

AGENDA FOR

HEALTH AND WELLBEING BOARD

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To: All Members of Health and Wellbeing Board

Members: J Gonda, L Jones, B Barlow, K Dolton
Councillor R Walker, Councillor S Briggs, Councillor
R Shori, S Taylor, Councillor A Simpson (Chair), S
Hashmi, Dr J Schryer, D Lythgoe, G Little, V Hussain
and Paul Walker

Dear Member/Colleague

Health and Wellbeing Board

You are invited to attend a meeting of the Health and Wellbeing Board which will be held as follows:-

Date:	Tuesday, 12 February 2019
Place:	Meeting Rooms A&B, Bury Town Hall
Time:	6.00 pm
Briefing Facilities:	If Opposition Members and Co-opted Members require briefing on any particular item on the Agenda, the appropriate Director/Senior Officer originating the related report should be contacted.
Notes:	

AGENDA

1 APOLOGIES FOR ABSENCE

2 DECLARATIONS OF INTEREST

Members of the Health and Wellbeing Board are asked to consider whether they have an interest in any of the matters on the Agenda, and if so, to formally declare that interest.

3 MINUTES OF PREVIOUS MEETING *(Pages 1 - 6)*

Minutes of the meeting held on 27th November 2018 are attached.

4 PUBLIC QUESTION TIME

Questions are invited from members of the public present at the meeting on any matters for which the Board is responsible.

Approximately 30 minutes will be set aside for Public Question Time, if required.

5 CHILDREN LOOKED AFTER - CQC SAFEGUARDING REPORT *(Pages 7 - 82)*

Maxine Lomax, representing Bury CCG will report at the meeting. Reports attached.

6 PENNINE ACUTE A&E TRIAGE ARRANGEMENTS AND WINTER PRESSURE UPDATE *(Pages 83 - 92)*

Steve Taylor, Chief Officer, Managing Director, Bury & Rochdale Care Organisation, Northern Care Alliance will report at the meeting. Report attached.

7 PENNINE ACUTE READMISSION RATE UPDATE *(Pages 93 - 98)*

Steve Taylor, Chief Officer, Managing Director, Bury & Rochdale Care Organisation, Northern Care Alliance will report at the meeting. Report attached.

8 STATE OF DELAYED TRANSFERS OF CARE IN BURY *(Pages 99 - 106)*

Dee Colam, Interim Assistant Director Adult Social Care Operations will present at the meeting. Report attached.

9 TRANSFORMATION PROGRAMME BOARD CHAIR'S UPDATE *(Pages 107 - 110)*

Dr Jeffrey Schryer, Joint Chair, Transformation Programme Board will report at the meeting. Report attached.

10 PENNINE CARE FUTURE OPERATING MODEL

This report will be sent to follow.

11 GM POPULATION PLAN UPDATE (*Pages 111 - 128*)

Lesley Jones, Director of Public Health will report at the meeting.

- Nutrition and Hydration Update – Carmel Burke, Nutritionist will also be in attendance.

12 URGENT BUSINESS

Any other business which by reason of special circumstances the Chair agrees may be considered as a matter of urgency.

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Minutes of: HEALTH AND WELLBEING BOARD

Date of Meeting: Tuesday 27th November 2018

Present: Cabinet Member Health and Wellbeing Andrea Simpson (Chair); Councillor Roy Walker, Opposition Member, Health and Wellbeing; Healthwatch Chair, Barbara Barlow; Director of Public Health, Lesley Jones; Interim Executive Director Communities and Wellbeing, Julie Gonda; Chief Officer/Managing Director Bury & Rochdale Care Organisation, Steve Taylor; Chair Bury Clinical Commissioning Group, Dr Jeff Schryer; Executive Director of Children and Young People, Karen Dolton; Pennine Care NHS Trust; Dan Lythgoe.

Also in attendance:

Warren Heppolette; Executive Lead, Strategy & System Development, Greater Manchester Health & Social Care Partnership
Mandy Symes; Interim Strategic Lead – Strategy and Development
Kathy Batt; Safeguarding Board Independent Chair
Kath Wynne-Jones; Interim LCA Executive
Chris Woodhouse – Improvement Advisor

Apologies: Leader of the Council, Councillor Rishi Shori; Cabinet Member for Children and Families, Councillor Sharon Briggs; Chief Executive, Bury Council, Geoff Little
Representing the voluntary sector Sajid Hashmi

Public attendance: There were no members of the public present.

HWB. DECLARATIONS OF INTEREST

Councillor A Simpson declared a personal interest in respect of all items to be considered due to her appointment as Lord Peter Smith assistant at the Greater Manchester Health and Social Care Partnership Board. Councillor Simpson is also employed by the NHS.

HWB. MINUTES OF PREVIOUS MEETING

It was agreed:

The minutes of the meeting held on the 27th September 2018 be approved as a correct record.

HWB. MATTERS ARISING

- Loneliness

Following on from the work being undertaken as part of the Action for Ageing project, the Chair provided information with regards to the development of the loneliness strategy and action plan.

- Triage

Responding to a question from the Chair with regards to triage arrangements at FGH, A&E. Steve Taylor; Chief Officer/Managing Director Bury & Rochdale Care Organisation reported that triage is undertaken by A&E staff, with an average length of wait into the Urgent Treatment Centre of 7 minutes. On average 20 patients a day are sent to the UTC. Following discussion of this issue the Chief Officer/Managing Director agreed to provide further information at a future meeting.

HWB. PUBLIC QUESTION TIME

There were no questions from members of the public present at the meeting.

Further to the published agenda the Chair agreed that the agenda would be re-arranged and the Safeguarding Adults and Children's Annual Report would be considered first.

HWB. SAFEGUARDING CHILDREN'S AND ADULT'S ANNUAL REPORT

Mandy Symes; Interim Strategic Lead – Strategy and Development
Kathy Batt; Safeguarding Board Chair attended the meeting to present the Annual Safeguarding reports for both Children and Adult services. An accompanying report circulated to members prior to the meeting provided information in relation to the following areas:

- Key achievements
- Facts and figures
- Deprivation of liberty applications
- Plans for 2018/19
- Safeguarding arrangements in Bury
- Supporting and coordinating safeguarding in Bury.

Kath Batt reported she had been appointed to act as an independent chair for both the Children's and Adult boards. The Boards have held development days to look at their functions and role and they reported that there was a consensus reported that there is duplication in membership and in some cases, 'cases'.

A new structure, is currently being developed, with an executive group and shared sub-groups, going forward there will be one report from the integrated board.

Responding to a Member's question the Independent Chair reported that there had been some issues with regards to attendance and involvement of some partners/stakeholders. Greater Manchester Police is undergoing structural changes including the removal of their specialist public protection role, this has

caused difficulty in terms of attendance. In respect of the Children's Board and attendance, there has been on occasion problems with attendance from representatives of Pennine Care this has improved since the publication of the annual reports.

Councillor Walker questioned the degree to which 'inappropriate handling' and 'inappropriate contact' was prevalent; the Independent Chair reported that there has been issues in relation to children with challenging behaviour. In particular when a child may have been restrained by a member of staff. To tackle this a whole training programme outlining how to do restrain properly has been developed with an emphasis on restraint being a last resort.

Dr Schryer wanted to ensure that there was mental health representation especially in relation to adults on the Board; the Independent Chair confirmed that this would be the case.

The Chair asked what levers are there in the system, especially with providers, to make sure that staff training is provided and procedures/protocols are in place to prevent incidents. Responding, the Interim Assistant Director outlined that the contracts would insist/require providers to have appropriate policies in place on a range of issues, including moving and handling, DOLs and safeguarding. Further assurance is provided via staff within the provider relationship team, the quality assurance framework, good contacts with CQC, as well as the Council provided training for providers, on request.

The Director of Public Health reported that the recently undertaken CQC inspection on safeguarding and Looked after Children had been positive.

It was agreed:

The Independent Chair and the Interim Assistant Director be thanked for their attendance.

HWB. GREATER MANCHESTER UPDATE

Warren Heppolette, Executive Lead, Strategy & System Development, Greater Manchester Health & Social Care Partnership attended the meeting to provide members with an overview of work being undertaken by the Health and Social Care Partnership. The presentation included information with regards to the partnership's aims, "where we are now?" The building blocks for transformation; neighbourhood working and expected developments in Bury.

The Executive Lead, Strategy & System Development reported that there are real signs of progress, as evidence by the stabilisation and subsequent reduction in emergency bed days as well as improvements in mental health services as a result of improved investment and better connectivity. Establishment of the LCA has accelerated locally over the last few months.

Responding to a Member's question, in respect of the low profile of drug services/support within GM; the Executive Lead, Strategy & System Development reported that this is an area currently not addressed across GM to

the level it could or should be. The Director of Public Health reported that a GM plan is under development.

In discussion that followed members discussed the support for those that require mental health support as well as that of drug and alcohol services. The Chair of the Clinical Commissioning Group reported that it is envisaged that the integrated neighbourhood teams will be able to effectively provide support to deal with specific local issues, including drugs, where applicable.

It was agreed:

The Executive Lead, Strategy & System Development be thanked for his attendance.

HWB. TRANSFORMATION PROGRAMME UPDATE – TRANSFORMING URGENT CARE

Kath Wynne-Jones, Interim LCA Executive attended the meeting to provide members of the Board with an overview of work being undertaken to transform urgent care. The presentation contained information in respect of:

- LCA key priorities
- Integrated neighbourhood teams
- Successes so far
- Home first priorities
- Integrated virtual hub
- Urgent treatment centre at FGH

The LCA Executive reported on the development of the Paramedic Green Car scheme. In October the car had attended over 170 incidents and 77% cases resulted in people being able to be treated at home rather than a hospital admittance.

Responding to a Member's question the LCA Executive reported that there is workshop this week on finalising solution for IMT/ Workaround for the next 12 months, including a Global Digital Exemplar scheme.

The Chair asked about Assistive Technology. The LCA Executive responded that some of the technological facilities were being looked at in light of the Integrated Neighbourhood Teams and these will be built on when the teams are in place.

Responding to concerns raised by the Healthwatch representative in respect of newspaper reports that included FGH's A&E in a list of potential Emergency department's earmarked for closure. Dr Schryer, Chair of Bury's CCG reported that he was not aware of any plans to close the A&E department at Fairfield. Steve Taylor, PAT confirmed this and reported that FGH A&E was and continues to be one of the best performing departments in the region.

It was agreed:

Kath Wynne Jones, Locality Care Alliance be thanked for her attendance.

HWB. TRANSFORMATION PROGRAMME BOARD CHAIR'S REPORT

Dr Jeff Schryer, Chair of Bury CCG's clinical commissioning board presented a report providing an overview of the work undertaken by the Transformation Programme Board. Work undertaken has included:

- Locality Care Alliance (LCA) Update
- Locality Plan Investment Agreement
- Transformation Performance and Finance Reporting
- One Commissioning Organisation (OCO) Update
- Devolution Difference Roadshow

The CCG Chair reported that the Transformation Board is made up of Commissioners and LCA. It is a collaborative board the emphasis has recently transferred from agreeing programmes/money to a focus on proactive new ways of working including commissioning strategically based on outcomes. There is now a clear budget and plan, which includes £4.6m that must be spent by end of March 2019.

It was agreed:

Health and Wellbeing Board is recommended to note the work of the Health and Care Transformation programme Board

HWB. COMBINED BCF AND IBCF MONITORING REPORT

Julie Gonda, Interim, Executive Director, Communities and Wellbeing, attended the meeting to provide members with updated performance information for the better care fund and improved better care fund. The presentation provided information in respect of the BCF metrics which include:

- Non-elective admissions - reduction in non-elective admissions
- Permanent admissions - rate of permanent admissions to residential care per 100,000 population (65+)
- Effectiveness of reablement - proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
- Delayed transfers of care (DToC) - delayed transfers of care (delayed days) from hospital

As well as the IBCF the local metrics related to areas of spend

- DToC for reason 'awaiting package of care'
- DToC for reason 'awaiting residential home'
- Time taken to grant DOLS application

With regards to each of the BCF metrics, the Interim Executive Director reported that a revised target has been established for non-electives admissions, a number of remedial actions have been put in place.

The Interim Executive Director reported that a targeted piece of work is currently been undertaken to address the permanent admissions to residential care and it is envisaged that this would reduce the numbers significantly.

The figures for the effectiveness of reablement are very close to the target. There does however continue to be high number of complex cases entering the system. The DTOC figures indicate that they are reducing though still not on track.

The Interim Executive Director reported that there would be an additional £5.4m from the IBCF which will allow some additional capacity in reablement.

It was agreed:

The Health and Wellbeing Board will continue to receive quarterly Better Care Fund and Improved Better Care Fund performance updates.

HWB. PENNINE ACUTE NHS TRUST READMISSION FIGURES

Steve Taylor; Chief Officer/Managing Director Bury & Rochdale Care Organisation reported that on average over the last 18 months the readmission rate is 6.1% within a 30 day period. The greatest percentage is not within the frail elderly cohort, rather the 19-64 age group and in general medicine and reported a 4.8 days average re-admission length of stay.

