good. The health representative in the MASH inputted relevant information onto an electronic message book for health visitors and school nurses which flagged urgency. Review of case records, pathways and systems demonstrated effective management of busy health visitor caseloads. This helped secure wider team awareness of urgent work to promote timely analysis of concern and decision-making about next steps to keep children safe.

2.2 Good use was made of special circumstance forms by midwives (PAHT) where they had identified concerns and recognised mothers and their unborn babies required additional support and monitoring of risks. Special circumstances forms were shared electronically. This supported timely response and tracking of concerns prior to the baby being born. Health visitors reported early flagging of mental health and domestic abuse concerns by midwives. Joint visiting was undertaken antenatally and postnatally as required to help maintain a strong focus on risks to the unborn or new born baby.

2.3 Record-keeping was not contemporaneous on two maternity records we reviewed. In one case the midwife visited a woman at home and was informed about a domestic abuse incident. Recording of the incident; including reporting the elevated level of concern and completion of the special circumstances form however, was not undertaken until four days later. Such delays in updating records to reflect changing circumstances and escalation of risks did not support effective safeguarding practice. (**Recommendation 11.2**).

2.4 Maternity staff in PAHT do not use chronologies to enable a holistic overview of risks to the mother or her unborn baby. Practice was reliant on the use and review of individual special circumstance forms to monitor changing need. This risked narrowing their focus on the most recent concerns, rather than appraisal of all relevant information. In one case record, historical risk had not been sufficiently explored in the antenatal period. It was not fully considered until the woman presented in labour. The named midwife had scheduled an audit of special circumstances forms for August 2018. This had not been progressed at the time of this inspection. The potential to strengthen practice through use of chronologies was highlighted to PAHT in our Manchester Children Looked After and Safeguarding (CLAS) inspection in August 2017. (**Recommendation 11.2**).

2.5 PAHT maternity records demonstrated risks to women's mental health and well-being were considered throughout the ante-natal period. However, the prompts for more detailed mood and anxiety checks within women's handheld records were not always completed to evidence decisions taken about the management of risk.

2.6 We saw good practice in one case where concerns about parental mental health were clearly identified at booking which led to relevant referrals to partner agencies to support the wellbeing of the Mum and her unborn baby. Whilst maternity assessment documents also prompted staff to assess partner's mental health, this field was not always completed on case records seen. The template did not include risks arising from partner's alcohol and substance misuse which may lead to gaps in awareness about wider risks within the household. (**Recommendation 11.3**)

2.7 Women and their babies living in Bury do not have access to specialist perinatal mental health services. There are plans to address this. Resources have been secured to establish perinatal provision in the local area next year.

2.8 Case records demonstrated some ongoing gaps in practice in ensuring routine enquiry of domestic abuse in line with PAHT's procedures. The named nurse had undertaken an audit of domestic abuse that included maternity services and an action plan had been developed to help strengthen practice. Maternity staff do not often complete Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) assessments to enable them to identify or review the level of risk and harms posed to unborn babies. This limited their oversight in tracking changes as the pregnancy progressed to inform ongoing care and safety planning.  
**(Recommendation 11.4)**

2.9 The use of prompts and tools for screening risks of child sexual exploitation (CSE) and neglect was also not well developed within midwifery practice. Maternity staff we met told us they had not identified any cases of CSE. They did not use neglect tools such as the Graded Care Profile to support safeguarding assessment and practice. Staff reported they had not received any training on the Graded Care Profile. Improvement actions identified from the recent multi-agency audit of neglect included the need for earlier signposting by midwifery services and stronger joint working with other professionals supporting school-aged children.  
**(Recommendation 11.4).**

2.10 Reporting of female genital mutilation (FGM) by maternity and health visiting staff was in line with national guidance and included appropriate handover arrangements. Current reporting levels in Bury are relatively low. GP's we spoke to were also vigilant to FGM risks.

2.11 The voice of the child was clear within health visitor records, with appropriate detail about their observations of parental attachment, play, and the safety of the home environment. Key details about immediate and extended family living within the home, their faith, culture and language were noted. Health visitors had easy access to interpreters when required. Good joint working with children's social care was evident on all cases seen. Information was promptly shared by health visitors when they were not able to access the home or when a child had not been brought to an appointment.

2.12 The role of the health visitor in supporting children with complex health needs or disabilities was well developed. Casework seen denoted health visitors were strong champions for the child and their family. Health visitors liaised with and brought together a range of health professionals, statutory and voluntary agencies to provide specialist care to children. They clearly recognised the vulnerability of parents in the early years of caring for a disabled child, including those who continued to experience a sense of loss, or who were socially isolated or living in unsuitable housing.

Child A was born prematurely and has significant health and disability- related needs. The health visitor made regular contact with parents and ensured all relevant specialists and voluntary sector organisations were actively involved in building a comprehensive picture of the child's needs and mapping their future support requirements.

The health visitor regularly convened 'Team around the Family meetings' and was alert to the stresses experienced by child A's parents in managing their day to day needs whilst also caring for an older sibling. Over time, meeting attendees reduced to it just being the health visitor and parents. The health visitor with parents' consent referred the child to children's social care recognising the need for additional help to support and sustain the whole family. She recognised the need to make an early start on planning A's education, health and care plan to ensure her needs were appropriately met in preparation for school.

2.13 There is a designated section 136 suite on the Fairfield site, based within the Urwell Unit, which is managed by Pennine Care. Patients identified by the police who meet section 136 of the Mental Health Act (1983) are taken directly to the Urwell Unit for assessment. Emergency department staff at Fairfield General Hospital advised us that although the number of occasions when they needed to involve HYM was episodic, the support they provided was good.

2.14 MASH referrals completed by the HYM team provided a clear picture of professional concerns. Good multiagency liaison was evident in the records viewed, including, proactively chasing up outcomes from MASH referrals. Advice was clearly documented within records. Consent was clear and well-managed. HYM staff recognised their ongoing responsibilities for safeguarding children and appropriately shared information with other agencies in line with good information governance. In one case seen, although the psychologist was aware that sharing sensitive information could impact on their relationship with the young person, this was necessary given the level and nature of concerns identified.

2.15 The HYM service recognised the challenges young people experience when receiving help with what can sometimes be painful emotional and mental health issues. Children and young people 'not brought to appointments' were risk assessed to determine whether they should be placed on the DNA (did not attend) pathway or if further intervention was required.

2.16 The HYM offer was still largely restricted to young people under the age of 16 years (except for young people with neuro-developmental issues). A clear transition protocol was in place to plan the handover of care from age 16 for young people who continued to require ongoing support. Joint working between child and adult mental health practitioners was well managed in the cases seen. The availability of provision post-16 was clearly recognised by local leaders as an area for improvement. Plans were in place and investment had been secured to implement a new transition model next year.

2.17 The CCG worked closely with NHS England to help safeguard children and young people with mental health difficulties who were admitted to hospital. Care and treatment reviews ensured plans for safe discharge were in place, including access to additional support as required. Monthly visits by the CCG's safeguarding team promoted greater vigilance of the safety and wellbeing of children and young people so accommodated.

