AGENDA FOR

HEALTH SCRUTINY COMMITTEE

Contact: Julie Gallagher
Direct Line: 01612536640
E-mail: julie.gallagher@bury.gov.uk
Web Site: www.bury.gov.uk

To: All Members of Health Scrutiny Committee

Councillors: C Cummins, J Grimshaw, S Haroon, K Hussain, O Kersh, C Morris, L Smith, S Smith (Chair), C Tegolo, R Walker and S Walmsley

Dear Member/Colleague

Health Scrutiny Committee

You are invited to attend a meeting of the Health Scrutiny Committee which will be held as follows:-

Date:	Wednesday, 18 September 2019
Place:	Meeting Romms A&B, Bury Town Hall.
Time:	7.00 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 Health Scrutiny Committee 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 PUBLIC QUESTION TIME

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

4 MINUTES *(Pages 1 - 4)*

Minutes from the meeting on the 25th June 2019 are attached.

5 ABUSE ALLEGATIONS IN CARE HOME *(Pages 5 - 10)*

Julie Gonda, Interim Executive Director Communities and Wellbeing and Adrain Crook, Assistant Director Social Care will report at the meeting. Report attached.

6 PERSONA UPDATE *(Pages 11 - 20)*

Kat Sowden Managing Director, Persona will report at the meeting. Report and Appendices are attached.

7 HEALTH VISITORS UPDATE *(Pages 21 - 74)*

Lesley Jones, Director of Public Health and Rachel Davies, Public Health Lead will report at the meeting. Report with Appendices attached.

8 ADULT CARE COMPLAINTS REPORT *(Pages 75 - 84)*

Julie Gonda - Interim Executive Director – Communities & Wellbeing, will report at the meeting. Report attached.

9 URGENT BUSINESS

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

Minutes of: **HEALTH SCRUTINY COMMITTEE**

Date of Meeting: 26th June 2019

Present: Councillor S Smith (in the Chair)
Councillors, C Cummins, J Grimshaw, K Hussain, C Morris, L Smith, C Tegolo, R Walker and S Walmsley.

Also in attendance: Geoff Little, Chief Executive Bury Council
Julie Gonda, Interim Executive Director Communities and Wellbeing
Chris O'Gorman, Independent Chair LCO
Tony Bruce, Director of Transformation,
Jon Hobday, Public Health Consultant
Jackie Summerscales, Corporate Policy
Julie Gallagher, Principal Democratic Services Officer

Public Attendance: 2 members of the public were present at the meeting.

Apologies for Absence: Councillor Andrea Simpson, Cabinet Member Health and Wellbeing
Marcus Connor, Corporate Policy Manager
Lesley Jones, Director of Public Health

HSC.45 DECLARATIONS OF INTEREST

There were no declarations of interest made at the meeting.

HSC.46 PUBLIC QUESTION TIME

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

HSC.47 MINUTES

It was agreed:

That the minutes of the meeting held on 25th April 2019 be approved as a correct record.

HSC.48 HEALTH AND SOCIAL CARE REFORM

- **One Commissioning Organisation**

Geoff Little, Chief Executive Bury Council and Tony Bruce, Director of Transformation attended the meeting to provide members with an update in respect of the development of the One Commissioning Organisation. The

presentation contained information in respect of the development of the Local Care Organisation (LCO), the One Commissioning Organisation (OCO) and also work that is underway with the public and communities in relation to Neighbourhood working.

The Chief Executive reported that the establishment of the OCO is necessary to close the financial gap of £25 million, improve outcomes and re-balance from a system that all too often results in late intervention in hospitals and residential care to early intervention in communities. GM Devolution is a once in a generation opportunity to do this. £19 million pounds of transformation monies have been made available to investment in transformation projects within the Borough.

The main objective of the proposed changes is to empower people to remain well for longer, make informed choices and create a different model of services for Bury people.

Ultimately and over time the Bury "One Commissioning Organisation" will encompass all strategic commissioning from the Council and CCG and other public services where possible. The Chief Executive reported that by 1st October 2019 the Strategic Commissioning Board, health and social care will commence work. The OCO staffing function (health and social care) will be fully operational by the 1st April 2020.

Those present were invited to ask questions and the following issues were raised.

Responding to a Member's question the Chief Executive reported that the majority of the 19 million pounds of GM transformation monies will have been spent within the Locality Care Organisation, transforming services and developing new services. Very little monies have been spent on organisational structures. The closer working arrangements across both the CCG and the Council including the appointment of joint posts for the positions of Chief Finance Officer, Chief Accountable Officer and Head of Communications will reduce costs and bureaucracy.