It was agreed:

Steve Taylor; Chief Officer/Managing Director Bury & Rochdale Care Organisation will provide a report for consideration at the next meeting of the Health and Wellbeing Board with regards to re-admission rates; the report will include information in respect of the reasons for the admittances, as well as comparative data/national averages.

**Councillor Andrea Simpson
Chair**

(Note: The meeting started at 6pm and finished at 8pm)



Meeting: Governing Body			
Meeting Date	28 November 2018	Action	Receive
Item No.	##	Confidential	No
Title	Briefing following the Children Looked After and Safeguarding inspection by CQC		
Presented By	Maxine Lomax Head of Safeguarding/Deputy Director of Nursing		
Author	Maxine Lomax Head of Safeguarding/Deputy Director of Nursing		
Clinical Lead	Executive Lead Cathy Fines and Executive Nurse Catherine Jackson		

Executive Summary
<p>In September 2018, NHS Bury CCG, coordinated a Children Looked After and Safeguarding (CLAS) inspection of the local health economy, following a notification of inspection from the Care Quality Commission. The inspection is extensive with a range of services being inspected. The services are commissioned by both the CCG and Public Health.</p> <p>The inspectors were on site for 5 days.</p> <p>Although there were found to be some deficits in the systems and processes in two parts of the health economy, there was high praise for other parts of the system, especially the health visiting service.</p> <p>The inspection looked at how services coordinated to ensure the health and safeguarding needs of children are met from the Early Help stage across to children becoming looked after. The inspection also looked at system leadership.</p> <p>The CCG leadership was recognised in a number of areas but there was concern about capacity and resilience within the team. This has now been addressed.</p> <p>The report states</p> <p><i>Para 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.</i></p> <p>There is no overall grade awarded, but a report and recommendations are provided and an action plan is expected.</p> <p>The report is attached to the briefing</p>

Briefing following the
Children Looked After and
Safeguarding inspection by

CQC

Recommendations	
It is recommended that the Governing Body <ul style="list-style-type: none"> Note the content of report 	

Links to CCG Strategic Objectives	
To encourage people so that they want to, and do, take responsibility for their own health and well-being.	<input type="checkbox"/>
To drive and support system wide transformation.	<input type="checkbox"/>
To commission joined-up health and social care for people in Bury through a Single Commissioning Framework.	<input checked="" type="checkbox"/>
To achieve financial sustainability for the Bury health and social care economy.	<input type="checkbox"/>
To support the Locality Care Alliance to deliver high quality services in line with commissioner intentions.	<input checked="" type="checkbox"/>
To be a high-performing, well-run and respected organisation with an empowered workforce	<input type="checkbox"/>
Does this report seek to address any of the risks included on the Governing Body Assurance Framework? If yes, state which risk below:	
GBAF <i>[Insert Risk Number and Detail Here]</i>	

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
<i>Elements of the report identify risk to safeguarding children if remedial action is not implemented rapidly</i>						
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input checked="" type="checkbox"/>
<i>If you have ticked yes provide details here. Delete this text if you have ticked No or N/A</i>						
Have any departments/organisations who will be affected been consulted ?	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
< <i>If you have ticked yes, Insert details of the people you have worked with or consulted during the process :</i> Governing Body Senior Management Team						
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input checked="" type="checkbox"/>
<i>If you have ticked yes provide details here. <Include details of any conflicts of interest declared></i>						

<Where declarations are to be made, include details of conflicted individual(s) name, position; the conflict(s) details, and how these will be managed in the meeting>
 <Confirm whether the interest is recorded on the register of interests- if not agreed course of action>

Delete this text if you have ticked No or N/A

Are there any financial Implications?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
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If you have ticked yes provide details here. Delete this text if you have ticked No or N/A

Has a Equality, Privacy or Quality Impact Assessment been completed?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input checked="" type="checkbox"/>
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Is a Equality, Privacy or Quality Impact Assessment required?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input checked="" type="checkbox"/>
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Are there any associated risks including Conflicts of Interest?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input checked="" type="checkbox"/>
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Are the risks on the CCG's risk register?	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>	N/A	<input type="checkbox"/>
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Governance and Reporting

Meeting	Date	Outcome
Quality and Performance	14/11/2018	To be presented to GB
Governing Body	28/11/2018	

Briefing following the Children Looked After and Safeguarding inspection by CQC

1. Introduction

- 1.1. The following paper is intended to brief the committee on the process and outcome of the recent inspection by CQC into the quality of provision and the implementation of the provision for children in need of protection and children who are looked after
- 1.2. The outcome of the inspection was a published 42 page report and 46 recommendations for commissioners and providers across the health economy of Bury. No grade is attributed to the outcome.

2. Background

- 2.1. The CCG were given notice of a semi unannounced inspection by CQC on Thursday 30th August and arrived on site on Monday 3rd September.
- 2.2. The inspection team consisted of a lead inspector and six additional inspectors
- 2.3. Prior to arrival, a long list of evidence had to be supplied from the CCG and the two main health providers. Additional evidence as provided throughout the inspection. In total over 200 documents were submitted to CQC. Ten cases had to be identified for the inspectors to review and track through services. Additionally, at all visits to services, dip sampling of cases was undertaken. A timetable of visits was populated; using the template provided which required visits to specific services.

3.

- 3.1 The inspection team visited the following services and spent up to 6 hours with each service
 - Health visiting (Pennine Care Foundation Trust PCFT)
 - School nursing (PCFT)
 - One Recovery (adult drug and alcohol services for adults)
 - Virgin Sexual Health Services
 - Walk in Centre, Bury and Prestwich (PCFT)
 - Two GP practices
 - Looked after Children Team at Pennine Care Foundation Trust
 - Telephone conversation with the Designated Doctor of Looked after Children (Pennine Acute Trust, PAT)
 - Maternity services (PAT)
 - A&E at FGH (PAT)

- Adult mental health Services (PCFT)
- Healthy Young Minds (PCFT)
- A meeting with Strategic Leads for commissioning and safeguarding from the CCG and Local Authority

- 3.2 The key concerns that emerged were from the visits to Fairfield General A&E department and to the two Walk in Centre's. There was an immediate request by the CQC, for an action plan to remediate the concerns identified at A&E. This was submitted, as requested by the end of the inspection. PAT have initiated an improvement board to monitor the action plan
- 3.3 Additionally, there were concerns around the sustainability of the Walk in Centre's, staff moral and systems and processes to safeguarding children. Pennine Care was made aware of the concerns immediately and the Head of Safeguarding for the CCG was informed. Pennine Care have provided some assurances around the WIC's however, there are a number of recommendations within the report. A deep dive is planned by the CCG by the end of November.
- 3.4 The report by the CQC, was submitted to NHS Bury CCG for accuracy and factual checking in late September and all providers were able to respond. The final report was published on the 12th October 2018 and the CCG, as the lead and coordinator of the inspection, is required to submit an action plan by the 9th November.
- 3.5 A provider/commissioner working group has been established to populate the plan and this will then be submitted to the CQC for agreement
- 3.6 The plan will be monitored via the CCG Safeguarding Assurance and Governance group and via the CQC as part of their inspections of health providers

4 Associated Risks

- 4.1 The recommendations are challenging as the majority require a number of providers, Public Health and the CCG to co-ordinate and response. The time required to service the plan will be considerable
- 4.2 Additional resources may be required to successfully complete some actions and providers may request additional funding from the CCG
- 4.3 The finding at A&E and the Walk In Centre require greater support from the Quality and Safeguarding team in terms of oversight
- 4.4 The Health and Well Being Board and the Local Safeguarding Children Board both have an interest in the outcome of the inspection and have requested a briefing. The Corporate Parenting Panel (oversight for Looked after Children) has not requested a briefing but will have an interest and, therefore, a briefing will be provided.

- 4.5 Potentially, there may be a reputational risk, when/if the report is presented at the Governing Body and consideration needs to be given to including the risk in the risk register (there has been no media interest so far)

5 Recommendations

- 5.1 It is recommended that the Governing Body
- Note the content of report

6 Actions Required

- 6.1 To note the report

Maxine Lomax
Head of Safeguarding/Deputy Director of Nursing
Maxine.lomax@nhs.net
November 2018

CQC action plan, transferred from the excel version 24/12/2018

Maxine Lomax Head of Safeguarding and Deputy Director of Nursing NHS Bury CCG

BLUE	Milestone successfully achieved
GREEN	Successful delivery of the project is on track and seems highly likely to remain so, and there are no major outstanding issues that appear to threaten delivery significantly.
AMBER/GREEN	Successful delivery appears probable however constant attention will be needed to ensure risks do not materialise into issues threatening delivery.
AMBER	Successful delivery appears feasible but significant issues already <u>exist</u> requiring management attention. These appear resolvable at this stage and if addressed promptly, should not cause the project to overrun.
AMBER/RED	Successful delivery is in doubt with major risks or issues apparent in a number of key areas. Urgent action is needed to ensure these are addressed, and to determine whether resolution is feasible.
RED	Successful delivery appears to be unachievable. There are major issues on project definition, with project delivery and its associated benefits appearing highly unlikely, which at this stage do not appear to be resolvable.

	Recommendation	Action	Target date	Lead	Update 24/12/2018	RAG
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.	<ol style="list-style-type: none"> 1. CCG agreed to create a further post to support the Safeguarding Children's agenda and free up time for strategic designated functions of role. 17.10.18 JD completed and with HR for banding prior to advertising the post. 2. The CCG has commissioned a review of the community paediatrics service delivered by PAT This will include the Designated Dr roles for Child Protection and LAC 	April 2019	CCG Head of Safeguarding	<p>Post advertised, closing date 18/11/2018 Interview date 11/10/2018, position appointed to on the 11/12/2018 Target start date 1/04/2019</p> <p>PAHT have increased the Designated Dr sessions to 2 per week from the next rota, so to commence to late January 2019</p>	
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.	Map current process. Consider and evaluate alternative pathways. Including IT solutions and implement	End of Nov stage 1	Petra Hayes Bowyer and Louise Palmer		
2.2	Ensure initial and review	PCFT to review LAC Level 3 training to incorporate importance	April 2019	PCFT LAC team	Meeting to 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.	of children’s heritage and parental health history. To develop and deliver training on the health of UCSA Safeguarding workshop to be delivered around unaccompanied asylum seekers planned for 2019.		and Designated Dr for LAC with the Specialist nurses for the CCG and PCFT	LAC level 3 training across the PCFT footprint planned. Safeguarding ‘message of the month’ produced November 2017 around UASC and available for information on the intranet.	
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.	Scope the current position of education against the Intercollegiate Document for LAC Source training/conference events for the Designated Doctor for LAC and paediatricians involved in the assessment of Looked after Children. Ensure all doctors involved in the IHA are aware of the requirements for the assessment Devise a QA programme and six monthly dip sample audits for quality by the CCG safeguarding team	April 2019	Designated Dr for LAC		
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.	To include in LAC Level 3 training. Quality Assurance process of health action plans to be reviewed to ensure plans are SMART and outcomes-focused	March 2019	PCFT	Meeting to review LAC level 3 training across the PCFT footprint planned 19.11.18. The GM Q.A tool includes a standard on S.M.A.R.T action	

					planning.	
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.	To be addressed by Q.A process of RHA's and analysis of SDQ's in the narrative of the assessment.	Ongoing	PCFT		
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.	To include in LAC Level 3 training. Quality Assurance process of health action plans to be reviewed to ensure the voice of the child is kept at the centre of looked after children health assessments and care plans	March 2019	PCFT and PAT	Meeting to review LAC level 3 training across the PCFT footprint planned 19.11.18. Safeguarding Message of the Month shared June '18 re: Voice of the Child' and is available on the trust intranet for practitioners.	
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.	PCFT current health passport to be reviewed with Care Leavers	December 2018	PCFT	Specialist Practitioner (LAC) attended the Children in Care Council 21.09.18 and discuss their views around a care leavers passport. Links have also been made with the	

					Care Leavers Council 09.10.18 and awaiting further consultation	
3	NHS Bury CCG together with Pennine Care NHS Foundation Trust 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.	Convene a meeting between the CCG, PCFT, the LA to review current position and establish the requirements for the role. Develop and agree and business case to increase funding	March 2019	NHS Bury CCG	Agreement reached with CFO for funding for a band 6 WTE 0.6 (18/12/2018) Email sent to K Dolton to request name of the best person to work with to agree the responsibilities of the role (19/12/2018)	
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	linked to 3.1 SG to work with the MASH health practitioner to review the health information sharing proforma in line with the 'think family agenda.' The MASH health practitioner to establish links with adult mental health services in PCFT to support with assessments and referrals into MASH.	Dec 2018	PCFT SG team	22/11/2018 Update 15.10.18- SG team met with MASH health practitioner to discuss action. Proforma to be reviewed and	