2.18 We found the capacity of school nursing in Bury was very stretched. Whilst all referrals to the service were triaged and prioritised, with a duty system in place in all teams, current pressures were impacting on the timeliness and quality of work. We saw examples of delay, drift and inconsistent responses in case recording. For example, two records of children who had moved into the area 3 months previously, identified as having 'child in need' status, had not been actively followed up. In another record, a multi-agency risk assessment conference (MARAC) outcome was not reviewed by the school nurse until 19 days later. This meant the needs and any risks experienced by the children were not actively followed up. Pennine Care managers were not monitoring waiting times within the school nursing service to provide assurance of the timeliness and equity of support between localities. In contrast, workload management was strong within the health visiting service. (**Recommendation 12.1**) *These issues were also brought to the attention of the Director of Public Health as commissioner of school nursing services.*

2.19 A system of 'one off' chronologies of significant events was used by school nurses to record changes to children's circumstances and risk. However, the electronic case management system was not able to provide an integrated analysis of escalating or de-escalating risk. Further development of the system was needed to produce a complete chronology of events to enable prompt review of the child's journey and of previous adverse experiences. This would also enable school nurses to have better oversight of ED attendances and of children not brought to appointments. (**Recommendation 12.2**) *These issues were also brought to the attention of the Director of Public Health as commissioner of school nursing services.*

2.20 Virgin Care Services Limited sexual health practitioners were vigilant to the risk of sexual exploitation and abuse, and acted promptly to share concerns with relevant other agencies. Consent was appropriately managed on cases seen. Virgin practitioners were involved in strategy discussions, but reported they had limited capacity to attend other relevant individual case discussions including team around the child, child in need or child protection meetings. (**Recommendation 13.1**) *These issues were also brought to the attention of the Director of Public Health as commissioner of sexual health services.*

2.21 We saw good joint working by adult mental health practitioners with parents who had high or significant mental health needs. Strong collaborative practice between the ward staff, care co-ordinator and the children's social worker was seen on one case record to support the safe discharge of a mother who had been admitted to hospital following an acute psychotic episode. This joint approach ensured a comprehensive assessment of risks and of ongoing support required.

2.22 For new referrals to adult mental health, assessment documentation provided appropriate initial recognition of children within the household or for whom they had parental responsibilities. However, the focus on children was generally not sustained or sufficiently visible within longer term work. We found limited analysis and review of the impact of parental mental health needs on their protective capacity and of the experiences of children following relapse of parental mental health. **(Recommendation 12.3)**

2.23 Referrals to One Recovery by other agencies were sometimes being made at too late a stage when the risks of child neglect were high, or children were at the point of being removed from their parent's care. One Recovery practitioners were vigilant in their recognition and recording of child neglect and made appropriate referrals to MASH. For example, they took prompt action to safeguard an adolescent who was often home alone and missing school who had recently experienced a significant loss. Children's social care were promptly informed when parents/adults within the household dis-engaged from using substance misuse services.

2.24 Alerts were in place where there were concerns about parental protective capacity. All One Recovery assessments seen provided relevant details of children, their ages and care arrangements, with a chronology/timeline completed to help track changes in levels of risk or engagement of parents. However, details of the schools' children attended and involvement of other health care professionals in supporting the family was not consistently recorded or known. **(Recommendation 14.1)** *This was brought to the attention of the Director of Public Health as commissioner of adult substance misuse services.*

2.25 One GP highlighted the need for stronger links and information sharing with the One Recovery adult substance misuse service. They reported they were not always kept informed about adults receiving treatment for opiate substitution replacement therapy where there were linked children registered at the practice. This limited their capacity to assess progress and the impact for children. **(Recommendation 14.2)** *This was brought to the attention of the Director of Public Health as commissioner of adult substance misuse services.*

2.26 The local area acknowledged the 'Think Family' approach was not yet embedded or driving safeguarding practice. Communication and joint working between child and adult health professionals overall was inconsistent. GPs had variable levels of contact with wider health professionals, including regular joint reviews of children and families where concerns about abuse or neglect were known. Safeguarding practice did not consistently reflect prompt communication, shared understanding or timely response where risks to children's safety, development or wellbeing were increasing. Joint working between school nursing and adult mental health and One Recovery practitioners largely took place within formal child protection meetings. The lack of established links outside formal meetings risked hindering the promotion of timely and effective identification of young carers. **(Recommendation 6.1)** *This also was brought to the attention of the Director of Public Health as commissioner of community health and substance misuse services.*



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### 3. Child protection

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3.1 Safeguarding children arrangements in ED at Fairfield General Hospital were a significant cause for concern. All case records we sampled denoted poor practice with systemic weaknesses in risk management and organisational practice. We asked the local area to provide an improvement plan which will be discussed further within the leadership and management section of this report.

3.2 It is of concern to CQC that our visits to Fairfield ED in October last year also highlighted key areas for improvement in the quality of assessment and recording, including professional accountabilities for ensuring children were safe. We found gaps in safeguarding leadership and management challenge to ensure effective checks were made and risks to children were promptly escalated. (**Recommendation 11.5**)

3.3 The ED at Fairfield General Hospital has one of the best performance rates nationally in seeing patients within the 4-hour target. However, the quality of safeguarding assessments within wider clinical assessment documentation was poor. The safeguarding screening tools did not have prompts to help departmental staff identify and make appropriate checks. For example, there were no CSE prompts for older children/young people or triggers to support exploration of bruises in infants. No one was regularly auditing the records to provide assurance of the quality of the work. (**Recommendation 11.5**)

3.4 Assessments were inconsistently completed in key areas such as family history and composition. We found a lack of professional curiosity about previous attendances and limited recording of parental responsibility and of their faith, culture or language. The voice of the child/young person was weak overall which left significant gaps in recognition of individual needs and circumstances. Discharge checklists were not consistently completed or missed out information about the designation of the clinician. Relevant information was not promptly shared with community health professionals, with delays and/or a lack of effective escalation of concerns to children's social care. Recognition of potential risks to children and young people in cases of assault of them, their parents, or other adults in domestic abuse incidents were poorly considered. (**Recommendation 11.5**)

A woman presented at ED having been assaulted by her partner. Her previous attendances were not reviewed or recorded on the most recent assessment documentation. A body map was completed to evidence the injury as would be expected practice in these circumstances.

Risks to the mother and baby were not explored. The referral paperwork at the time was completed by a health practitioner who had not sought advice or guidance from a senior member of staff. The emergency duty social work team had not been contacted to see if the family was known. A referral had not been made to MASH, with a delay of over two weeks in concerns being raised. Information had not been shared with the health visitor.

3.5 Our inspection visit prompted review by PAHT's safeguarding leaders of the case records we examined. This led to the submission of additional referrals by the emergency department to MASH given that significant issues of concern had not been appropriately identified or followed up. The management of such incidents was not in line with Trust policy and guidance or multi-agency child protection procedures.

3.6 Further review of these referrals by the inspection team within MASH, indicated significant weaknesses in professional curiosity and focus on the child. They did not provide any relevant information of concern about children's vulnerability or wider risks of harm they may be exposed to. Gaps in basic recording in areas such as the date of birth, child's NHS number, time of presentation and checks of multiple previous presentations should have flagged wider urgent enquiry prior to their discharge. It was notable that a thirteen-year old who had been assaulted had attended on 6 previous occasions, and another child of the same age, had 22 previous attendances. Had children or families been asked if they had a social worker, this may have led to ED staff being better informed about the involvement of children's social care. Such gaps in key information on referrals added further to the demands on the part-time health professional within the MASH as they sought out additional basic information which had not been provided. (**Recommendation 11.5**)

3.7 Although the ED at Fairfield General Hospital had implemented the Child Protection Information System (CP-IS) earlier this year, staff we spoke to were not clear about their roles and responsibilities for this. This included professional accountabilities for following up of alerts on the booking-in form that indicated the child was on a child protection plan or was looked after. We could not be assured that the system was working effectively. (**Recommendation 7.1**).

3.8 CP-IS had gone live in Prestwich Walk-in centre in October 2017. Alerts were clearly visible when a patient record was opened. However, further enquiry about known risks to the safety of children was not routinely undertaken or recorded. For example, in one case record seen, where there had been 3 presentations to the Walk-in centre, none of the centre records referred to the fact that the young child was on a child protection plan. When Prestwich Walk-in staff made a referral to children's social care, they were required to share this with the quality and compliance lead in Bardoc. This post holder was responsible for submitting the referral and any following up communications with other relevant health professionals. This provided some oversight and tracking of child safeguarding practice. However, the outcomes of such referrals were not clearly visible on the child's record. This in turn risked contributing to gaps in ensuring all relevant safeguarding information was effectively co-ordinated. (**Recommendation 7.1**).