Members asked for assurance in respect of how the development of these organisations will assist those most vulnerable in society whom rely and depend on these services and how these organisations link in with the development of the anti-poverty strategy. Responding, the Chief Executive reported that the anti-poverty strategy will at a population level, help people to secure economic growth, better quality of life. The LCO via the integrated Neighbourhood teams will result in integrated service provision and improve the quality of services for residents in the Borough.

The Chief Executive reported that health outcomes need to improve in the Borough, this cannot be done in isolation. Schools, further education colleges and higher education institutes are vital partners in this process. Improvements to the education and skills of the Borough's residents will ultimately lead to better health outcomes and reduce costs across the public sector.

With regards to the establishment of the Strategic Commissioning Board, the Chief Executive reported that the Board will still be accountable to the Council's Cabinet. There will be no loss of democracy/accountability, the new arrangements will help to increase the effectiveness of both of these organisations. The Board will primarily focus initially on health and social care issues and will consider key strategic joint issues, while at the same time looking at some of the other wider determinants of health, air quality, housing, parks and leisure etc. The Strategic Commissioning Board will be subject to scrutiny by the Council's two scrutiny committees.

It was agreed:

Geoff Little, Chief Executive Bury Council and Tony Bruce, Director of Transformation be thanked for their attendance.

- **Locality Care Organisation**

Julie Gonda, Interim Executive Director Communities and Wellbeing Chris O'Gorman, Independent Chair LCO attended the meeting to update members on the work of the Locality Care Organisation. The presentation had been forwarded to members in advance of the meeting and included information in respect of:

- Delivering transformational change for six priority areas: Integrated neighbourhood teams; The intermediate tier; End of life care; Community stroke/neurorehabilitation; The rapid response service; Urgent care and care home support
- Overseeing the transfer of community services from Pennine Care Foundation Trust to Northern Care Alliance
- Supporting the developing children's health and social care transformation programmes
- Developing the transformation programmes for other services not yet transformed across partners
- Building relationships and collaboration across partners
- Develop an infrastructure for April 2020 onwards

Those present were invited to ask questions and the following issues were raised.

Members sought assurances that following these transformational changes all the affected organisations would remain financially sustainable. The LCO Chair reported that savings would be generated from the Acute Sector and invested into Primary care to provide support and care closer to home. Where appropriate, investment will be agreed based on a cost benefit analysis, it is envisaged that in some circumstances it may take two to three years to generate savings.

With regards to recruitment to the new organisation, the LCO Independent Chair reported that Integrated Neighbourhood Teams will be staffed predominately by the existing workforce. Recruitment to the senior posts for the intermediate tier work stream has also commenced. A further recruitment exercise including, re-branding with a range of jobs under the umbrella of transformation, began week commencing 24th June 2019.

It was agreed:

Julie Gonda, Interim Executive Director Communities and Wellbeing
Chris O'Gorman, Independent Chair LCO

HSC.49 JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) UPDATE

Jon Hobday, Public Health Consultant attended the meeting to provide members with an overview of key health and wellbeing data for Bury and to highlight the interventions which will improve health and wellbeing over the life course. The presentation included information in relation to:

- Life expectancy
- Healthy life expectancy
- Mortality from preventable causes
- Impact of health inequalities across the life course
- What works
- Actions to promote health equity and tackle health inequalities

Members discussed using JSNA data more effectively to provide meaningful neighbourhood profiles. Work is undertaken to understand what interventions should improve outcomes and then to commission and target resources into the areas of most impact.

It was agreed:

Members will be kept informed of the work undertaken to expand the neighbourhood profiles and developments with the Joint Strategic Needs Assessment.

HSC.50 WORK PROGRAMME

The Principal Democratic Services Officer presented a report outlining a proposed work programme for the Health Scrutiny Committee.

It was agreed:

1. Amendments will be made to the work programme to include:
   A more extensive mental health update including Healthy Young Minds and waiting times; Fairfield Hospital update and a report from the Coroner.
2. A training session will be arranged prior to the next meeting to discuss health and social care reform.