	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.	completion of reports by attending team meetings to support them with the new documentation.				
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.	Fully implement the standards agreed by the Children's Trust to promote a positive culture of co production		NHS Bury CCG commissioning team and LA Public Health		
5	NHS Bury CCG together with Pennine Acute Hospitals NHS Trust and Pennine Care NHS Foundation Trust, One Recovery and primary care practices 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.	SG team to support the WIC around increasing knowledge and awareness of key issues, MDT group supervision dates, Domestic abuse / FGM pathways to be shared and supported by an education workshop delivered by a Specialist Practitioner. Education sessions to be delivered on Friday morning's. BARDOC All staff to complete Level 3 safeguarding training. Clinical manager to review all safeguarding forms and feedback to staff, to support learning A percentage of cases	November 2018	PCFT SG team	05.10.18-SG team attended the WIC to provide general update of SG processes. DV&A co-ordinator visit 12.10.18- SG session around FGM Pathway 19.10.18- SG session around the	

		are reviewed to ensure that safeguarding is flagged All ANP have completed spotting the sick child module			Domestic Abuse Pathway with support from the DV&A co-ordinator. CCG undertook a visit on 26/11/2018 to both WIC's To revisit Bury February BARDOC completed Tested out on the visit and staff were well informed(see report)	
5.2	Ensure Walk-in centres benefit from having a stable, well trained workforce with appropriate levels of safeguarding and paediatric expertise.	PCFT A scoping exercise to be undertaken to establish what additional assurance nursing agencies can provide in relation to individual nursing competencies. Safeguarding Children Champion to be identified within the WIC to strengthen links with the Safeguarding Team and act as a channel of communication and support going forward. BARDOC Undertake a recruitment drive to support stabilising of workforce and reduce requirement for use of agency staff	November 2018		See report	
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.	Develop opportunities for effective communication as the Integrated Neighbourhood Team approach is strengthened. Continue to roll out the "Think Family" training in all health organisations Assurance of training to be provided via the Assurance and Governance meeting of the CCG Request the ASB and LSCB include specific "Think Family" training course Review the Terms of Reference for the CCG Safeguarding Governance and Assurance Group to include One Recovery and Virgin HealthCare as members	Letter to the Chair of the Boards End of December 2018 Review TOR's End Dec 2018	All organisations Head of Safeguarding CCG to submit request to LSCB/ASB	letter to LSCB Chair sent 18/12/2018 response received 18/12/2018 TOR amended following meeting on the 5/12/2018	
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).	PAHT: CP-IS in place. New 7 minute briefing developed to reiterate purpose of CP-IS and the flagging arrangements. CP-IS included in new recognition and response to children safeguarding workshops delivered to all staff in ED in November 2018. Standard Operating Procedure to be developed	End December 2018	PCFT/PAT		
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	Develop guidelines in conjunction with IG colleagues on retaining information around legal status	March 2019	NHS Bury CCG	18/12/2018 email sent to IG lead for the CCG	

	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.	The current pathway requires the provider of health assessments to obtain GP information for IHA, PCFT to implement the pathway	Dec 2018	PCFT LAC team	reminder sent to PCFT 18/12/2018	
9	NHS Bury CCG together with Pennine Care NHS Foundation Trust and NHS England should:					
9.1	9.1 Ensure dentists are appropriately informed about and contribute to the health care arrangements of children who are looked after.	Establish the pathway developed by Wokingham CCG and liaise with colleagues at NHSE to ensure the information is included in the training for dentists	March 2019	NHS Bury Spec Nurse LAC		
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.	Establish a joint pathway with the LA for visits to local children's homes to ensure that safeguarding arrangements are place for YP where over 18's are in the same accommodation as under 18's. Request that a member the CCG safeguarding team join the placement planning meeting to ensure children and YP's needs can be met in placement	March 2019 December 2018	HOS Bury CCG	Initial conversation between the HoS at the CCG and the DCSC at the LA and agreed the HoS will join the planning meeting in the New Year	
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.	PAT and PCFT to map the current process and benchmark against Royal Bolton Hospital process and PAT to HV process to be amended as required Audit follow up to ensure new process is embedded	End of March 2019	PCFT and PAT Julie Dean and Wendy Thompson	Service Manager (WT) has liaised with the Named Midwife for Safeguarding at the Northern Care Alliance to explore what the difficulties are in antenatal information being shared with HV in a timely way. Meeting planned for November 18.	
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.	1. Undertake review of current staffing against national guidance and submit briefing paper / business case to DoN by end Nov 18 2. Re advertise RSCN posts, with radio advert and clear specification to enable term time working and potential cross system working and have advert placed	Nov-18	DoN PAT	review completed and advert placed 14/11/2018	
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.	PAHT: Review the feasibility of chronology of significant events to be included in midwifery notes where Special circumstances are recorded. Add chronologies to maternity risk register if unable to find appropriate solution. Any solution must include appropriate risk assessment and mitigating factors for not implementing an interim chronology format PAHT: Establish timescales for transition to use of K2	March 2019	Midwifery Named Midwife PAT	Nov 2018 Findings of report shared with wider midwifery team to ensure prompt escalation of issues in relation to specific safeguarding	

		<p>maternity database. Establish the capability of K2 to generate automatic visible chronologies when SCF is uploaded</p> <p>All staff to be reminded of the importance of contemporaneous record keeping. This was felt to be an isolated incident Safeguarding midwife has not previously highlighted this as a concern nor has our record keeping audit process. However in order to provide assurance a retrospective audit will be undertaken in relation to recent safeguarding cases by the safeguarding Midwife. This also to be highlighted on level 3 training and Midwives public Health days</p>	<p>March 2019</p> <p>December 2018</p>		<p>concerns. There is an issue with no community IT access which may delay input of special circumstances forms and this is being reviewed as part of the wider IT access issues across PAT. staff currently return to base to input data which should occur on a daily basis</p> <p>December</p> <p>An audit of records has been completed and has highlighted a wider issue</p> <p>Report awaited by the CCG</p>	
11.3	<p>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.</p>	<p>The national maternity Hand held notes ask these questions and we will include review of this aspect in our retrospective documentation audit. This will also be added to our safeguarding training and disseminated to staff via the Governance newsletter</p>	01/01/2019	PAT maternity	<p>HH notes capture these questions and we will undertake a retrospective audit with regards to completion of the information. We understand that the HH notes were not available for review at the inspection.</p>	

					<p>December</p> <p>An audit of records has been completed and has highlighted a wider issue</p> <p>Report awaited by the CCG</p>	
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.	<p>PAHT: Establish role and function of maternity IDVA as part of a wider review of the training that midwives receive in relation to safeguarding, domestic abuse, neglect and exploitation.</p> <p>PAHT: Review use of 'upside down' triangle to identify DA.</p> <p>PAHT: Domestic abuse training delivered by IDVA (provided through DA plan with Bury Community Safety Partnership) to key ED staff at FGH - domestic abuse champions</p>	Nov 2018	PAT Maternity	<p>We have identified through audit and incident reviews that our screening in relation to domestic abuse is not consistent or as robust as we would like. The CQC inspection has just confirmed that.. A plan is currently being devised to relaunch screening for domestic abuse to ensure it is carried out consistently, and to revamp the training our staff receives including the use of tools.</p>	
11.5	Ensure strong emergency department leadership with	PAHT: Workshop programme on recognition and response commences 05/11/18	Commence Nov 2018	PAT Named Nurse	Local action plan fortnightly	

	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.		Completion date ???	Safeguarding Children / ADNS ED	meetings to update and track progress. Workshops set up November 2018 to address recognition and referral professional curiosity and the use of screening tools safeguarding champions identified check list standardised	
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.	PAT are developing a business case for additional named nurse resource for children and adults (2 posts) Additionally, PAT is scoping and preparing a proposal for increased named midwife capacity, The scoping includes reviewing rates of births, deprivation, scoping against like neighbours, and, demands of statutory reviews to project future need	March 2019	Safeguarding lead PAT		
11.7	Strengthen recording arrangements for the supervision of midwives to enable tracking of the quality and impact of practice.	Record of safeguarding supervision for midwifery is recorded on the U drive. Maternity managers have access to the database in order to monitor staff accessing supervision. Supervision guide currently being updated to policy PAHT: conduct evaluation of the experience of supervision with midwives PAHT: Audit the new recording process	March 2019	PAT Named midwife		
12	Pennine Care NHS Foundation Trust should:					
12.1	Ensure the capacity of its school nursing service effectively meets demand;	A review of current staffing levels in the School Nursing Service in line with National Standards. School Nursing Service Leads to complete a scoping exercise around the allocation of	31/01/2019	PCFT and PH	02.11.18- Review of School Nursing Staffing Levels	

	<p>with good management oversight of the caseloads of frontline practitioners to prevent delays in identifying risks and meeting children and their families' needs.</p>	<p>safeguarding cases and provide assurance that cases are triaged appropriately in line with identified risk, with management oversight consistent with the health visiting service.</p>			<p>completed by Community Service Manager found the current provision of skill mixed teams to be in line with National Standards as outlined by Choosing Health (2004)</p> <p>Email to Consultant in PH sent by ML (7/12/2018) requesting clear reassurance are sought from PCFT, namely 1. How many vacancies is the service carrying? 2. Levels of maternity or sick leave?</p> <p>PH consultant emailed PCFT SanFran2018 Can you also provide information on what % of capacity you are working against the specification that is commissioned?</p>	
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					Also, within the CQC report, there is concern about the use of Eview by school nursing - could you confirm the short and longer term solutions to the fact CQC did not consider it fit for purpose?	
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.	To escalate the concerns identified with the Eview system through the PCFT assurance framework. To ensure the electronic case management system for school nursing is reviewed as a priority within the organisation.	01.04.2019	PCFT	Concerns escalated to the trust wide Records Manager by the Bury community service DBU assurance meeting 12.10.18. External document consultancy employed to review the school nursing electronic records as a priority. Meeting with Consultant and School Nursing Township Lead, 02.11.18	
12.3	Ensure the focus on children within adult mental health services assesses the impact of	To review the assessment process in adult mental health services to ensure the children's needs within the family are assessed appropriately. Trust wide safeguarding audit of	01.04.2019	PCFT	Documentation has been reviewed with adult acute in-	

	parental mental health on their protective capacity; and that such risks are clearly identified, monitored and recorded throughout the period of care.	CMHT planned 2019- awaiting allocation of clinical audit lead.			patient wards across PCFT to include more guidance of safeguarding assessments on admission. Discussed at the PCFT Named Professionals Forum 22.08.18 and is now live across the trust.	
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.	To complete a 'dip sample' of HYM records to review the quality of the safeguarding assessment, risk analysis and S.M.A.R.T action planning.	1.04.2019	PCFT		
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.	To introduce a process of quality assuring PCFT MASH referrals as part of annual safeguarding activity. Planned for quarter 4 with analysis in Quarter 1 (2019).	1/04/2019	PCFT		
12.6	Ensure adult mental health	To create a tab on the PARIS electronic record system that	1/04/2019	PCFT		

	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.	separates safeguarding reports from mainstream correspondence. Trust wide safeguarding audit planned with CMHT in 2018/2019				
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.	BSCB / PCFT Case Conference Template to be shared with adult mental health services to ensure there is consistency in reports. Trust wide safeguarding audit to be completed with CMHT's 2018/19	1/04/2019	PCFT	23.10.2018 PCFT template for Case Conference report shared with Adult Community Service Lead and CMHT Service Manager	
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.	Safeguarding Supervision SOP to be developed to support local implementation of the trust wide Supervision Strategy	1/04/2019	PCFT		
12.9	Ensure looked after children's health records provide all	The Quality Assurance of IHA /RHA's to ensure all essential information is included to allow meaningful holistic	July 2019	PCFT		

	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.	assessment. PCFT LAC Specialist Nurse to support the CCG with a repeat audit of the Q.A of health assessments planned 2018/19.				
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.	To review the function of the LAC administrator and ensure there is robust system in place to track and records LAC health records through different organisational systems.	31/12/2018	PCFT		
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.	A scoping exercise to be undertaken to establish what additional assurance nursing agencies can provide in relation to individual nursing competencies. Safeguarding Children Champion to be identified within the WIC to strengthen links with the Safeguarding Team and act as a channel of communication and support going forward.	31/12/2018	PCFT	20.11.18- Agency staffing added as an agenda item on Corporate People and Workforce Steering Group	
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.	Implement log of meetings attended (and invited to) in relation to safeguarding, LAC and child protection to track attendance and invitations. Ensure resilience in safeguarding leads and support roles and all positions are appointed to. Ensure that Safeguarding Champions have clear Full Time Equivalent time allocated.	9/11/2018	Virgin Care	Implemented Evidence needed and requested via SG meeting	
13.2	Develop its local safeguarding	Review Under 18 assessment template and amend mandatory	31/12/2018	Virgin Care	Awaiting audit	

	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.	fields where applicable Review Under 18 assessment template with feedback from Virgin Care sexual health network (further to changes made in action 1). Sexual Health Network meeting to be held in January 2019. Implement annual audit programme for completion of under 18 Proforma.			programme	
13.3	Strengthen its safeguarding leadership assurance processes to enable case audits and regular safeguarding supervision to be provided.	Ensure Safeguarding supervision is taking place as per the Safeguarding Supervision Policy and group safeguarding supervisions sessions are arranged for all areas and attendance confirmed. Agree dates for safeguarding Supervision sessions with CCG (offer of 4 per year from Maxine Lomax). This is to commence from January. Implement log for all ad-hoc supervision to ensure documentation and audit trail is present. Ensure safeguarding discussion is documented in structured 1:1 and peer review sessions.	31/12/2018	Virgin Care	Supervision dates set for 2019	
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	A specific prompt for schools, Health Visitors etc., is required and the Safeguarding Lead is going highlight this issue with staff at the Service Meeting on 23 November 2018 and will raise this issue at the next ADS Safeguarding Effectiveness Committee on 11 December 2018 and will establish whether children's schools, Health visitors details can be added as a prompt on our assessment form.			Dec 2018 update Our assessment currently includes a free text box in the safeguarding section that prompts Practitioners to add other services involved with a child, this is reviewed	