3.9 CP-IS had only been introduced to Bury Walk-in centre the week of our inspection visit. We found that its implementation had not been well-planned for or managed. The staff we met had not yet received training in advance of it going live, and were not clear about its use or how to record outcomes. There was a lack of clarity about the role and responsibilities of agency staff in checking whether children were on a child protection plan or looked after. On the day of inspection, staff could not locate relevant safeguarding policies and the contact details for the MASH were out of date. Recognition of their safeguarding responsibilities for children was not embedded in practice (**Recommendation 7.1**)

3.10 The assessment paperwork in both Walk-in centres did not contain any specific safeguarding questions or prompts. Frontline staff were reliant on a single assessment form for children and adults. The vulnerability of some children and young people, including those aged 16-18 years, could easily be missed. This meant important information about specific child health issues or safeguarding concerns may not be recorded or shared with wider health partners and children's social care. (**Recommendation 5.1**)

3.11 The health professional within MASH, an employee of Pennine Care, provided expertise to inform the wider partnership about a range of health matters and risks to the safety and wellbeing of children. They maintained tight scrutiny of timescales for multi-agency decision-making on high risk cases, and contributed to strategy discussions if available. However, the role is a part-time one, and capacity had not been assessed since the post was developed some years previously.

3.12 In their absence, the wider MASH team make the telephone calls and follow up queries with other health professionals. Gaps in capacity risked contributing to inconsistencies in practice including not having a full understanding of the relevance of health information. There is minimal contingency cover when the MASH health practitioner is on leave. (**Recommendation 3.1**) *This was brought to the attention of the Director of Public Health as commissioner of community health services.*

3.13 Information exchange worked best with health visitors and school nursing staff. Adult mental health and One Recovery substance misuse teams were not part of MASH health pathways. Systems to support communication and information-sharing were inefficient and reliant on time-consuming tracking by telephone to ascertain what was known about children and their parents by GP's, Healthy Young Minds (HYM) and midwives, all of whom were using different electronic systems. The potential for further expansion of links with the full range of child and adult health professionals operating in the local area had not been explored. (**Recommendation 4.1**) *This was brought to the attention of the Director of Public Health as commissioner of community health, sexual health and adult substance misuse services.*

3.14 Health visitors were largely reliant on paper records to record activities with children and families. Despite this outdated system, the records were complete, effective and robust. The health visiting service had a combined family health record which was routinely informed by use of chronologies and genograms. Record keeping was good and promoted effective recognition of the needs, place and role of all children within large or diverse household compositions.

3.15 Health visitor safeguarding practice was informed by a high degree of professional curiosity, with good awareness and challenge of 'disguised compliance', 'invisible men' and vigilance to escalation of parental mental health or substance misuse issues. Referrals to MASH where safeguarding concerns had been identified, reports to child protection conferences and court reports were of a consistently high quality. They provided good analysis of the impact for the child living with domestic abuse or neglect.

Child B was 3 months old at the time they moved with their family to live the local area. The handover from their previous health visitor included disclosure of domestic abuse by the father and maternal mental health issues. Child B was previously open as a child in need, but closed prior to transfer.

The named health visitor contacted the family promptly and arranged a visit within 6 days of the referral. The health records clearly captured the voice of this young child. A full assessment was completed including a genogram, with good consideration of family dynamics and the impact this had on child B.

Since the move, a further incident of domestic abuse had taken place. Appropriate safeguarding measures were taken to protect child B and their unborn sibling including the completion by the health visitor of a high-quality referral to MASH and a DASH assessment. Casework demonstrated good liaison with the GP, specialist midwife, children's social care and the police. A MARAC discussion was held, and children's social care were in the process of completing a child and family assessment.

3.16 Child protection reports written by health visitors were routinely discussed with parents in advance of formal meetings. Attendance at multi-agency meetings was clearly documented by health visitors, including recording and analysis of key concerns and action plans. Minutes of meetings and child in need and child protection plans were appropriately filed in all records reviewed. This ensured a complete health record thereby ensuring the health visitor was in possession of all relevant information to inform their work with families.

3.17 The mental health needs of the young people were appropriately identified within HYM screening and assessment processes. Safety plans were detailed and regularly reviewed. However, we found variable practice in the identification and recording of safeguarding children issues and the potential impact of their social circumstances or previous adverse experiences on their emotional and mental wellbeing. Whilst issues of wider exploitation were prompted within the core assessment documentation, the process could be strengthened through reference to specific risks such as CSE to encourage more focused enquiry and learning from the use of nationally validated tools. (**Recommendation 12.4**)

3.18 Safeguarding issues were sensitively considered within safety planning for young people at high risk of harming themselves or others. Risks were clearly identified within discharge planning, with due consideration given to handover of care for young people 16 years and older, who were in transition to adult mental health services.

Child C was about to be discharged from hospital when they attempted to take their own life. This led to their being sectioned under the Mental Health Act. Further assessment led to the identification of serious concerns about abuse within their home environment. The HYM practitioner made a thorough referral to MASH outlining the complexity of the young person's needs and risks to their safety and wellbeing.

Ward staff worked closely with child C and the wider network of HYM and adult mental practitioners. A safety plan was put in place which ensured appropriate recognition and support for addressing the traumatic impacts of the abuse they had previously experienced. A detailed transition letter was prepared by the HYM team to support the handover of their care to adult mental health services. This included a chronology clearly outlining significant incidents in their life, with contact details of relevant other partner agencies involved in multi-agency safeguarding work. The voice of Child C, including their wishes were clearly documented in case records.

3.19 Referrals by school nurses to children's social care were generally of good quality and articulated risks to children. However, there was no formal quality assurance process for tracking or reviewing the quality of referrals. This meant opportunities to acknowledge good practice and improve weaknesses were not driving practice. (**Recommendation 12.5**) *This was brought to the attention of the Director of Public Health as commissioner of school nursing services.*

3.20 Casework seen evidenced skilled and sensitive work by a school nurse with a young person with low self-esteem and self-harming behaviours.

Child D had previously been referred to and discharged from the HYM service. Having established a trusting relationship with the school nurse, they felt able to disclose a previous incident of sexual abuse. Consent to share information with family and wider multi-agency partners was appropriately managed and progressed through multi-agency child protection systems.

The school nurse continued to provide regular support to the young person and their family. They were vigilant to the risk of escalation of self-harming behaviours following disclosure in the lengthy period whilst awaiting the case being heard in court. Child D was actively engaged in shaping their safety plan. They were helped to be aware of the triggers for self-harm and had adopted appropriate tools for managing their anxiety. Child D said they feel relieved they had spoken out, and valued the ongoing support they received from the school nurse.

3.21 School nurses engaged well in wider child protection multi-agency meetings and were involved in the child's LAC statutory reviews. Attendance at such meetings was prioritised. If practitioners were unable to attend, they prepared a report outlining concerns and progress to help inform future planning and decision making. Casework seen denoted good professional vigilance to child sexual abuse.

3.22 Whilst Virgin sexual health records had a mandatory prompt to identify children who were looked after or missing; recording of the status of children on child protection plans or children in need was not mandatory. Our review of case records indicated that this was inconsistently recorded without always clearly identifying the level of concern in relation to safeguarding thresholds. Given the assessment template used in Virgin (based on 'Spotting the Signs' national guidance) allowed for a high level of professional discretion, with relatively few mandatory fields; some key information about wider safeguarding contextual risks may not be adequately explored or used to inform a more holistic assessment of risk. (**Recommendation 13.2**) *This was brought to the attention of the Director of Public Health as commissioner of sexual health services.*

3.23 Safeguarding children alerts were clearly flagged on One Recovery adult substance misuse records, including for Bury families who had temporarily moved out of the area. Appropriate systems were in place for recording and following up adults who did not attend appointments or who had dropped out of recovery programmes.

3.24 The safeguarding lead in One Recovery had appropriate oversight of safeguarding children activity and of their safeguarding/legal status which helped promote strong recognition of the vulnerability of children within adult substance misuse services. Quality assurance arrangements included oversight of referrals to children's social care and of the quality and timeliness of submission of reports to CP conferences. However, case records seen did not contain copies of MASH referrals and copies of child protection plans. Practitioners were not consistently involved in core group meetings. More assertive involvement and challenge by One Recovery workers was needed to ensure they were effectively engaged in multi-agency safeguarding work. (**Recommendation 14.3**) *This was brought to the attention of the Director of Public Health as commissioner of adult substance misuse services.*

3.25 The One Recovery team provided safe storage boxes for parents to keep their drugs and drugs paraphernalia safe within the home, although this was not part of local commissioning arrangements. Team members undertook joint home visits with relevant others such as social workers, midwives and health visitors where there were concerns about home conditions when they were requested to do so. A lead professional in One Recovery regularly attended MARAC discussions and ensured case holders were kept informed of the agreed outcomes.