Councillor S Smith
In the Chair

(Note: The meeting started at 7pm and ended at 9.10pm)

Agenda Item 5

SCRUTINY REPORT

MEETING: **Health Scrutiny**

DATE: **19th September 2019**

SUBJECT: **Abuse Allegations in Care Homes**

REPORT FROM: **Adrian Crook, Assistant Director Adult Social Care**

CONTACT OFFICER: **Adrian Crook / Amanda Symes**

1.0 BACKGROUND

In June 2019 a Bury MP posed the following parliamentary question:

"To ask the Secretary of State for Health and Social Care, how many reports of abuse there have been in care homes in (a) Bury, (b) the North West and (c) England in the last 5 years"

A response to this question was provided by the Minster of State for the Department of Health and Social Care, Caroline Dinenage using Care Quality Commission (CQC) data which stated:

"The following table shows the number of allegations of abuse in care home locations received by the CQC between 2014 to 2018.

Table1 Year Received	Number of Notification Bury Local Authority	North West Region	England
2014	99	5,741	37,060
2015	122	6,948	43,064
2016	164	7,856	46,227
2017	176	9,304	57,738
2018	182	9,936	67,590
Grand Total	743	39,785	251,679

This data includes multiple notifications about individual locations."

There was no additional explanation of the data contained within the table.

The above information was forwarded to Bury Council by the MP with a request for comment, and also forward to the Bury Times who produced an article entitled "Allegations of abuse in Bury care homes on the rise".

2.0 ISSUES

For the purposes of these notifications abuse is defined within the Care Quality Commission (Registration) Regulation 18 paragraph 5:

a. "abuse", in relation to a service user, means—
   i. sexual abuse,
   ii. physical or psychological ill-treatment,
   iii. theft, misuse or misappropriation of money or property, or
   iv. neglect and acts of omission which cause harm or place at risk of harm;

Part IV of this regulation means that any mistake, near miss or potential harm is also reported as an abuse. These notifications can include a range of incidents such as missing a dose of medication, missing reviewing an element of someone's care plan or providing a meal different from a residential dietary requirements for example.

These incidents must not be ignored as they can cause harm and care homes are encouraged to report them in order that they can learn from these mistakes and acts of omission and learn how to improve. Reporting these incidents is positive as it shows a learning system but does increase the number of notifications headed abuse.

This additional information and explanation was not referred to when the table was published.

Additional contextual information provided by Bury Council to the MP's request for comment, was also not reported in the Bury Times article and therefore the opportunity to provide context was not given.

The contextual information that was forwarded to the MP is as below:

"Figures from the 2014 data cannot be compared to subsequent years, as the recording and definitions of what constituted abuse changed in 2014 with the introduction of the Care Act in that the scope was widened to include additional categories.

When comparing the % increase reported for Bury both with regional and national figures Bury is clearly not an outlier and shows a considerably lower overall increase than the national average, as illustrated by the table below:

Table 2 Year Received	Number of Notification Bury Local Authority	North West Region	England
% increase from 2015 to 2018	49% increase	43% increase	57% increase

A great deal of the increase from 2015 onwards can be attributed to organisations and community members starting to recognise and therefore report on the widened scope."

This is a positive and expected response to a policy change which saw Adult Safeguarding embedded into law and the definitions widened.

On speaking to CQC with regard to their reported figures, they advised that they had also set context to their data which had again not been reported in the article in that there had been a number of internal changes to their data recording systems therefore year on year data comparison would be flawed.

Bury Adult Safeguarding Board have been proactive since the changes brought about by the Care Act to increase awareness with regard to adult abuse. This has had an impact in that reports have steadily increased. Below is a table which shows the numbers of concerns and enquires received from 2015 by Bury Council – as defined by statutory recording definitions.

Table 3 Year	Concerns	Enquiries	Conversion rate
2015/16	1055	422	40%
2016/17	1744	460	26%
2017/18	2311	869	38%
2018/19[1]	2777	519	19%

Key:

- A “Concern” is a sign of suspected abuse or neglect that is reported to the Council or identified by the Council.
- An “Enquiry” is action taken or instigated by the Council in response to a concern, an enquiry could range from a conversation to a more formal multi-agency plan or course of action.
- The Conversion rate is the number of concerns that have moved over to a safeguarding enquiry.

As illustrated above the number of concerns continues to rise, this can be attributed to local campaigns, local and national news stories which also raise awareness and multi-agency training programmes which increases the ability to identify and report.

In addition The Bury Times article regarding the death of six residents proved unhelpful as it gave rise to the impression that the deaths at Elizabeth House related to abuse, this was not the case. The deaths related to a virulent strain of Invasive Pneumococcal disease which affected many care settings across the UK.

Elizabeth House were supported by Bury Council Infection control team at the time of the Invasive Pneumococcal disease outbreak and were found by the team to have acted quickly and appropriately. Unfortunately, due to the inference that these sad deaths were abuse related, Elizabeth House are now struggling to attract new customers to their facility and at this time the future of the business is not known.