					<p>throughout client's care.</p> <p>However, we feel following the CQC Inspection that this needs a specific prompt for schools, Health Visitors etc., therefore, Angie Boast, Safeguarding Lead is going highlight this issue with staff at our Service Meeting on 23 November 2018 and will raise this issue with Quality and Performance Team and at the our next ADS Safeguarding Effectiveness Committee on 11 December 2018 and will establish whether children's schools, Health visitors details can be added as a prompt on our assessment form.</p> <p>To provide some reassurance, these details are already</p>	
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					included on the paper hard copy (Pink) child details form that is used within the service as a contingency should electronic systems fail and safeguarding details are urgently required. This record is kept with the Safeguarding Lead. We can also provide minutes from meetings where this matter has been discussed and subsequent actions.	
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.	<p>There is a communication pathway in place</p> <p>To support GP's understanding any current prescribing by One Recovery the following paragraph is mandatory on any communication with GP's regarding our prescribing. This paragraph was provided by CCG:</p> <p>"Please could you ensure the medication prescribed by One Recovery Bury as per this letter is added to the patient's record as a drug prescribed by an outside agency (using the same procedure as for adding a RED drug to a patient's record) as this will allow for Vision to check for interactions and maintain an accurate record of what medication the patient is taking."</p>			December 2018 update One Recovery reviewed our communication pathways following an alert raised by Oldham Rochdale Coroner in relation to a Turning Point client. Although these concerns are in relation to a different service in another area this gave us the	

					<p>opportunity to review our existing communication process. Our review included service users new into treatment, currently in receipt of pharmacological interventions from us or are being discharged.</p> <p>I initially undertook an audit of 20 cases to establish the length of time it took for a GP to be sent a comprehensive Clinic Outcome letter (please see attached audit). Although we were quite satisfied that a comprehensive letter was sent to a GP within 7-14 days following attendance at clinic, it was agreed at our August Clinical Operations meeting held that there should be a more immediate</p>
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					<p>response from us and that a fax should be sent to the service users GP immediately following clinic whereby medication has been initiated or changed this included any service user being prescribed by our service as part of continuation of their care.</p> <p>To support GP's further in understanding any current prescribing by One Recovery the following paragraph is mandatory on any communication with GP's regarding our prescribing. This paragraph was provided by CCG:</p> <p>"Please could you ensure the medication prescribed by One Recovery Bury as</p>
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					per this letter is added to the patient's record as a drug prescribed by an outside agency (using the same procedure as for adding a RED drug to a patient's record) as this will allow for Vision to check for interactions and maintain an accurate record of what medication the patient is taking."	
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.	<p>The safeguarding lead will attend meetings and speak to CSC Manager and other individual teams to strengthen information sharing and links between One Recovery and Children Social Care.</p> <p>Cases will be jointly tracked by One Recovery and Children Social Care.</p> <p>The Social Work Practice lead will speak to relevant people to ensure all plans and meeting minutes etc are shared with One Recovery.</p> <p>The safeguarding lead is now part of the MASH referral screening process.</p>			December 2018 update Angie Boast, Safeguarding Lead and Anita McWilliam, Service Manager, met with Jane Darrington, Social Work Practice Manager on 27 September 2018. At this meeting we had already discussed this issue and agreed to address the lack of sharing of plans and	

					<p>minutes from Children Services to One Recovery.</p> <p>It was agreed that Angie Boast will attend EMM meetings and speak to CSC Manager and other individual teams to strengthen information sharing and links between One Recovery and Children Social Care.</p> <p>Also, cases will be jointly tracked by One Recovery and Children Social Care.</p> <p>Jane Darrington will also speak to relevant people to ensure all plans and meeting minutes etc are shared with One Recovery.</p> <p>Angie Boast is also now part of the MASH referral screening process.</p>	
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					We are due to meet again in January 2019 to review progress	
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Review of Health Services for Children Looked After and Safeguarding in Bury

Children Looked After and Safeguarding The role of health services in Bury	
Date of review:	3 rd September to 7 th September 2018
Date of publication:	12 th October 2018
Name(s) of CQC inspector:	Sue Talbot Tahir Hussain Elaine Croll Karen Collins-Beckett Rebecca Hogan Jeffrey Boxer Paula Morgan
Provider services included:	Pennine Acute Hospitals NHS Trust Pennine Care NHS Foundation Trust Virgin Care Services Limited One Recovery (ADS) Bardoc (Prestwich Walk in Centre)
CCGs included:	NHS Bury Clinical Commissioning Group
NHS England area:	North region- Greater Manchester
CQC region:	North
CQC Deputy Chief Inspector, Primary Medical Services and Integrated Care:	Ursula Gallagher

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Summary of the review

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.

About the review

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

- The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.
- The focus was on the experiences of looked after children and children and their families who receive safeguarding services.
- We looked at:
 - the role of healthcare providers and commissioners.
 - the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
 - the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.
- We also checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, Working Together to Safeguard Children 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.

How we carried out the review

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.

Context of the review

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.

The report

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

What people told us

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.

The child's journey

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

1. Early help

1.1 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.

2. Children in need

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.*

3. Child protection

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**)

4. Looked after children

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**)

5. Management

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

5.1 Leadership and management

5.1.1 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**)

5.2 Governance

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**)

5.3 Training and supervision

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.

Recommendations

- 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.

Next steps

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 The plan will be considered by the inspection team and progress will be followed up through CQC's regional compliance team.

Bury Health and Wellbeing Board

Title of the Report	Winter update
Date	30/1/19
Contact Officer	Steve Taylor
HWB Lead in this area	

1. Executive Summary

Is this report for?	Information <input checked="" type="checkbox"/>	Discussion <input checked="" type="checkbox"/>	Decision <input type="checkbox"/>
Why is this report being brought to the Board?	At the request of committee members		
Please detail which, if any, of the Joint Health and Wellbeing Strategy priorities the report relates to. (See attached Strategy) www.theburydirectory.co.uk/healthandwellbeingboard			
Please detail which, if any, of the Joint Strategic Needs Assessment priorities the report relates to. (See attached JSNA) http://jsna.theburydirectory.co.uk/kb5/bury/jsna/home.page			
Key Actions for the Health and Wellbeing Board / proposed recommendations for action.	N/A		
What requirement is there for internal or external communication around this area?	N/A		
Assurance and tracking process – Has the report been considered at any other committee meeting of the Council/meeting of the CCG Board/other stakeholders....please provide details.	Yes. Regular discussion on urgent care at Urgent Care Board and LCA		

2. Introduction / Background

Overview of urgent care during the 18/19 winter period

3. key issues for the Board to Consider

Urgent care pressures across the Bury system

4. Recommendations for action

For information/discussion

5. Financial and legal implications (if any)
If necessary please seek advice from the Council Monitoring Officer Jayne Hammond (J.M.Hammond@bury.gov.uk) or Section 151 Officer Steve Kenyon (S.Kenyon@bury.gov.uk).

N/A

6. Equality/Diversity Implications. Please attach the completed Equality and Analysis Form if required.

N/A

CONTACT DETAILS:

Contact Officer: Steve Taylor

Telephone number: 0161 778 3118

E-mail address: steve.taylor@pat.nhs.uk

Date: 30/1/19

Bury Health and Wellbeing Board

Title of the Report	PAT Update – Fairfield General Hospital <ul style="list-style-type: none"> • ED triage Arrangements • Winter Update
Date	12 th Feb 2019
Contact Officer	Keeley Gibbons, Divisional Managing Director. Division of Integrated Care
HWB Lead in this area	Steve Taylor, Chief Officer, Managing Director. Bury & Rochdale Care Organisation, Northern Care Alliance.

Introduction

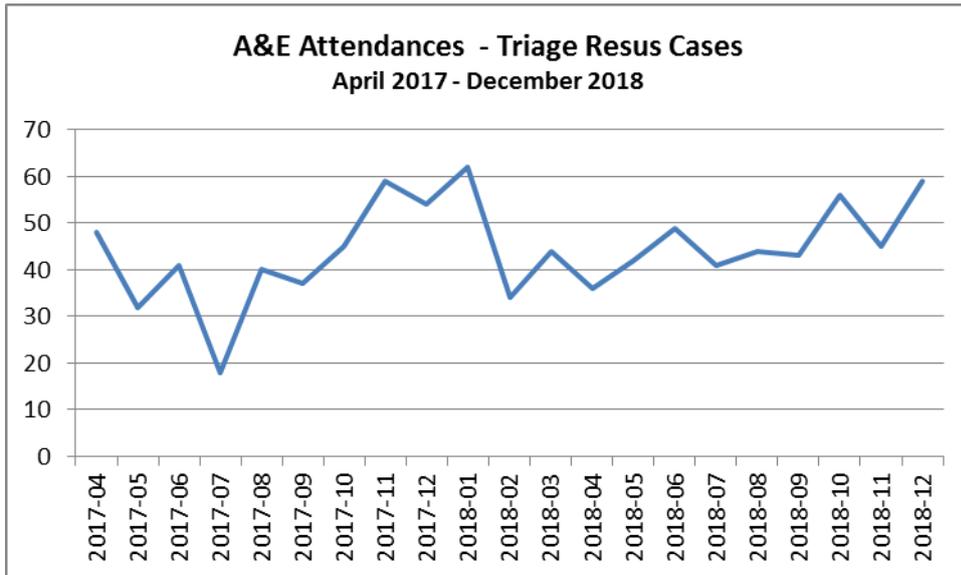
At the request of the Health Overview and Scrutiny Committee this report has been provided to update on the Emergency Departments Winter arrangements particularly with regards to the following metrics:

- A&E Attendances by triage category
- A&E Attendances time to triage
- A&E Attendances - SPC
- A&E Ambulance Arrivals
- FGH Performance against Greater Manchester Performance

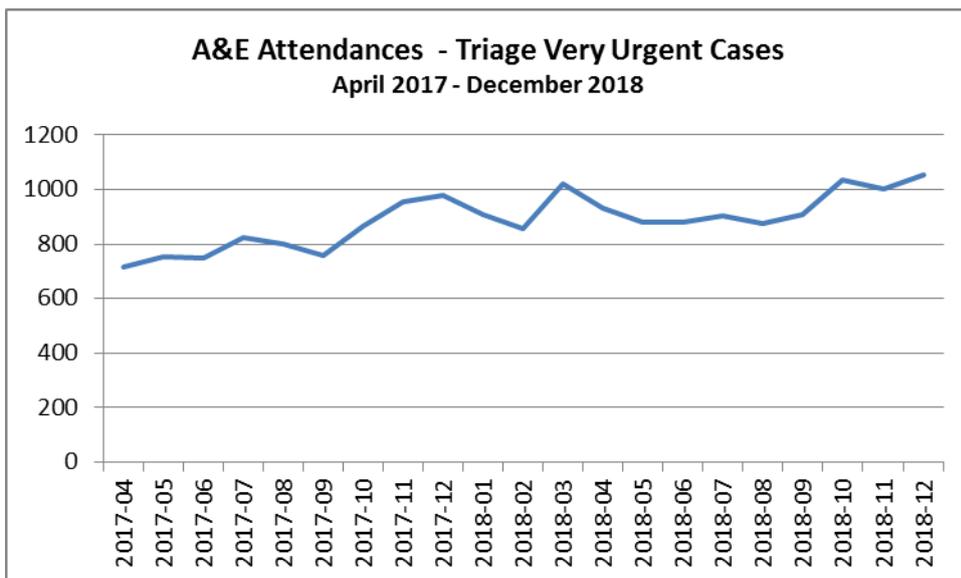
Fairfield General Hospital A&E triage – Presentation Profiles

The table below outlines performance by month throughout from April 2018 – December by triage category, over the recent months there has been an increased demand of patients who are triaged as a Very urgent or requiring immediate resuscitation indicative of a rising acuity profile.