3.26 Adult mental health teams benefitted from weekly 'zoning' meetings chaired by a senior medical practitioner. Cases of concern, including child safeguarding concerns, were discussed at these multi-disciplinary meetings and allocated a risk rating according to the level of concern. This meant that all staff in the service were aware of ongoing issues with high risk service users and were better informed to respond appropriately.

3.27 The electronic patient record system (PARIS) in adult mental health services was not well used to support identification of safeguarding risk to children associated with adult clients of the service. In all records we looked at, the safeguarding children section of the client record contained no data even though there were known safeguarding children concerns. In addition, there were no safeguarding alerts on the system for those families. Safeguarding documents, such as child protection conference minutes were missing in most cases. We were only able to identify those concerns through discussion with the staff members who knew the cases personally. The incomplete records meant that safeguarding risks would not be understood by other users of the record and risked being overlooked. (**Recommendation 12.6**)

3.28 Staff within mental health teams attending child protection meetings generally gave their information verbally. This is not best practice as there is no opportunity for the practitioner to share their views with parents. In two records we reviewed where a written report for conference was provided, whilst there was considerable detail about the parent's mental health and medication, there was little analysis of the impact of this for the child or of their parenting capacity. In these cases, the information shared had limited value and could lead to challenge about the appropriateness of disclosure. (**Recommendation 12.7**)

3.29 Primary care professionals had received additional training and support which helped them feel more confident about sensitively asking about domestic abuse. This was leading to an increase in the number of referrals GPs were making to MARAC and in some cases good information-sharing with independent domestic abuse advisers (IDVAs).

3.30 Alerts were in place to support primary care practices in recognising children and families where there were known concerns, using the nationally developed read codes. In both practices visited further work was required to review and cleanse the data to ensure it only captured relevant and up to date activity about the status of children. (**Recommendation 8.1**)

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## 4. Looked after children

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4.1 Pennine Care NHS Foundation Trust gave high priority to ensuring prompt follow up and review of children's health needs from the point of their placement in care. We found that the local authority did not always promptly inform the specialist health team about new children entering care. This risked delay in follow up by medical practitioners. A joint action plan had been put in place to secure continuous improvement in information-sharing that was helping to promote better performance in the achievement of statutory timescales for health assessments.

4.2 We found core information was missing from Part A of the child's record. This included the child's current care status, reason for placement in care, parental and sibling details, and most importantly, consent. Professional challenge and review of the accountabilities by health and social care partners was needed to ensure a full and up-to-date record of each child's personal circumstances, including parental responsibilities. (**Recommendation 12.9**)

4.3 Recording of the child's or parental ethnicity, language and religion was not always clear, nor was its meaning for the child/young person sufficiently explored within initial and review health assessments. Three records seen of unaccompanied children seeking asylum indicated insufficient exploration of their lived experience and the continuing impact of significant childhood events on their emotional and mental health. (**Recommendation 2.2**)

4.4 Initial health assessments (IHAs) were undertaken by PAHT's paediatricians. A clear pathway was in place that aligned the roles and responsibilities of the two provider trusts. We found the quality of IHAs completed by paediatricians at Pennine Acute Hospitals NHS Trust was variable, including recording of the physical examination of children and of the complexity of children who are older when they were placed in care (**Recommendation 2.3**)

4.5 Good quality initial assessments seen included detailed recording of the tools used to assess children's health and development and help prevent future risks; but others only provided limited information to help inform clinical judgement. For example, the record of one young person with asthma did not include relevant details about levels of risk including peak flow measurement, with superficial recording of the frequency of inhaler use and possible triggers. Lack of professional curiosity was also seen in levels of exploration of issues for children and young people including personal safety, sleep, diet, relationships and sexual health. The use of multi-vitamins for young children was not promoted in line with national guidance. Historical gaps in the comprehensiveness of initial assessments are likely to impact on the local area's capacity to track improved outcomes in children's development and health needs over time. (**Recommendation 2.3**)

4.6 Health action plans were not consistently outcomes-focussed or specific, measurable, actionable, measurable and timebound (SMART). The focus was largely on the completion of outstanding health screening or other 'one-off' tasks. Urgent health needs were clearly identified with timely referrals to other services, including specialist health services in most cases. In some records, however, timescales for completing tasks were referred to as 'ongoing' and did not support measurable improvement in health needs. Health action plans for IHAs were shared with all relevant partners and carers. (**Recommendation 2.4**)

4.7 Children looked after within Bury benefitted from review health assessments (RHAs) that mostly achieved the required statutory timescales. The specialist LAC health administrator had developed a management tracking tool which enabled effective scheduling. Performance was monitored closely. In the absence of any other record-keeping system, the tracker aided monitoring and allocation of children's health assessments.



4.8 The LAC health team was diligent in its approach to identifying and following up children and young people who did not attend appointments to ensure their health and wellbeing was fully recognised and safeguarded. In all cases seen, review health assessments were re-arranged in a timely manner. Practice in this area had been informed by learning from audits.

4.9 Bury council's children and young people placed out of area however, did not always benefit from the timely assessment and review of their health needs, particularly in respect of children over the age of five years. We saw an assessment for a young person placed in a secure environment that did not adequately identify risks to their health and wellbeing, including suicidal thoughts. The plan did not provide a clear picture for how their needs would be effectively met.  
**(Recommendation 2.5)**

4.10 These inequalities and challenges in influencing external partner organisations were clearly recognised as a concern by operational and senior leaders. Various initiatives, including timely escalation to the designated nurse had been attempted to effect change, but a sustainable solution to this unwarranted variation in performance remained outstanding. We acknowledge this is recognised as a challenge nationally with further work being led by NHS England to ensure a high standard of health care practice and improved outcomes for children irrespective of where they are living.

4.11 In most case records we examined, the focus on parental health history in initial and review health assessments was limited. This prevented practitioners from being vigilant in the early identification of health issues that could impact on the child or young person. However, we saw sensitive action in one case record following the death of an estranged parent. This triggered an appropriate and timely response to screening for future risks to their health and wellbeing. **(Recommendation 2.2)**

4.12 The voice of children and young people was not always heard or effectively considered when initial and review health assessments were completed. Gaps in standards had been recognised within audits of practice. Recent work evidenced a stronger voice and focus on the lived experience of children including their worries and concerns that were impacting on their behaviour and wellbeing. Better practice was seen in the review health assessments of older children. In two RHAs the voice of younger school-aged children was absent as the practitioner had recorded they were too young to contribute. Children and young people were often not given the choice about the timing and location of their appointment or asked whether they wished to be seen on their own. Further work is needed to ensure the views, needs and experiences of the child/young person are consistently kept at the centre of the process. **(Recommendation 2.6)**

4.13 School nurses made effective use of child/young person-centred assessment tools to support their engagement and assess their mental wellbeing and personal safety. This helped ensure their voice informed RHAs and individual action plans. Feedback from young people was sought to inform clinical decision-making and proactively enabled children and young people to take ownership of their health plans. In one record seen, it was good to see how drawings made by one child were effectively used to enable better understanding of their feelings and of the relationships that mattered most to them.

4.14 The C Card (contraception) scheme helped promote young people's awareness and protect their sexual health. Child sexual exploitation was clearly considered as part of the health assessment in two cases seen. The assessment and recording supported good consideration of the sexual health needs and safety of the young person. Practice could have been enhanced through use of a nationally accredited assessment tool.

Child E was actively involved in their assessment and in decision-making about the areas where they needed further help. The assessment considered actions from the previous review. Checks were made to ensure Child E was satisfied with the support they had previously received.