Indeed a comment was posted on-line in relation to the article which appears to come from a friend or family member of an Elizabeth House resident it stated:

“Very upsetting to see Elizabeth House tagged in this story about abuse when the reason for the sad deaths within the home had nothing to do with abuse.”

[1] Note this figure at time of reporting has not officially be ratified by NHS Digital (holders of the national statutory return).

If Elizabeth House does close this could potentially have a very serious impact on their long-standing elderly and frail residents who would have to be re-located, as well as the impact on removing a number of residential beds out of the health and social care system. Bury Council Provider Relationship Team are currently supporting Elizabeth House.

3.0 WHAT IS WORKING WELL?

In April 2019 we introduced a specialised Adult Safeguarding Operations Team, who will be supporting adults who have suffered from or are in danger of suffering abuse. This dedicated service allows our general social work teams to concentrate on care planning and provision leaving the management of safeguarding cases to the new team.

Bury Council have a well-established Provider Relationship Team (PRT), the Team's primary function is to develop effective relationships with social care providers and to work in partnership to support continuous improvement, working flexibly to offer assistance.

A working group, GM Quality Improvement and Best Practice in Care Home Group was established with the aim of developing a GM Quality Framework. Two authorities where identified as part of the Greater Manchester Care Home Improvement work as having care home quality rated above the England average, these were Bury and Bolton. The improvement methodology used by these two authorities is now being embedded across GM and as a result Greater Manchester is now the fastest improving region in England for Care Home Quality improving at twice the national average.

The success of this Council's Quality Assurance approach locally in driving up quality over the last 5 years should be celebrated. This is a direct result of the importance the Council placed on this area of work by prioritising resources and increasing the capacity to manage performance, enabling us to work in close partnership with our local providers, the Care Quality Commission (CQC) and NHS Bury Clinical Commissioning Group who again play a significant role in ensuring standards are maintained to achieve this. We have no 'inadequate' rated homes in Bury.

4.0 WHAT NEEDS TO WORK BETTER AND WHAT ACTION IS IN PLACE TO ADDRESS THIS?

As a provider of social care and in conjunction with our health partners we will continue to strive to improve services for customers and patients within our residential homes. The initiatives above have laid out how we are already working to improve quality of service, choice and safety.

The safety of our most vulnerable residents is a key priority for services and in order to facilitate a more aligned and all age service offer a decision was made to combine the Adult and Children's Safeguarding Boards. Development and oversight superficially around safeguarding and tackling/preventing abuse will now be driven through the new Bury Integrated Safeguarding Partnership (first meeting September 2019). The Partnership will be supported by 5 distinct subgroups:

1) Complex Safeguarding Sub Group
2) Case Review Subgroup
3) Learning and Development Sub Group
4) Quality Assurance Sub Group
5) Schools, Colleges and Adult Learning Sub Group

3.0 CONCLUSION

The Bury Times article correctly reported the data which was tabled in response to the parliamentary question but did not unfortunately include the rationale which clearly explained the reasons for the increases. If included this would have given a different view.

Whilst it imperative that we effectively tackle abuse and deal with perpetrators of abuse, we also have a duty to support our care providers learn and improve and as such do not want to discourage them from reporting incidents from which we can help them learn.

We must also work with and support our care providers to make sure we have enough high quality provision within our area to support our ageing population. The connection of Elizabeth House to this article was undeserved and poses unnecessary risk to the sustained delivery of Good quality care at this home.

Safeguarding vulnerable people will remain a key priority for Bury Council and its partners and it is right, proper and welcome that scrutiny is given to our approach to local care provision and responses to abuse. However, it is essential that we are cognisant and aware of the wider negative impact to social care provision and our endeavour to encourage a system of learning and improvement such an article can have.

List of Background Papers:-

Contact Details:- Adrian Crook, a.crook@bury.gov.uk

[Report Author]

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Agenda Item 6

SCRUTINY

MEETING: Health Overview and Scrutiny

DATE: 18 September 2019

SUBJECT: Update on Persona Care and Support Ltd

REPORT FROM: Kat Sowden, Managing Director

CONTACT OFFICER: Kat Sowden, Managing Director

1.0 BACKGROUND

1.1 Persona Care and Support Limited was established 1 October 2015. The services which comprise Persona had previously been in-house services of the Council. In order to improve the sustainability of these services for the future the decision was taken to separate them off into a Local Authority Trading Company. This is a company which operates independently but is wholly owned by Bury Council.