Triage	2018-04	2018-05	2018-06	2018-07	2018-08	2018-09	2018-10	2018-11	2018-12	Total
Non Urgent	35	34	40	31	27	21	18	18	31	255
Standard	2086	2552	2521	2524	2211	2135	2326	2309	2210	20874
Urgent	2810	2727	2638	2900	2814	2611	2633	2661	2622	24416
Very Urgent	931	878	880	902	873	910	1034	1004	1052	8464
Resus	36	42	49	41	44	43	56	45	59	415
Total	5898	6233	6128	6398	5969	5720	6067	6037	5974	54424



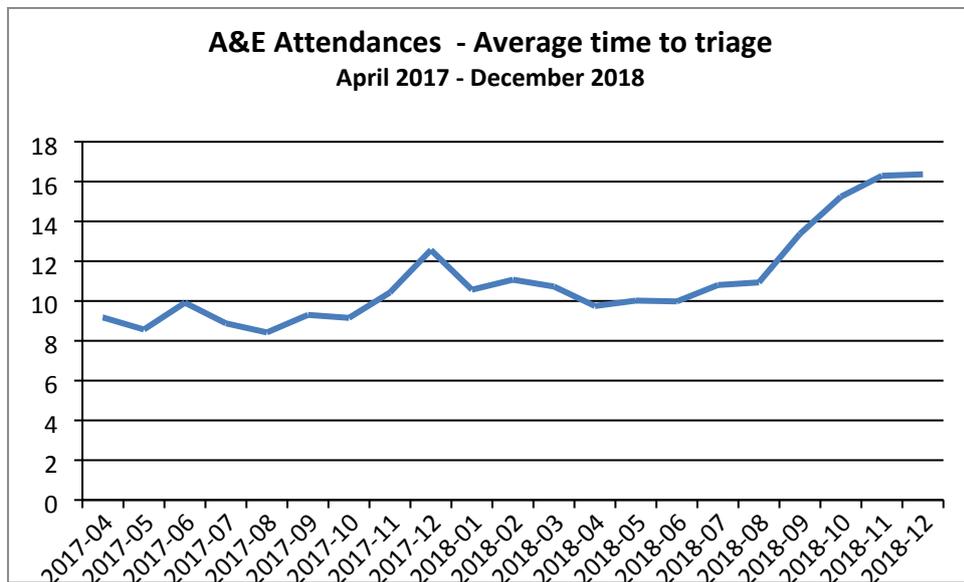
Patients triaged to the resus category have been steadily increasing since April 2018.



Very Urgent A&E cases have been consistently rising month on month since April 2017

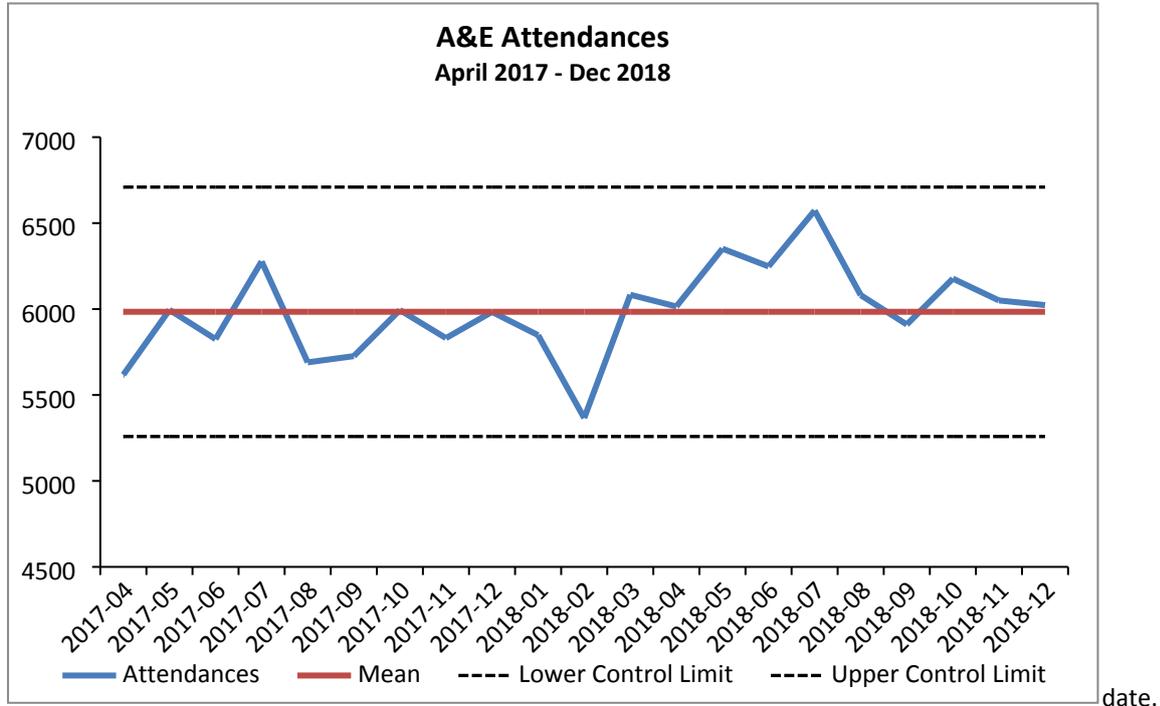
Fairfield General Hospital A&E attendances time to triage

The table below demonstrates the number of minutes that it is taking on average per month to triage those patients that present at the Emergency Department. Please note this information is inclusive of both ambulance and walk in patients and the average time to triage over recent months has increased proportionately in line with acuity as per the above table.



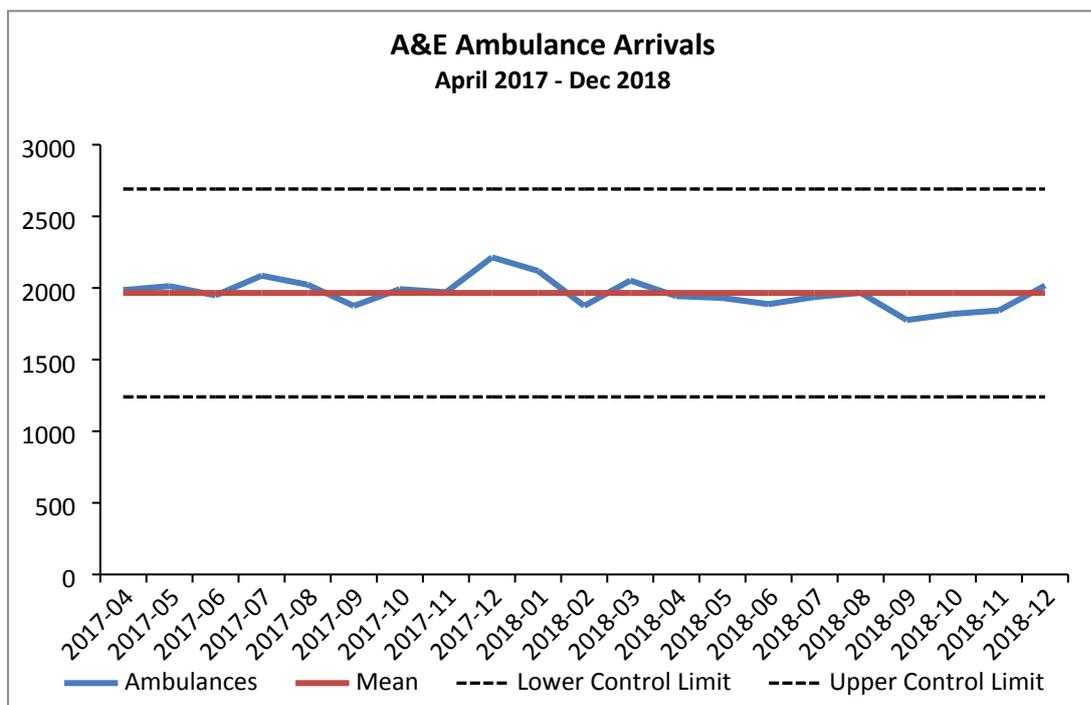
A&E Attendances

A&E Attendances have risen in 18/19 by 5% compared to last year, this approximately equates to an additional 2500 patients year to date



date.

ED Ambulance Arrivals



Ambulance arrivals have remained consistent across the year, however a point to note is that due to the increased community offers i.e. Green Car and the Integrated Virtual Clinical Hub arrangements the whilst these figures have remained static these are a more true reflection of demand and requirements of an Emergency Department.

Summary of FGH Winter Performance to date

The table below demonstrates the performance of FGH in comparison to other Trusts in Greater Manchester to which Bury is the best performing year to date.

Greater Manchester UM Gold Summary Tables:

Type 1

	Financial Year to Date 2018/19	Quarter to Date - Q4 2018/19	Month to Date - Jan-19	Daily 4hr Performance - 29/01/2019	Performance Direction Compared with Previous Day and Target	Performance Direction Based on Site Daily Average Only	A&E (Type 1) Attendances	% A&E Attendances Admitted	% Medical Outliers	NWAS Total Turnaround Time	NWAS Ambulance Attendances
Bolton	83.06%	79.93%	79.93%	81.17%	↑	↑	324	20.68%	1.01%	29.55	100
Bury	90.13%	82.52%	82.52%	84.36%	↓	↑	211	0.00%	0.00%	31.12	65
Central Manchester (MRI)	72.57%	63.91%	63.91%	60.61%	↓	↓	330	33.33%		30.04	94
Central Manchester (Children's)	90.94%	85.79%	85.79%	60.61%	↓	↓	330	33.33%			
North Manchester	75.84%	68.32%	68.32%	73.20%	↑	↑	250	0.00%	5.34%	28.13	75
Oldham	76.37%	58.38%	58.38%	49.17%	↓	↓	303	0.00%	8.49%	40.88	99
Salford	83.97%	71.00%	71.00%	63.19%	↑	↓	307	35.18%		39.85	103
South Manchester	77.31%	70.56%	70.56%	66.55%	↓	↓	284	44.72%		38.42	71
Stockport	73.89%	64.06%	64.06%	66.43%	↓	↑	283	31.10%	0.29%	33.56	70
Tameside	87.40%	82.43%	82.43%	77.25%	↑	↑	233	29.18%	0.45%	32.48	73
Wigan	82.42%	60.15%	60.15%	53.09%	↓	↓	243	33.33%	3.62%	53.34	69

Steve Taylor

Chief Officer

WINTER ASSURANCE
BURY & ROCHDALE CARE ORGANISATION

CAPACITY INCREASES

- Fit to Sit designated area in ED opened mid-November
- Re-design of ACU - extra clinical space with designated assessment areas .
- Designated NIV - higher acuity respiratory bay opened December
- Additional 3 cubicles to enable rapid assessment area opened mid-November
- Ward 18 - 10 escalation beds identified
- Paediatric area re-design to increase capacity and flow as of mid-December
- Ward 9 - 28 escalation beds operational from 26th December until end of January 19 - reduction in elective activity to enable this to occur
- Transformational re-design of bed capacity with LCA support for medically optimised ward to open- February
- Transfer of senior staff member from HMR team to Bury team to actively manage flow and provide additional senior support to IDT

FLOW AND DISCHARGE

- Medical Director to provide in -reach to ED 3 days per week through January
 - Revised Discharge lounge criteria for ambulant and non ambulant patients to encourage flow and early discharges
 - Redesign of board rounds through QI and Medical teams to promote early discharges using the SHOP model operational on 2 wards and roll out plan in place
 - Weekly in reach from community arranged as from December
 - Twice daily Silver control meetings in place with a forensic review of top 20 stranded patients - Director Led
 - Gold system meetings to be activated from December through the LCA management structure
 - Dedicated ambulance provision for FGH funded through SRG monies
 - all wards 'buddied' up by member of site senior team to ensure robust patient flow data collection
- New Risks to Flow**
- Potential risk to the provision of domiciliary care via Allied Health Care who supply services within HMR
 - Potential risk to care home provision in Bury and HMR
 - 3 Care homes temporarily suspended inc D2A provision (58 closed beds)

SAFETY

- ED to ensure a corridor nurse is on shift each day to enable safe and timely handover of patients
- On site silver command to be in place from the end of December throughout January to be lead by Divisional Director/Divisional Director of Nursing to ensure site safety during pressures
- Revised and updated OPEL cards - each area/ward has specific triggers and actions
- Prioritisation of intentional rounding and Bristol checklist in A&E at times of increased pressure
- Dedicated lead nurse rota to support non-clinical SMOC to ensure safety and staffing
- Application of site OPEL cards to reflect safety concerns and acuity around staffing levels

- Elective and orthopaedic profile has been adjusted to release ward staff to assist in pressured as required and provide medial escalation capacity - operational from 26.th December
- Consultant in reach to ED by all specialities - reduced elective commitments throughout January
- ED and Medical rotas redesigned to match anticipated demand for January and February
- DMT and all Senior site teams have cleared diaries for first two weeks to assist with site management
- Outpatient and theatre staff have undertaken refresher training in ward based skills to assist on Wards when needed .
- Revised site ops/clinical management rota in place from December
- Additional IDT nurses added to current establishment funded through SRG funding to provide 7 day working cover to commence end of Jan/Feb.
- Bed management rotas redesigned to align with predicted surge in activity through ED

- Newly designed Urgent Treatment Centre for FGH operational
- Introduction of a mental health safe haven - from January
- Green car scheme introduced 7 day working across Bury - this has reduced conveyance to hospital via ambulance
- Additional winter funding agreed (£800k) for local authority to help reduce DTOCs and LoS on hospital site with the provision of additional reablement service. Also being used as a 'top up' fee for patients moving into nursing homes/residential homes.
- Agreement of care package extensions to be held for 5 days when admitted to hospital
- Introduction of integrated virtual clinical hubs for Bury

WORKFORCE

LOCALITY SCHEMES

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Bury Health and Wellbeing Board

Title of the Report	Readmission rates
Date	30/1/19
Contact Officer	Steve Taylor
HWB Lead in this area	

1. Executive Summary

Is this report for?	Information <input checked="" type="checkbox"/>	Discussion <input checked="" type="checkbox"/>	Decision <input type="checkbox"/>
Why is this report being brought to the Board?	At the request of committee members		
Please detail which, if any, of the Joint Health and Wellbeing Strategy priorities the report relates to. (See attached Strategy) www.theburydirectory.co.uk/healthandwellbeingboard			
Please detail which, if any, of the Joint Strategic Needs Assessment priorities the report relates to. (See attached JSNA) http://jsna.theburydirectory.co.uk/kb5/bury/jsna/home.page			
Key Actions for the Health and Wellbeing Board / proposed recommendations for action.	N/A		
What requirement is there for internal or external communication around this area?	N/A		
Assurance and tracking process – Has the report been considered at any other committee meeting of the Council/meeting of the CCG Board/other stakeholders....please provide details.	no		

2. Introduction / Background

This report contains an overview of readmission rates for Fairfield General Hospital, providing comparisons and analysis on reason for readmissions and length of stay

3. key issues for the Board to Consider

4. Recommendations for action

No

5. Financial and legal implications (if any)

If necessary please seek advice from the Council Monitoring Officer Jayne Hammond (J.M.Hammond@bury.gov.uk) or Section 151 Officer Steve Kenyon (S.Kenyon@bury.gov.uk).