The school nurse proactively sought to hear their voice of the young person. They made good use of tools such as the Strengths and Difficulties Questionnaire (SDQ) and the CRAFFT screening test (a short clinical assessment tool designed to screen for substance-related risks and problems in adolescents) to underpin their assessment. Feedback from Child E, their wishes and feeling was clearly recorded. Sensitive enquiry about sexual health promoted important joint discussion about choice and control, and of unacceptable situations and the law. The school nurse later checked the young person's awareness to ensure they understood the risks and were aware of actions they could take to keep themselves safe.

4.15 Analysis of the emotional health and wellbeing of children within assessment and health care plans was relatively basic. it did not sufficiently focus on the impact of adverse childhood experiences on children's health and wellbeing. Although there had been improvements made in the coverage of Strengths and Difficulties Questionnaires (SDQ's); gaps and analysis and review of the needs and experience children remained. Given research indicates a relatively high number of children (estimated at approximately two thirds of the looked after children population) continue to experience a range of emotional, mental health and behavioural difficulties; better awareness is needed to help children feel emotionally safe and that their resilience to change is closely monitored. (**Recommendation 2.5**)

4.16 When SDQs scores indicated concerns, this prompted additional specialist assessment with appropriate actions taken on case records seen. The Healthy Young Minds local offer had been enhanced and promoted a flexible joined-up approach to meeting the needs of older children and care leavers. Partnership working with Streetwise (a local charity committed to improving the emotional wellbeing and mental health of young people 14-25 years in Bury) and Early Break aimed to provide a more holistic one-stop approach to meeting individual needs. Such agencies together with the LAC specialist team also offered targeted support to foster carers and children's home staff.

4.17 The role and contribution of GPs to initial and review health assessments was not effectively embedded in local arrangements for looked after children. GPs reported they were not consistently asked to provide input to children's assessments. Gaps in communication and co-ordination of all relevant information impacted on the quality and completeness of assessments. The CCG had given high priority to raising the profile of looked after children and care leavers within local GP practices over the past year. Whilst there was growing recognition of the vulnerability and impact of adverse childhood experiences on children, there was limited evidence of primary care practitioners being actively engaged in work to effect change and improve child health outcomes (**Recommendation 8.2**).

4.18 Liaison with local dentists was also not secured by shared care pathways and information-sharing. We were advised dentists commonly refused to share information with professionals involved in completing health assessments. Records seen demonstrated that whilst health practitioners routinely considered children's oral health, lack of feedback from dentists meant they were not able to effectively report on outcomes. Given the level of dental caries in the local area combined with it featuring highly in cases of neglect, stronger partnership working and information-sharing was needed to positively promote the dental health of children looked after. (**Recommendation 9.1**).

4.19 A significant gap remained in the quality and provision of health passports for children leaving care, including ensuring they benefited from effective support through transition up to the age of 25 years. This had been identified by the local area as an area to strengthen and an action plan had recently been put in place to address this. Although progress was being made, it is recognised that it will take some time to address the backlog (**Recommendation 2.7**).

4.20 The health passports we reviewed contained some basic historical information about the child's health needs, but this was largely confined to immunisation data and hospital attendances. The remainder of the health passport was predominantly an information leaflet to help signposting to other services. Work was planned to improve the engagement of children and young people in shaping the local health offer to ensure it is relevant and of value to them in helping them understand and address future health concerns. (**Recommendation 2.7**).

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## 5. Management

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This section records our findings about how well led the health services are in relation to safeguarding and looked after children.

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### 5.1 Leadership and management

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5.1.1 Leaders in NHS Bury CCG and Public Health Bury together with the local authority, had a clear and ambitious vision for the delivery of high quality care in the local area. This was centred on securing a strong integrated response to meeting local need through the development of the new One Commissioning organisation. Promoting wider recognition of the diversity of its townships was fundamental to its approach to continuously improving care delivery.

5.1.2 Commissioners had a good understanding of unmet needs and had mapped actions to address gaps in the availability of services. We found evidence of comprehensive plans in some areas, with a range of development work due for completion. The performance of specialist child mental health services (HYM) had significantly improved, and was good compared to other areas nationally. Current data indicated waits of 7-8 weeks within the 12 weeks target from point of referral to treatment.

5.1.3 Strengthened partnership working with the other 9 Greater Manchester localities was also helping drive forward a shared ambitious plan and targets. Priority had been given to improving performance in early years provision, including 'school readiness'- a recognised area of challenge for Bury and the wider region. We found that the role and expertise of community health practitioners was used well in strengthening the early help offer. This was evidenced in the responsive 'flexing up or down' of support provided by health visitors.

5.1.4 New partnerships were evolving and promoted wider sharing of expertise between teams and organisations. For example, a new care pathway between Early Break and GPs was helping to strengthen local approaches to meeting the needs of young people who misused drugs or alcohol.

5.1.5 Some areas for transformation, however, were taking longer, given the complexity of change and capacity of local leaders. Further work was required to embed joint commissioning approaches between the CCG, Public Health Bury and the wider council. This was an area identified for significant improvement in the SEND inspection last year. As highlighted in an earlier section of this report, the contribution of health to MASH operations was under-developed. This would benefit from urgent joint review to ensure best use is made of the capacity and expertise of all health practitioners. (**Recommendation 4.1**)

5.1.6 Local leaders acknowledged work was still needed at strategic as well as operational levels to achieve the level of co-production with local children, young people and their families that they aspired to. Some recent progress was evident in the involvement of parents in shaping the new autism diagnostic and support pathway. Plans to involve care leavers in the future design of health support were being firmed up. However, overall, the voice of children and young people was not actively driving leadership priorities or promoting effective challenge and feedback on the quality of practice. (**Recommendation 4.3**)

5.1.7 CCG designated safeguarding professionals provided strong leadership locally and regionally. The Head of Safeguarding was actively engaged in promoting shared learning and development activity within wider safeguarding networks facilitated by NHS England. Partner agencies valued their advice and support in helping them manage complex cases.

5.1.8 The capacity and sustainability of local safeguarding leadership within the CCG overall though was of concern to inspectors. The roles and statutory duties for safeguarding and looked after children were vested within a single Head of Safeguarding (the Designated Nurse for Child Protection and Looked After Children) who was also the Deputy Director of Nursing. This busy portfolio also included management oversight of other areas of activity including the work of Designated Doctors and designated nurse for safeguarding adults. The designated doctor for looked after children, a PAHT employee, acknowledged they were not able to fulfil all aspects of the job role within their contracted hours. Their capacity to support strategic improvement work was limited. The designated doctor for safeguarding children did not have a development plan, but was active in promoting learning from complex cases. The capacity of the safeguarding leadership within the CCG required urgent review given current demands and the size of the local transformation agenda. (**Recommendation 1.1**)

5.1.9 The earlier sections of this report reflect a mixed picture about the leadership capacity and effectiveness of local safeguarding arrangements within provider services. Work was urgently required within and between organisations to ensure information technology and management systems are fit for purpose. The need for improvements in organisational capabilities in this area has been highlighted as a concern in all recent inspection reports. Current arrangements are a significant barrier to partnership working on many levels, including management oversight of risk. (**Recommendation 4.2**)

5.1.10 Whilst PAHT, supported by the Northern Alliance, has made strides to improve its maternity services; with almost all posts now filled; further work is needed to equip midwives with additional tools to promote early recognition of concerns. The leadership capacity of the named midwife and named nurse was tightly stretched given the birth rate, child population and complexity of needs in the areas the Trust serves. The visibility of the named midwife to frontline practitioners had reduced, and the post holder was not always able to provide leadership within wider multi-agency development work. (**Recommendation 11.6**)

5.1.11 The Pennine Acute Hospitals Trust submitted an improvement plan following this inspection that provided a comprehensive initial response to the range of systemic failures and organisational risk found in its ED at Fairfield General Hospital. Timescales within the new plan reflected the urgency of actions, with leadership accountabilities for improvement clearly mapped. Stronger management oversight and quality assurance was planned by PAHT's leaders to maintain tight scrutiny to prevent drift. Progress will be further discussed within CQC's wider regulatory quality and risk meetings with the Trust.

5.1.12 The Walk-in Centre workforce in Bury had experienced a significant period of uncertainty about its future. Staff morale was low, with relatively high turnover, resulting in heavy reliance on the use of agency to backfill posts on a regular basis. The Prestwich Walk-in Centre operated by Bardoc, although it too was awaiting the outcome of further review of its operations, had a more stable workforce and was less dependent on the use of agency staff. Turnover within urgent care staff groups risked impacting on the quality of care provided and familiarity with organisational procedures. (**Recommendation 5.2**)

5.1.13 Pennine Care benefited from a stable, experienced and flexible health visiting workforce. Practice was secured by a strong team working culture and a well-targeted focus on risks to children and their families. Gaps in the capacity of the school nursing team and management oversight however, had led to inconsistencies in practice. Public health commissioners reported they planned to undertake a review of operations to provide better understanding of current challenges. (**Recommendation 12.1**)

5.1.14 The contribution of health practitioners to child protection meetings overall was inconsistent. Stronger management oversight and challenge was needed in some areas to ensure the right professionals were effectively engaged at all points in the process. Recent data indicated that whilst attendance and provision of reports by midwives, health visitors and school nurses was good; the involvement of child and adult mental health, One Recovery services and GP's remained below the required standard. The LSCB annual report 2016-17 had also previously flagged concerns about the levels of engagement of child and adult mental health services. All Bury sexual health services spoken to told us that their capacity to participate in child in need and child protection meetings was limited. (**Recommendation 4.4**)

5.1.15 The CCG named GP/executive clinical lead, together with the Head of Safeguarding, had focused on strengthening the engagement of primary care in local safeguarding arrangements. A new report template and information booklet have been developed to strengthen awareness of professional accountabilities. Recent audits of the quality of child protection reports submitted by GP practices identified the need for GPs to consistently provide clear and comprehensive medical and social histories of children and their parents, with appropriate analysis of risks to children who may be exposed to multiple harms. Gaps in essential practice in these areas meant that information was not being effectively shared, and could result in delays in progressing shared work to achieve better outcomes for children. (**Recommendation 4.4**)

5.1.16 Work to prevent children missing or at risk of child sexual exploitation (CSE) had a high profile. Safeguarding leaders were actively learning from other areas to ensure alerts and care pathways worked effectively to reduce risk of harm. Appropriate leadership and partnership arrangements were in place to ensure ongoing vigilance of risk to children and young people who had been sexually exploited or were at risk of being groomed. Although the local area had not yet identified any 'County Lines' activity- the term used for children at risk of gang-related exploitation, it was recognised as an area of potential risk.

5.1.17 The local area's safeguarding practices recognised the risk of children and young people becoming radicalised or being harmed by acts of terrorism. New emotional and well-being services aimed to build children's resilience and awareness of grooming risks.

5.1.18 Strong leadership by the Head of Safeguarding through the work of the Looked After Children Steering Group brought together leaders from a range of organisations to help build shared ownership of the local improvement agenda. This approach encouraged a strong shared focus on driving improved performance. Key achievements for children who had been in the care of the local authority for the past twelve months included 100 per cent coverage of immunisations and of development checks of children under 5 years of age (2017-18).

5.1.19 Priority was being given to expanding the offer of support to care leavers in line with the Social Work and Families Act 2017 and to strengthening links with the Corporate Parenting Board. Whilst Pennine Care had implemented an improvement plan based on the recommendations of case audits, paediatric doctors within PAHT had yet to agree relevant actions to strengthen practice. (**Recommendation 1.1 and 2.7**)

5.1.20 Further work was required to improve health outcomes for children in the care of the local authority. Scrutiny by NHS England had highlighted gaps in local arrangements for establishing a baseline of the health needs of children at the point of their admission to care. This work had recently commenced, but was still at a relatively early stage of development. It had not yet informed Bury's joint strategic needs assessment (JSNA). Given the rate of children looked after in Bury is relatively high compared to other areas, robust and up-to-date intelligence about their health and development is critical in ensuring inequalities and vulnerabilities to future health risks are effectively identified and addressed. (**Recommendations 2.3 and 2.7**)

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## 5.2 Governance

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5.2.1 The Safeguarding Governance and Assurance Committee led by the Named GP provided effective challenge and support for the work of health providers. Regular reporting and tracking of performance included analysis of trends, referral rates and training coverage. Regular scrutiny of frontline activity, benchmarking of performance and review of the impact of improvement actions was evident.

5.2.2 The CCG had effectively used learning from audits to help promote shared ownership of local priorities and secure improvement in areas where the required standards were not being met. Annual audit of the quality of health assessment and review activity for children looked after enabled effective tracking of progress and the development of shared actions to address barriers to joint working.

5.2.3 Other CCG-led assurance work included strengthening links with local children's homes to improve understanding of the nature of specialist placements. This included checks of safeguarding leadership, governance and training provided within individual settings. This activity would benefit from a joint approach with children's social care, with stronger reporting on the quality and impact of the therapeutic offer. Additional assurance was needed of the safeguarding arrangements where young people over the age of 18 years were placed with younger children. (**Recommendation 9.2**)

5.2.4 Management oversight was hindered by the additional burdens and barriers the whole workforce faced daily in not having adequate or effective IT systems to support timely and safe sharing of confidential information. The multiplicity of systems in use contributed to gaps in the identification and co-ordination of multi-agency responses to risk. Record-keeping systems used by the looked after children health service were fragmented and did not support effective practice. Drift and delay occurred whilst documents were scanned and uploaded onto EView (**Recommendation 4.2 and 12.10**).

5.2.5 The Bury Divisional Quality Assurance and Risk Committee (part of PAHT's Northern Alliance governance processes) identified and was working to address legacy gaps in organisational capacity and service delivery within Fairfield General Hospital. For example, a recent review of paediatric arrangements against the national standards for children within emergency care settings highlighted some ongoing significant shortfalls in practice. These included gaps in paediatric medical and nursing expertise and the availability of a play specialist. Shortfalls in the knowledge and expertise of frontline staff in the delivery of emergency care and trauma were recognised and were informing the priorities of the Trust-wide improvement plan. (**Recommendation 11.1**)



5.2.6 The Trust, in common with many other ED's nationally, was also aware its arrangements for young people attending the ED in mental health crisis were under-developed in relation to the Standards for Children in Emergency Care Settings. Access to records was not readily available to promote safe management of their care until they could be followed up by specialist mental health practitioners.

5.2.7 As highlighted elsewhere in this report, internal assurance of the quality of safeguarding children work within Fairfield General Hospital ED had not been sufficiently challenging or robust following our inspection last year. The new action plan put in place as an immediate response to this inspection contained key measures to improve scrutiny including leadership accountabilities for driving change and tracking progress against urgent timescales.

5.2.8 Governance of safeguarding children activity within Bury Walk-in Centre was weak. Whilst PCFT has a temporary staffing team who works with agencies to check the qualifications and training of agency staff; we found tighter scrutiny of safeguarding and paediatric life support training was needed to ensure all staff maintained the required levels of knowledge and skills. Management oversight of safeguarding information such as incidents or referrals raised within the Bury Walk-in centre was very limited. (**Recommendation 12.11**)

5.2.9 Virgin Care was not able to provide full assurance of the quality of safeguarding work within its local sexual health services. The lead safeguarding professional worked part-time and the role spanned a wide geographical footprint in the North West. This led to key gaps in assurance. Audits of case records and the provision of supervision to frontline practitioners were not actively driving practice. This meant the effectiveness of safeguarding practice and outcomes for young people were not adequately recognised or reported. (**Recommendation 13.3**) *We also brought this to the attention of the Director of Public Health as commissioner of sexual health services.*

5.2.10 Whilst we found increased attention had been given to strengthening 'Think Family' approaches through training and audits of practice, this was not fully embedded. A recent learning review was helping to promote greater awareness of the impact of parental mental health on the safety and well-being of children. Case auditing had flagged areas to strengthen to promote earlier identification of risk. Strengthening joint approaches to the identification of domestic abuse and the adoption of nationally accredited safeguarding tools (CSE, Graded Care) would help promote more robust safeguarding practice. (**Recommendation 6.1, 11.4 and 12.4**)

5.2.11 Pennine Care adult mental health services did not have an effective system in place for the receipt of safeguarding documentation from the local authority. Key documents, including child protection plans and minutes of meetings were missing and/or had not been uploaded on to the Paris electronic case management system. There was no mechanism for generating and tracking actions arising for adult mental health practitioners to ensure ongoing vigilance to risks to children.