N/A

6. Equality/Diversity Implications. Please attach the completed Equality and Analysis Form if required.

N/A

CONTACT DETAILS:

Contact Officer: S Taylor

Telephone number: 0161 7783118

E-mail address: steve.taylor@pat.nhs.uk

Date: 30/1/19

Bury and Rochdale Care Organisation

Fairfield General Hospital Readmission Rates

This report contains an overview of readmission rates for Fairfield General Hospital, providing comparisons and analysis on reason for readmissions and LOS.

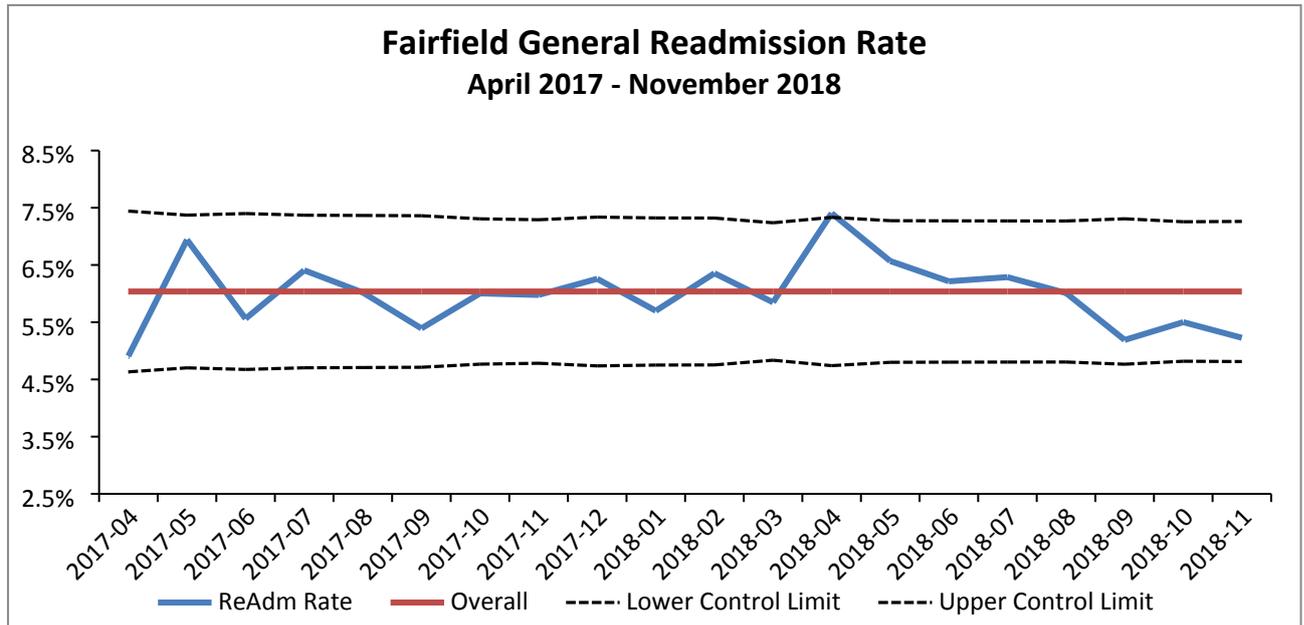
Contents

1. Fairfield General Hospital Readmission SPC chart April 2017 – November 2018
2. Fairfield General Hospital compared with North Manchester General Hospital and The Royal Oldham Hospital
3. Fairfield General Hospital – Breakdown of the reason for re admission (HRG based most recent 12 months)
4. Readmission length of stay & bed days

Criteria

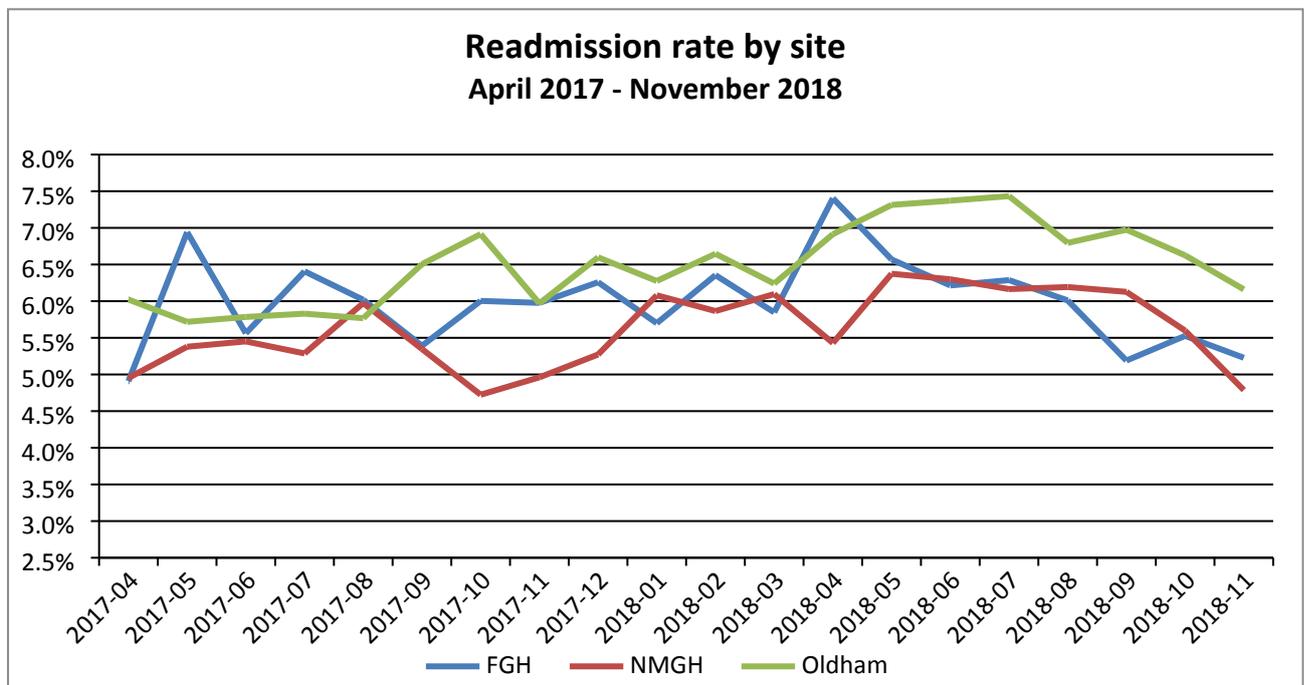
- Re admissions based on discharges and re admissions to same site only
- PBR national methodology

1. Fairfield General readmission rates



Re admission rates at Fairfield have remained consistent since April 2017, showing an improvement in performance over recent months with 3 consecutive months below the average.

2. Pennine Acute site comparison



Fairfield General Hospital has a similar readmission rate to North Manchester General with Oldham having a consistently higher rate. All sites are showing a reduction in re admission rates over recent months.

3. Top 10 HRG groups on readmission (Dec 2017 – November 2018)

HRG	Readmissions	% of Total
Lobar, Atypical or Viral Pneumonia - DZ11	255	10.8%
Chronic Obstructive Pulmonary Disease or Bronchitis - DZ65	124	5.2%
Heart Failure or Shock - EB03	103	4.4%
Non-Malignant Gastrointestinal Tract Disorders - FZ91	92	3.9%
Non-Malignant, Ear, Nose, Mouth, Throat or Neck Disorders - CB02	88	3.7%
Skin Disorders with Interventions - JD07	73	3.1%
Kidney or Urinary Tract Infections - LA04	73	3.1%
Unspecified Chest Pain - EB12	73	3.1%
Sepsis - WJ06	71	3.0%
Muscular, Balance, Cranial or Peripheral Nerve Disorders - AA26	65	2.7%
Top 10 Total	1017	43.0%
Other	1348	57.0%
Total	2365	

Key Points:

- 2365 readmissions in 12 month period
- 43% (1017) of the re admissions are made up by the top 10 HRG groups
- The 12 month period contains 149 HRG Groups (362 individual HRG's)

4. Readmission length of stay and bed days (Dec 2017 – November 2018)

	2017-12	2018-01	2018-02	2018-03	2018-04	2018-05	2018-06	2018-07	2018-08	2018-09	2018-10	2018-11	Total
Readmissions	189	176	197	207	225	219	208	211	202	164	189	178	2365
Bed Days	910	688	788	1078	1237	965	1050	853	1054	730	994	736	11083
Avg. LOS	4.8	3.9	4.0	5.2	5.5	4.4	5.0	4.0	5.2	4.5	5.3	4.2	4.7

Key Points:

- 11083 bed days used due to re admission, 924 bed days used on average per month.
- Average LOS of 4.7 days, this equates to approximately 30 beds per month.

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Bury Health and Wellbeing Board

Title of the Report	State of Delayed Transfer of Care in Bury
Date	30.01.19
Contact Officer	Dee Colam Interim Assistant Director, Adult Social Care Operations
HWB Lead in this area	Julie Gonda Interim Executive Director, Communities and Wellbeing

1. Executive Summary

Is this report for?	Information <input type="checkbox"/>	Discussion <input type="checkbox"/>	Decision <input type="checkbox"/>
Why is this report being brought to the Board?	Report requested for up-date		
Please detail which, if any, of the Joint Health and Wellbeing Strategy priorities the report relates to. (See attached Strategy) www.theburydirectory.co.uk/healthandwellbeingboard	Priority Areas 3 & 4 Living Well with a long-term condition or as a Carer & Ageing Well		
Please detail which, if any, of the Joint Strategic Needs Assessment priorities the report relates to. (See attached JSNA) http://jsna.theburydirectory.co.uk/kb5/bury/jsna/home.page	N/A		
Key Actions for the Health and Wellbeing Board / proposed recommendations for action.	To monitor progress in the reduction of DToCs across the Bury Health and Social Care System		
What requirement is there for internal or external communication around this area?	None		
Assurance and tracking process – Has the report been considered at any other committee meeting of the Council/meeting of the CCG Board/other stakeholders....please provide details.	No		

2. Introduction / Background

2.1 A 'delayed transfer of care' occurs when a patient is ready to leave an acute or non-acute hospital but is still occupying a bed. Delays can occur when patients are being discharged home or to a supported care facility, such as a residential or nursing home, or are awaiting transfer to a community hospital or hospice.

2.2 Delayed transfers – also referred to as 'DTCs' or sometimes, often in the media, described as 'Bed-blocking' – can cause considerable distress and unnecessarily long stays in hospital for patients. They also affect waiting times for NHS care, as delayed transfers reduce the number of beds available for other patients.

2.3 Delayed Transfers of Care are a national Key Performance Indicator (KPI) for both the NHS and Adult Social Care (ASC). Figures are reported daily to NHS England by the local NHS following a set process that allows a multi-disciplinary team (MDT) time for plans to put in place for a timely discharge to an appropriate, safe place for patients with complex needs.

2.4 Reasons for the delays are coded according to the area of responsibility and are very specific, eg,

- waiting for "further non-acute (including community and mental health) NHS care (including intermediate care, rehabilitation services etc)" is attributable to the NHS whilst
- waiting for a package of home-care is usually attributable to social care (although there are circumstances where it is attributable to the NHS or Both).

2.5 The detailed Statutory Guidance, which is complex and often open to different interpretations, can be found at,

<https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2015/10/mnth-Sitreps-def-dtoc-v1.09.pdf>

2.6 NHS England, the body responsible for monitoring delayed transfers of care nationally, defines a patient as being ready for transfer when:

- a clinical decision has been made that the patient is ready for transfer, and
- a multidisciplinary team has decided that the patient is ready for transfer, and
- the patient is safe to discharge/transfer.

2.7 As soon as a patient meets these three conditions the patient is classified as MOAT (Medically Optimised, Awaiting Transfer) and the 'clock' starts until they are classified as 'a delayed transfer'. The process is explained in 2.8 below.