5.2.12 The Pennine Care safeguarding team did not keep a record of the number or nature of referrals made by mental health service staff to the MASH. As a result, we were not able to identify any referrals to assess how well risk to the safety and wellbeing of children had been identified and analysed by mental health service staff. This also meant that the safeguarding team was not able to carry out quality assurance on referrals made and outcomes. This was a significant gap in the Trust's governance arrangements. (**Recommendation 12.5**)

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## 5.3 Training and supervision

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5.3.1 Pennine Care staff had good access to safeguarding children training. The latest figures (July 2018) indicated the required target (85%) has been exceeded for levels 2 and 3. However, the more challenging Trust target (95%) for level 1 safeguarding children and adult coverage had not yet been achieved.

5.3.2 Health visiting and school nurse staff had good and flexible access to safeguarding training and supervision in line with intercollegiate guidance. All staff working with children were expected to complete a training passport, which had been revised to capture their continuing professional development. Staff also had access to action learning set workshops to help embed consistent practice in the identification and management of risk. These approaches were effective in equipping them for a wide range of complex safeguarding children work.

5.3.3 Community health professionals were encouraged to act as safeguarding supervisors and relevant training had been provided to promote sensitive and effective challenge of peers' practice. In a recent audit, health visitors and school nurses reported feeling confident and competent to deliver good quality safeguarding supervision.

5.3.4 Healthy Young Minds teams received appropriate safeguarding training at level 3, which included recognition of 'hidden risk' and disguised compliance. The service benefitted from having specific HYM link workers whose role was to develop and deliver training to a wider group of professionals. This for example included training for ED staff in understanding and managing self-harm.

5.3.5 All HYM practitioners were expected to access clinical, management and peer supervision which incorporated safeguarding. Complex case safeguarding discussion panels included review of cases where safeguarding concerns had been escalated. Safeguarding supervision training was available to all team managers.

5.3.6 The safeguarding children training offer and coverage by adult mental health practitioners was good. Adult mental health practitioners also provided enhanced risk formulation training and dual diagnosis training to a wider group of professionals. The Trust had enhanced its knowledge and expertise in this area in response to learning from a serious case review.

5.3.7 In adult mental health teams, safeguarding children was an agenda item in one-to-one clinical supervision which was scheduled 4-6 weekly. However, adult mental health practitioners told us that they had not received safeguarding supervision recently. There was no evidence of supervision within any of the case records we looked at. This did not enable reflective practice and carried the risk that staff holding complex cases were not being appropriately supported. (**Recommendation 12.8**).

5.3.8 All One Recovery staff had received appropriate training for their role in safeguarding children at level 3 in line with intercollegiate standards. Recent training included domestic abuse and the provision of safe sleeping advice. Group supervision was available and had been strengthened in the past few months.

5.3.9 Safeguarding children training coverage in PAHT was below the Trust required target of 90%. Progress in achieving the target has been relatively slow, with ongoing challenges to the accuracy of data until the new training data base system is operational. Recent data indicated 75% Trust coverage overall. Performance in relation to community midwives in Bury was lower at 72%. This has been flagged as an area for improvement on the Trust action plan, with the deadline for achievement of the target expected December 2018.

5.3.10 Supervision was not routinely undertaken and available to all staff in ED. Nursing staff told us they did not always have protected time for supervision to promote reflection and learning in a supportive structured environment.

5.3.11 Safeguarding group supervision had been strengthened in maternity and was helping to promote wider assurance of the quality of practice. Recording of supervision discussions, however, was not yet well-established to inform analysis of the quality and impact of practice. (**Recommendation 11.7**)

5.3.12 The designated doctor and medical staff involved in undertaking initial health assessments required further development to enable them to fully identify and record the complexity of older children/young people coming into care and enable children and young people to feel more empowered in the process. (**Recommendation 2.3**)

5.3.13 Virgin Care sexual health practitioners had good access to relevant safeguarding children training. This was effective in enabling its workforce to keep up to date with changes in legislation and practice. Organisational leaders had identified that some practitioners, who previously only saw adults, were less professionally curious and provided additional targeted training to promote wider awareness of the risks of harm to children and young people. The Virgin team offered training on the Condom distribution Card to any other frontline practitioner who needed this.

5.3.14 We did not see any documented evidence of supervision on children and young people's records in Virgin Care services. Virgin's supervision policy indicates group supervision is available 3 monthly and individual supervision on an 'ad hoc' basis. We were advised group supervision was taking place 6 monthly. The level of take up of individual supervision was not clear. (**Recommendation 13.3**). *We brought this to the attention of the Director of Public health and commissioner of sexual health services.*

5.3.15 Not all staff in the Bury Walk-in Centre had relevant and up to date training in key areas of practice. We found one practitioner was not up to date with their paediatric life support training, which had expired two years previously. The Walk-in centre did not have a dedicated training budget and staff were not receiving updates in key areas of practice such as FGM, CSE, gangs and other relevant exploitation training. Safeguarding supervision was not actively driving practice in this setting. Given the dependence on agency staff and recent introduction of CP-IS greater assurance was needed of the standard of professional practice. (**Recommendation 5.2 and 12.11**)

5.3.16 The Prestwich Walk in Centre reported it was compliant with safeguarding children training requirements. However, one nurse spoken to was not aware of tools for assessing domestic abuse and did not know about local procedures for assessing bruising within non- mobile babies and children. Tighter scrutiny was needed of the levels of knowledge and expertise of frontline practitioners including agency staff. (**Recommendation 5.2**)

5.3.17 GPs and primary care staff in the two surgeries we visited had good access to a range of safeguarding training. Almost all staff were up to date with their training in line with intercollegiate requirements (including CSE and PREVENT). We saw effective practice in reporting FGM where such training has been used well to build the confidence of the GP and helped strengthen their approach to identifying and escalating risk.

5.3.18 GP's, however, had not received training on how to complete a MASH referral and the areas they were worried about were not detailed or analysed to provide a clear picture of the impact for children. This was due to be actioned following the inspection. GPs would welcome additional training in GDPR (General Data Protection Regulation) to ensure they shared information appropriately in relation to parents and other adults within households.

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## Recommendations

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- 1. NHS England local area team together with NHS Bury CCG should:**
  - 1.1 Review the capacity of the designated safeguarding professionals to address gaps in strategic capacity and ensure the sustainability of local arrangements to drive forward its significant continuous improvement and transformation agenda.
  
- 2. NHS Bury CCG together with Pennine Acute Hospitals NHS Trust and Pennine Care NHS Foundation Trust should:**
  - 2.1 Devise effective and efficient methods for ensuring community health practitioners are promptly informed about children and young people presenting at ED.
  - 2.2 Ensure initial and review health assessments provide appropriate detail about children's heritage and parental health history, including their faith, culture and language to provide a clear picture of children's identity and of their experiences, including those who are unaccompanied children seeking asylum.
  - 2.3 Ensure the quality of initial health assessments undertaken by paediatricians provides a comprehensive picture of the impact of neglect and other adverse childhood experiences on their growth and development, health and wellbeing; in line with national guidance. This should provide a clear benchmark to assess progress and help monitor ongoing risk.
  - 2.4 Ensure health action plans are SMART and outcomes-focused to enable joint scrutiny of the effectiveness of actions taken to address risks to children's health and development.
  - 2.5 Ensure children placed in care placements within and outside Bury benefit from comprehensive assessments and health care plans, including recognition of their emotional and mental health needs and of actions being taken to safeguard them.
  - 2.6 Ensure the voice of the child is kept at the centre of looked after children health assessments and care plans; with evidence of choices being given to them about the time and location of the appointment and whether they wish to be seen alone.
  - 2.7 Ensure children and young people leaving care are equipped with relevant health information about their health histories and actions they can take to continue to promote their personal health and wellbeing.