2.8 An Assessment Notice (known as an N2 for historic reasons) is issued to the Integrated Discharge Team (see para 3.2.1) by the Ward that gives an estimated discharge date which cannot be less than 2 days away unless the notice is received after 2.00pm. In this case the timing slips over into the next day, ie if the notice is received at 12.00noon on Monday, services must be in place before 11am on Wednesday but if it's received at 2.30pm the team have until 11 am on Thursday to complete their arrangements. The IDT can then begin its assessment process to determine the most suitable onward destination. Once the discharge date is confirmed and the 3 conditions overleaf are met, the ward will issue a Discharge Notice (N5) and the clock then begins to tick down for 48 hrs (depending on time of referral as explained above) to the person becoming classified as a DToC.

2.9 Each month NHS England publishes two measures of delayed transfers –

- the total number of bed days taken up by all delayed patients across the whole calendar month and
- the average daily number of delayed transfers across the month. These reports are produced two months in arrears.

2.10 The latest detailed report available from ADASS in respect of November's performance across the region can be found at:

<file:///C:/Users/d.colam/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/ST0JZUT3/NW%20ADASS%20DToC%20Dashboard%20January%202019.pdf>

3. key issues for the Board to Consider

3.1 Mental Health DToCs

3.1.1 In May last year Bury had a significantly higher number of DToCs than either the national, regional or GM-wide and was seen as an outlier in this KPI. On undertaking a 'deep dive' into the reasons for this it was found that patients in the Irwell Unit (Mental Health) at Fairfield General Hospital (FGH) had been responsible for a large proportion of DToCs since October 2017, when their method of reporting changed. Previously a patient was consider a DToC once an onward placement had been found and the patient was ready to transfer. PCFT changed this to reflect the requirements of the Statutory Guidance and reported patients as DToCs once the time-scale after receipt of the N5 had ended.

3.1.2 At this time 15 patients had been delayed for over 1,800 days with 7 of them having individually been delayed over 100 days.

3.1.3 The problem was compounded by the way the Community Mental Health Team (CMHT) worked to strict 'Zoning' criteria based on risk and as these patients were in a safe place they were considered low risk, so they were not prioritised. There was also no escalation process in place to alert senior managers to the situation. Once the issue was understood and CMHT management and workers engaged, the problem significantly reduced.

3.1.4 A link manager was put in place to liaise between the CMHT and the Irwell Unit and discharge planning began in earnest. This eventually reduced the list of those waiting discharge along with the number of bed-days they'd been delayed.

3.1.5 However, a significant issue in these figures is the lack of mental health beds available across the country for onward discharge for those suffering mental ill-health and the lack of social housing within the area. This remains a concern both nationally as well as across GM and the GM Commissioning Unit is looking at ways to stimulate the market to provide more of these types of beds across the authority.

3.1.6 The DToC situation is much improved although the full effect has only gradually been felt due to the NHSE method of calculation. There are currently 2 people waiting to be discharged accounting for 24 days (as at 31.01.19) and one additional patient who is on leave to a placement and not occupying a bed but technically classed as a DToC for 119 days. In addition there is one person from Rochdale who is

3.1.7 In addition to the Irwell Unit, which caters for those in an acute episode of mental illness who are sectioned under the Mental Health Act, the Ramsbottom Unit caters for those older people with mental health issues such as dementia which is often complicated by psychosis. DToCs here are common because of a lack of EMI Nursing Homes across the region that can cater for complex behaviour which challenges.

3.2 Acute hospitals

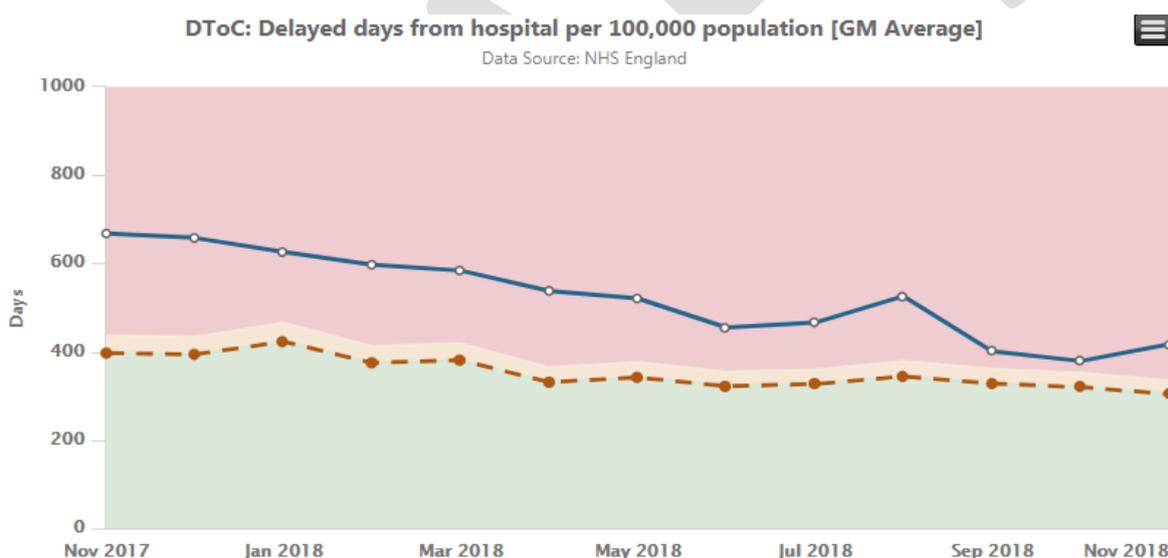
3.2.1 Bury's performance has also improved across both acute hospitals which serve its population, FGH and North Manchester General Hospital (NMGH). The Integrated Discharge Teams comprise of Social Workers and Discharge Liaison Nurses/Transfer of Care Nurses who liaise with ward staff and therapists to discharge plan as patients become MOAT.

3.2.2 Ideally the discharge planning process would start on admission but this is not possible at the present time for a variety of factors, not least of which is related to staffing. However, the IDTs work in a truly integrated way and over the past year this has proved invaluable in reducing the DToCs in the area.

3.2.3 In addition, the Provider Relationship Team have worked with care home providers to create Discharge to Assess (D2A) beds where patients can be safely discharged for full assessment once they have had a period of recuperation and reablement, rather than at a point of crisis in their health or social care needs.

3.2.4 At the end of last year we were able to negotiate the provision of all these beds at Heathlands and this has proved a much improved situation. The whole service was able to be provided on one site so therapy staff were not having to travel across the borough to work with patients at the three previous, different sites.

3.2.5 The graph below, for November, demonstrates the overall progress that is being made in the reduction of DToCs in Bury (despite the increase in the summer, which was unprecedented, with related high acuity of patients), along with tables which show the overall downward trend for Bury compared to last year. There is still some way to go to achieve our target of 3.8% of delayed days but delays attributable to Social Care have shown the most progress and are now approaching the national benchmark.



Responsible Organisation	Social Care		NHS		Both		Trend compared to last month SC		Trend compared to 6 months ago SC	
	National %	30%		62%		8%		N/A		N/A
Bury figures	241	39.6%	272	44.7%	95	15.6%	↓	30.8%	↓	46%

Average delayed days per 100,000	Bury	NW Average	GM Average	Trend compared to last month	Trend compared to 12 months ago
	417	366	304	 379	 668

3.2.6 It was agreed last autumn that part of the System Resilience Grant (SRG) could be used to enhance the staffing levels in FGH's IDT for both nurses and social workers but it has proved impossible to recruit staff on such short-term contracts. Further efforts are being made to increase staffing levels in the team moving forward in the New Year and negotiations are taking place with the CCG in order to secure the SRG funding on a 3 years basis.

3.2.7 In addition to the D2A beds, the provision of Intermediate Care (IMC) beds for both nursing (at Bealeys) and Choices for Living Well at Killelea has been invaluable in the reduction in delays. Choices has flexed its admission criteria wherever possible to accommodate requests for patient transfer, particularly at times of crisis in the hospitals. A request to enable Choices to provide nursing, as well as residential care, has recently been made to CQC to enable greater flexibility within the system.

Non-Acute Hospital DToCs

3.2.8 This includes community & private hospitals and, whilst there are occasional DToCs from Bealeys waiting for Choice's Community Reablement service, the main cause of DToCs in this sector is again mental health provision and Out-of Area patients who are awaiting assessment for onward placement.

Winter Pressures Grant

3.2.9 In December the Local Authority received £817k from the Government to assist in the flow of patients out of hospital. It was decided to use a large part of the money to create extra capacity within the D2A bed-base; to contract the GP Federation to provide medical cover for the additional beds at Heathlands; to purchase specialist equipment which may be delaying a discharge; to employ additional therapists in the reablement service to enable earlier discharge from Choices, therefore improving flow; and to have a contingency fund for any emergency which may arise. A detailed account of spend against this is being maintained and reports are provided to the Department of Health on a regular basis on how it is being spent.

3.2.10 Staff in our IDTs have worked hard and have proved their dedication to the patients in their hospitals by working extended hours, coming in on days off and focussing on the reduction of DToCs based on the safety of patients and an appropriate onward destination.

3.2.11 The numbers of DToCs in Bury have reduced significantly since close monitoring of these, although there was a recent increase over the December period, linked to high attendances at A&E, high admissions rates and associated high patient acuity. Patients, when moved, were often really poorly and required longer periods in D2A or IMC beds, which in turn reduced flow across the system. However the situation has improved once more with DToCs showing a marked reduction (as reported from the hospitals in January), especially in those that are attributable to Adult Social Care.

4. Recommendations for action

4.1 The Board are asked to note the contents of the report and support the actions being taken to reduce DToCs across Bury.

5. Financial and legal implications (if any)

If necessary please seek advice from the Council Monitoring Officer Jayne Hammond (J.M.Hammond@bury.gov.uk) or Section 151 Officer Steve Kenyon (S.Kenyon@bury.gov.uk).

6. Equality/Diversity Implications. Please attach the completed Equality and Analysis Form if required.

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Bury Health and Wellbeing Board

Title of the Report	Chair's Briefing – Bury Health and Social Care Transformation Programme Board
Date	12 February 2019
Contact Officer	Helen Smith – Head of Assurance PMO
HWB Lead in this area	Dr J Schryer, CCG Clinical Chair

1. Executive Summary

Is this report for?	Information <input type="checkbox"/>	Discussion x	Decision <input type="checkbox"/>
Why is this report being brought to the Board?	To advise the Board of key issues discussed and agreements made at Bury's Health and Social Care Transformation programme Board		
Please detail which, if any, of the Joint Health and Wellbeing Strategy priorities the report relates to. (See attached Strategy) www.theburydirectory.co.uk/healthandwellbeingboard	All		
Please detail which, if any, of the Joint Strategic Needs Assessment priorities the report relates to. (See attached JSNA) http://jsna.theburydirectory.co.uk/kb5/bury/jsna/home.page			
Key Actions for the Health and Wellbeing Board / proposed recommendations for action.	The Health and Wellbeing Board is asked to review the work of the Transformation Programme Board in line with the Board's accountability for the Locality Plan		
What requirement is there for internal or external communication around this area?	N/A		
Assurance and tracking process – Has the report been considered at any other committee meeting of the Council/meeting of the CCG Board/other stakeholders....please provide details.	None		

2. Introduction / Background

- 2.1 Bury's Health and Care Transformation Programme Board (TPB) is accountable to the Health and Wellbeing Board (HWB) for the successful delivery of Bury's Locality Plan: Transforming Health and Social Care.
- 2.2 This report advises HWB of the key TPB discussions and agreements at its December 2018 meeting in support of this accountability. Since the last report most of the work for the Board has focussed on Programme 6 – Transforming Primary, Community and Social Care.

3. Transformation Programme Board Highlights – December 2018

3.1 Transformation Models of Care

- 3.1.1 The Board received a presentation on the outputs of the work regarding proposals for transforming models of care. The proposals were for new services in areas such as MDT (multi-disciplinary team) Case Management, rapid response and intermediate care. Together these are designed to improve the quality of care and user experience of care – leading to improvement in health and wellbeing outcomes; and deliver a return on investment that contributes to long-term financial sustainability. Primary features of these new services include:

- New standard operating procedures for MDT and Rapid Response
- More effective use of the current bed base to create capacity in the system
- Understanding the future demand on intermediate care packages and designing the model around this
- Creating a single service for the intermediate tier

3.2 Mutually Binding Agreement

- 3.2.1 The Board received an update on the progress of the mutually binding agreement for the LCA – to form as an LCO on 1 April 2019. The Board was informed that a number of schedules (such as the Locality Plan Investment Agreement and Risk and Reward arrangements) appended to the agreement that would require agreement across the OCO and LCO with the core document to be agreed by the five partners within the LCO. This work is now in its final stages.

3.3 **Estates for Integrated Neighbourhood Teams**

3.3.1 The Board received a report on the shortlisting of estate options for location of the integrated neighbourhood teams. It was highlighted that staff consultation was due to commence on the 7 January 2019 prior to any relocation which proposed bases for teams. It was highlighted that in certain areas of Bury there is little suitable public sector estate which produces limited options. The Board were reminded that if suitable estate is not agreed it is unlikely that the deadline to have 5 co-located health and social care teams within neighbourhoods will be met.

The Board agreed the next steps around approving delegated decision making in light of the timescales required, to agree any estates proposals in advance of the next Transformation Board meeting.

At the time of writing, 4 out of 5 office bases have been identified.