**3. NHS Bury CCG together with Pennine Care NHS Foundation Trust in consultation with Public Health should:**

- 3.1 Ensure the role of the health practitioner within MASH is reviewed to provide sufficient capacity and expertise in supporting wider multi-agency awareness and decision-making about risks of harm to children.

**4. NHS Bury CCG together with Pennine Care, Pennine Acute Hospitals Trust, primary care practices, Bardoc, One Recovery and Virgin Services Limited should:**

- 4.1 Ensure a clear, well-managed system is in place in MASH to promote timely collection, co-ordination and analysis of information from all relevant child and adult health practitioners. This should provide a full picture of what is known about the lived experiences of children and risks to their health, development and safety.
- 4.2 Review the quality of information and communications technology (ICT) across the whole system to enable well-co-ordinated, streamlined and efficient transfer of information about children and young people who move between health and care services.
- 4.3 Strengthen local arrangements to promote a positive culture of co-production that enables children, young people and their families to shape the design and delivery of services and support ongoing learning from their feedback.
- 4.4 Ensure good levels of involvement and provision of clear reports to child protection conferences by all child and adult health practitioners to provide a comprehensive picture of the experiences of children living in situations of abuse or neglect.

**5. NHS Bury CCG together with Pennine Care NHS Foundation Trust and Bardoc should:**

- 5.1 Equip Walk-in centre staff with appropriate knowledge and assessment documentation to help them to recognise wider risks to children and promotion of child-centred practice.
- 5.2 Ensure Walk-in centres benefit from having a stable, well trained workforce with appropriate levels of safeguarding and paediatric expertise.

- 6. NHS Bury CCG together with Pennine Acute Hospitals NHS Trust and Pennine Care NHS Foundation Trust, One Recovery and primary care practices should:**
  - 6.1 Ensure regular and effective communication between midwives, health visitors, adult health practitioners and GPs to strengthen joint awareness of escalating concerns and embedding of 'Think Family' approaches.
- 7. NHS Bury CCG together with Pennine Acute Hospitals NHS Trust and Pennine Care NHS Foundation Trust and Bardoc should:**
  - 7.1 Ensure frontline clinicians and managers are fully aware of their professional accountabilities for checking, following up and recording actions to safeguard children and young people on child protection plans and who were looked after identified on the Child Protection Information System (CP-IS).
- 8. NHS Bury CCG together with primary care practices should:**
  - 8.1 Ensure the nationally agreed read codes are appropriately maintained and kept up to date to reflect changes in children's legal status or care arrangements.
  - 8.2 Ensure GPs are effectively involved in the assessments and care plans for children who are looked after so that they are able to support joint work to effect change and improve child health outcomes.
- 9. NHS Bury CCG together with Pennine Care NHS Foundation Trust and NHS England should:**
  - 9.1 Ensure dentists are appropriately informed about and contribute to the health care arrangements of children who are looked after.
  - 9.2 Ensure local specialist children's homes effectively deliver therapeutic support to children with high and complex needs, and ensure appropriate safeguarding arrangements are in place for children under the age of 18 sharing the facilities with young adults.
- 10. Pennine Acute Hospitals NHS Trust together with Pennine Care NHS Foundation Trust should:**
  - 10.1 Ensure that midwives routinely share all antenatal information with health visitors to enable timely contact and coverage of antenatal visits.

## **11. Pennine Acute Hospitals NHS Trust should:**

- 11.1 Ensure the emergency department at Fairfield General Hospital has appropriate levels of paediatric doctor and nurse expertise in line with national guidance.
- 11.2 Ensure record-keeping in maternity services is completed in a timely manner to provide a full and up-to-date picture of incidents and risks to mothers and their unborn babies.
- 11.3 Ensure maternity records clearly identify any concerns about partner's mental health or misuse of drugs or alcohol that could impact on their parenting capacity or availability to support the mother and unborn/new born baby.
- 11.4 Equip maternity staff with the knowledge and tools to enable them to strengthen their safeguarding practice in identifying domestic abuse, neglect and exploitation.
- 11.5 Ensure strong emergency department leadership with good recognition, management and review of risks to children. This includes making effective use of safeguarding screening tools to inform judgements about the safety of children, making accurate records in line with professional standards, and sharing relevant information with other agencies, including ensuring prompt referrals to MASH.
- 11.6 Review the capacity of its named midwife and named nurse to strengthen their visibility alongside frontline practitioners and partner agencies across its whole footprint.
- 11.7 Strengthen recording arrangements for the supervision of midwives to enable tracking of the quality and impact of practice.

## **12. Pennine Care NHS Foundation Trust should:**

- 12.1 Ensure the capacity of its school nursing service effectively meets demand; with good management oversight of the caseloads of frontline practitioners to prevent delays in identifying risks and meeting children and their families' needs.
- 12.2 Address shortfalls in the capabilities of its school nursing electronic case management system to enable prompt retrieval and oversight of key information about children's safety and wellbeing.
- 12.3 Ensure the focus on children within adult mental health services assesses the impact of parental mental health on their protective capacity; and that such risks are clearly identified, monitored and recorded throughout the period of care.



- 12.4 Strengthen Healthy Young Minds approach to assessment and safety planning to provide a comprehensive picture of the impact of children's social circumstances and previous adverse experiences to ensure ongoing recognition of their resilience and risks.
- 12.5 Ensure an effective system of quality assurance of all referrals to MASH. This should promote wider understanding of factors that lead to escalation and tracking of the impact of safeguarding work undertaken and review of the outcomes for the child/children.
- 12.6 Ensure adult mental health practitioners make effective use of their electronic case management system; including routine use of alerts and uploading of child protection documentation to inform their case work. Records should provide a complete picture of the ongoing challenges and risks within the family, and the impact of support given.
- 12.7 Ensure adult mental health practitioners provide clear and succinct written reports to child protection conferences that provide appropriate analysis of the impact of parental mental health difficulties on care provided; and ensure their reports are routinely shared and discussed with parents in advance of the conference.
- 12.8 Ensure adult mental health practitioners benefit from regular safeguarding supervision to support their work, ensuring effective vigilance of children where there are fluctuating risks or complex family circumstances.
- 12.9 Ensure looked after children's health records provide all essential information about children's care status, parental and sibling details and consent to provide a full and accurate record of each child's personal circumstances.
- 12.10 Ensure recording and tracking systems in use within the LAC specialist health team are supported by a case recording system that promotes timely and efficient transfer and management of information.
- 12.11 Ensure stronger management oversight and safeguarding leadership within Bury Walk-in centre; including assurance about the currency of paediatric and safeguarding children training undertaken by agency staff.

**13. Virgin Care Services Limited should:**

- 13.1 Ensure the capacity of sexual health practitioners is sufficient to support their contribution to child protection and prevention case discussion meetings when this is needed.

- 13.2 Develop its local safeguarding children assessment processes to ensure appropriate flagging, recognition and recording of the vulnerability of children and young people including those whose care is being managed within child in need and child protection arrangements.
- 13.3 Strengthen its safeguarding leadership assurance processes to enable case audits and regular safeguarding supervision to be provided.

#### **14. One Recovery should:**

- 14.1 Ensure case records contain all relevant information about children within the family and other professionals involved in the delivery of care to promote effective liaison and support for the whole family.
- 14.2 Promote good information-sharing with GP's to enable strong shared vigilance of the care and treatment of adults within the household and recognition of impacts for children.
- 14.3 Ensure case records contain all relevant child protection information to guide the work of adult substance misuse practitioners and ensure they are actively involved in all relevant child protection planning and review meetings.

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## Next steps

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An action plan addressing the recommendations above is required from NHS Bury CCG within **20 working days** of receipt of this report.

Please submit your action plan to CQC through [childrens-services-inspection@cqc.org.uk](mailto:childrens-services-inspection@cqc.org.uk) The plan will be considered by the inspection team and progress will be followed up through CQC's regional compliance team.