4. Recommendations for action

4.1 Health and Wellbeing Board is recommended to note the work of the Health and Care Transformation programme Board.

CONTACT DETAILS:

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Date: 29 January 2019

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GM Population Health Plan

Lesley Jones
Director of Public Health
January 2019

Introduction

- GM Population Health Plan launched January 2017
- Overseen by GM Population Health Programme Board
- GM Population Health Team/GM DsPH/ PHE working in partnership to lead & coordinate
- 20 programmes with SRO identified for each
- System wide engagement across all programmes
- Programme Phases - Discover: Define: Design & Develop: Deliver: Evaluate
- £30m Transformation Funding now fully allocated

Person Centred Approaches

GM Plan	Bury
Person centred conversations	<p>Training in 3 conversation approach being commissioned for INTs.</p> <p>Development of a 'quality of life conversational tool'</p>
Personal budgets	<p>Currently in place for those Fast Track (EoL) customers with homecare package & people in receipt of complex care packages</p> <p>Plans in 2019 to expand to personal wheel chair budgets, Mental Health Section 117 budgets</p> <p>Scoping further opportunities</p>
Social Prescribing	<p>Social prescribing model agreed across stakeholders</p> <p>VCFA grant to implement model from April 2019.</p> <p>GP practice staff are being identified to undertake the training as a 'care navigator'</p> <p>The Bury Directory is an online tool available 24/7</p>
Asset based approaches	<p>The Voluntary Community and Faith Alliance (VCFA) is now established and is focussed on supporting the development and sustainability of the VCF sector and groups.</p> <p>Neighbourhood engagement framework in place</p> <p>GM Leaders programme in Radcliffe</p> <p>Participatory Budgets, Discretionary Budgets, Social Capital Grant and other Council and VCFA led/ managed grants, are aimed at empowering local people through conversations to start groups, schemes, projects and initiatives that are person centred and support local people.</p> <p>Dr Robin Pharoah (instigator of the Wigan Deal) working with Bury to support transformation.</p>

Starting Well

GM Plan	Bury	Performance
<p>Implement core elements of Early Years Delivery Model within all 10 localities & IMT proposition to improve data processes</p>	<p>8 stages in place Early adopter for digitisation Pilot site for Essential Parent E Care – Implementation of Parent Infant Mental Health, Speech, Language & Communication and Physical Development pathways Contributing to development of GM ‘High Needs’ pathway Good quality early years education provision</p>	<p>School Readiness: 70.9 (2nd in GM)</p> <p>Breastfeeding 6-8 weeks: 37.4% (6th in GM)</p>
<p>Smoking in Pregnancy: GM approach to ‘Baby Clear’ & targeted incentive Scheme</p>	<p><u>Babyclear</u> project: smoking support given by midwives/maternity support workers during antenatal appointments. <i>Phase One</i>- Pennine Acute – Bury residents recruited to the scheme are 3rd highest in the Cluster); although data quality issues exist. Active analysis underway. <i>Phase Two</i> – Bolton Hospitals –early stages: progress and figures for Bury residents to be reported when available.</p>	<p>Smoking at time of delivery: 12.0% (4th in GM)</p>
<p>Oral Health: Distribution of toothbrushes/paste via Health Visitor reviews Supervised tooth brushing nursery settings & Year 1 Development of GM Oral Health Strategy</p>	<p>Not part of GM programme but have implemented locally. All HVs distributing toothbrush packs and promoting drinking cups. 68 Bury Nurseries plus Millwood School have ‘Brush Bus’ supervised tooth brushing.</p>	<p>Proportion of 5 year olds free from tooth decay 64.8% (5th in GM)</p>

Living Well: Work & Health

GM Plan	Bury	Performance
<p>Work and Health:</p> <ul style="list-style-type: none"> •Early intervention system for those in work who become ill and risk falling out of the labour market. •Early enhanced intervention for those newly out of work •Better support for people who are long-term economically inactive •Development to enable GM employers to provide ‘good work’, and for people to stay healthy and productive in work 	<p>GM procurement complete and contract awarded. Provider in place for Bury</p> <p>Local preparatory work including a meet the provider meeting underway.</p> <p>Go live March 2019</p> <p>Bury Workplace Health Programme in place</p>	<p>Gap in employment rate between those with long-term health condition and overall employment rate: 25.5% (5th in GM)</p> <p>Business engagement</p> <p>Light touch: 139</p> <p>Medium touch: 16</p> <p>Intensive: 6</p> <p>8 people remained in work due to intervention</p>

Living Well: New models of Primary care for deprived communities

GM Plan	Bury	Performance
Provide proof of concept for Focus Care approach by testing in 10 GM practices	Not part of the GM pilot	N/A

Living Well: Incentivising and supporting healthy behaviours

GM Plan	Bury	Performance
<p>Work with pathfinder locality to develop & test effective 3 tier delivery model</p> <p>Develop and test innovative incentive based digital platform at procurement stage</p> <p>Develop standards and performance framework for GM integrated wellness services including exercise referral.</p>	<p>Transformation and integration of wellness services i.e. Healthy Lifestyle Service (including Stop Smoking Service), BEATS, SAPAS & Leisure underway.</p> <p>Investment in additional capacity via Locality Plan transformation fund.</p> <p>Working to embed pathways based on model with MSK & Physiotherapy e.g. mental health and pharmacy and building on work with GP practices.</p>	<p>Performance indicators under review & development.</p>

Living Well: Incentivising & supporting healthy behaviours

GM Plan	Bury	Performance
Smoking: GM Tobacco Control Plan	Final Draft of local Tobacco Strategy completed. Local alliance being set up. Implementation of Cure Programme – July 19 Smoke free Summer programme Amplification of Stoptober & GM mass media campaigns Local enforcement of illicit sales	Regular smoking at age 15: 4.7% (3 rd in GM) Smoking prevalence adults: 16.3% (5 th in GM)
Alcohol: Refreshed integrated substance misuse strategy	CICA Alcohol Champions active Big Alcohol conversation – Kay Gardens Alcohol exposed pregnancies project initiated GM Collaborative review of Tier 3 & 4 substance misuse services	Successful completion of treatment: Opiate users: 6.0% (4 th in GM) Non opiate users: 38.5% (6 th in GM) Alcohol: 35.5% (7 th in GM) Alcohol related admission episodes 564 (1 st in GM)
Obesity: Physical Activity: GM Moving Plan	Local Physical Activity Strategy in place – due for refresh Local Delivery Pilot in Whitefield at planning stage Implementation of Daily Mile (highest % schools in GM) Local Transport Planner being recruited to optimise opportunities e.g. ‘Beelines’	Physically active adults: 63.6% (5 th in GM) Overweight & obese adults: 64.3% (5 th in GM) Overweight & obese 4-5 yr olds: 21.2% (2 nd in GM) Overweight & obese 10-11yr olds: 34.2% (3 rd in GM)
Comprehensive Plan for nutrition and healthy weight	Nutrition/ Food & Health Strategy a gap	

Living Well: Disease Prevention

GM Plan	Bury	Performance
<ul style="list-style-type: none"> •Cancer prevention & early detection (Cancer Vanguard prevention workstream) <p>Social Marketing strategies</p> <ul style="list-style-type: none"> •Cancer Champions •New approaches to Breast, Bowel & Cervical Screening uptake/access •Lifestyle support for those surviving cancer 	<p>General prevention strategies are also Cancer prevention strategies</p> <p>Promoting early detection</p> <p>Promoting screening uptake linked to GM primary care standards</p> <p>Living with & beyond cancer programme includes lifestyle support</p>	<p>Under 75's mortality rate from cancer considered preventable: 86.5/ 100,000 (3rd in GM)</p>
<p>HIV eradication: GM approach FAST TRACK cities initiative</p>	<p>Active partner in GM Sexual Health Network</p> <p>Signed up with GM to Fast Track Cities Programme</p>	<p>New HIV diagnosis rate/100,000 aged 15+: 5.9% (2nd in GM)</p> <p>Late HIV diagnosis: 35% (1st in GM)</p> <p>HIV diagnosed prevalence rate/1000 aged 15-59: 1.73 (4th in GM)</p>
<p>Lung Health Check Pilot</p>	<p><i>Not part of pilot. GM feasibility programme complete. Waiting national guidance.</i></p>	<p>N/A</p>

Ageing Well

GM Plan	Bury	Performance
<p>Housing: Develop and Implement a GM Home Improvement Model for over 60 and disabled people across GM, incorporating a range of areas.</p>	<p>Services in scope are delivered in Bury Staying Well service links Peachment Place extra care scheme opened Concept of ‘Wellbeing Neighbourhoods’ being explored as part of place-shaping & development plans</p>	<p>N/A</p>
<p>Nutrition & Hydration: Develop, test and scale model based on ‘Salford Together Nutrition Armband’</p>	<p>Raising Awareness on malnutrition risks and dehydration in the 65+ population across Bury Working Together with all willing community services across Bury and training their care staff and looking at further opportunities to support those at risk Identifying Malnutrition by using the Paperweight Armband © Providing individuals and care staff with “Are you Eating Enough” booklets</p>	<p>At Dec 2018 Potential reach of awareness raising & training activity: 12,751 Number identified at risk: 40 (Highest of 5 participating GM boroughs. Total GM 71)</p>
<p>Falls: Develop, Test and roll out FLS across GM</p>	<p>Part of Locality Plan programme 3 New Falls Prevention service designed Falls Liaison Service Specification developed Strength & Balance Programme up and running Manger cushions purchased & care home training initiated Handy person scheme designed – Grant to VCFA to implement</p>	<p>Hip fractures in people aged 65+: 594 per 100,000 (2nd in GM)</p>

System Reform

GM Plan	Bury
<p>Unified PH system: GM Population Health Commissioning Plan; unified GM Pop Health function; Model for future resourcing of population health in GM</p> <p>100 day challenge think piece: How we realise a 'Population Health System'</p>	<ul style="list-style-type: none"> •PH Commissioning aligned to GM plans •Collaborative commissioning of Sexual Health & drug and alcohol treatment services. •Local HWBS/Locality Plan aligned to draft GM Plan •GM DsPH, PHE & GM PH team leading a design piece for how to realise a 'Population Health System' and the role of Specialist Public health within a new system.
<p>Social Value Develop & embed GM approach which maximises H&WB and Procurement spend in GM</p>	<p>Social Value Policy & work-stream in place linked to GM Procurement network</p> <p>GM DsPH funding collaborative work on Social Value. GM selected as an NHS England accelerator site.</p> <p>Funding to develop:</p> <ul style="list-style-type: none"> • A portfolio showcasing Social Value in action in GM services • An economic assessment of the potential financial value of social value within GM Public Service • All localities including Bury involved.

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Greater Manchester Nutrition and Hydration Programme

Programme Delivery in Bury area:

Carmel Berke

Nutritionist



What is the issue?

- 14% of over 65s are at risk of malnutrition
- In hospitals and care homes the prevalence rises to around 1 third
 - Reduced independence and mobility
 - Increased ill health
 - Longer convalescence
- The risk of dehydration increases dramatically with age
 - Reduced mental performance
 - Increased tiredness and risk of falls
 - Frequent infections (in particular urinary tract infections)

Big impact on individuals and their carers
Big cost to health and social care
In many cases it is preventable and treatable



What we are doing in Bury?

- Raising Awareness on malnutrition risks and dehydration in the 65+ population across Bury
- Working Together with all willing community services across Bury and training their care staff and looking at further opportunities to support those at risk
- Identifying Malnutrition by using the Paperweight Armband ©
- Personalising Care and Support by providing individuals and care staff with “Are you Eating Enough” booklets
- Monitoring and Evaluating the programme when hitting milestones



The Paperweight Armband ©

- Based on a clinical screening tool
- Non-clinical and non-intrusive
- Enable carers, volunteers or health and social care professionals to broach the subject of appetite in the elderly
- Greater Manchester wide KPI'
- Screen 13% of the over 65 population over 2 years (40,000 people)
- 80% of care home staff complete the e-learning tool
- Reduce cost of SIP feed prescribing and hospital admissions related to malnutrition
- Increase GP recording of malnutrition
- Report from each area highlighting a differentiated approach to meet the needs of specific groups of people



Bury case studies

An 84 year old lady spoke to me during a lunch club. She told me she had fallen twice over the weekend. I asked her if she thought she was drinking enough fluids. It was 1 o'clock in the afternoon on the day of our conversation and she said she hasn't had a drink yet. She had a bottle of water with her which was full but because she was carrying it around with her she was not offered drinks at the lunch club.

"I don't like to eat because I am sad and lonely. My husband passed away two years ago and now I live on my own and don't find any pleasure in eating- I just don't see the point in it" This was said by an elderly lady I spoke to during a meeting in Age UK Bury.

"I know why I am getting thinner- its because I am old!" In fact, getting old is not an excuse for losing weight- if anything weight should increase with age as metabolism goes down and we use less energy.

"I was married to my wife for nearly 60 years before she unexpectedly passed away last year. I was left on my own and because she had always done the cooking I was left with grief and with not knowing what to do in the kitchen. For the first weeks after her passing I lived on cups of tea and biscuits and lost a lot of weight. One day my neighbour noticed this and started bringing me meals and take me shopping for food"

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