1.2 Persona provides a range of adult social care services to people who are vulnerable due to age or disability. These include:

- *Day Services supporting 354 customers per week (Based on attendance 1 January 2019 – 30 June 2019)*
  Pinfold Lane Centre (40 places per day for people living with dementia)
  Grundy (70 places per day for older people)
  These services provide support to 193 older people per week which contributes significantly to them being able to remain living independently at home.
  10 Learning disability community bases plus some outreach facilities providing support to 161 customers per week.

- *Short Stay Services supporting 175 customers via 240 separate stays (Based on 1 January 2019 – 30 June 2019)*
  Spurr House (36 beds for older people) supported 109 customers through 157 separate stays
  Elmhurst (27 beds for older people) supported 66 customers through 83 separate stays
  Woodbury (4 beds for people with a learning disability) supported 23 customers through 66 separate stays

- Supported Living Services
  Supporting 83 customers living in 47 different properties to maintain a tenancy and live independently in their own home
  29 people supported with lighter touch floating support

- Extra Care Support (3 schemes)
  Redbank – supporting 41 tenants with a 24/7 emergency response service
  Peachment Place – supporting 39* tenants with a 24/7 emergency response service and 10 customers with care and support needs via personal budgets

  *This will increase to 60 once the scheme is fully let

- Shared Lives
  Providing 34 placements of which 16 are long term, 9 are respite based and 9 are for day care

1.3 Persona's vision is to be the leading provider of adult social care in Bury, delivering excellent service all the time, every time. This involves providing support which improves quality of life and is tailored to the individual.

1.4 Over the past four years Persona has focussed on three main priorities. The Business Plan containing these has recently been refreshed to take the organisation through until 2021 (Appendix 1):

1.4.1 Maintaining High Quality Efficient Services
1.4.2 Building Effective Governance
1.4.3 Developing and Growing our Business

1.5 Further background information was provided to Health Scrutiny in the report of March 2019.

2.0 ISSUES

➢ Risk Management

Persona has a comprehensive risk register which identifies a range of operational and corporate risks and highlights mitigating action. This is regularly reviewed and included as standard in Board agendas.

➢ Equality and Diversity

Persona continues to observe high standards of practice in its approach to equality and diversity and this is enshrined within the values of the organisation under the Respect value.

Demographic data on the workforce is included in Board agendas as standard. The workforce is predominantly female (81%), and older with 52% aged 51 years and above. As an employer of more that 250 staff Persona is obliged to undertake Gender Pay Gap reporting. The current gender pay gap is 6.05%.

➢ Consultations

Persona has a number of mechanisms in place to ensure that the views of customers, staff and stakeholders are gathered and taken into account in the operation of the business.

Customers are asked to complete satisfaction surveys to feedback on their experience. Compliments and Complaints are collated and reported.

Staff have a number of opportunities to provide input through:
- Managerial arrangements – supervision, appraisal, team meetings

- HIVE – a digital survey system which also allows colleagues to give each other praise and recognition through Hive Fives
- Formal consultation arrangements – effective shop steward and Joint Consultative Committee arrangements in place
- Employee Forum is in place where representatives across teams meet to support information sharing, explore operational challenges, and obtain workforce feedback
- Annual Staff Conferences to share information and gain feedback on developments within the organisation

A forum for stakeholders including carers, family members and other professionals, Friends of Persona, is in place to gather feedback and ideas.

3.0 WHAT IS WORKING WELL?

3.1 PersonAwards

The annual PersonAwards take place in October and will fall in the week of the organisation's fourth anniversary. This year 125 nominations were received from staff, customers and family members. We have also been successful in securing sponsorship through a range of partner organisations for each of the awards.

3.2 Finance

Persona has consistently maintained a healthy financial position since its creation, achieving the £1.2 million savings target set at the outset and generating a surplus each financial year (See Appendix 2). Income increased from 2017/18 as a result of new contracts (Peachment & Pennine houses - £180K in 18/19, £1M in a full year), additional self funding income, improved debtor recovery and contract price increase to cover the pay award. In addition, costs have been controlled so additional income has allowed us to spend more on building maintenance and compliance, investing in ensuring our building base is of a good standard without adversely impacting overall profitability.

Due to the favourable financial position, Board has recently approved the distribution of a £200K dividend to the Council.

3.3 Customer Satisfaction

The annual customer satisfaction survey was completed in July/August and results are currently being analysed. An annual complaints review is also being finalised.

3.4 Workforce

The workforce has grown from 350 in October 2015 to 466 in April 2019. This growth is linked to increasing resilience in flexible staffing as well as business growth. The workforce is now comprised of 62% Local Authority terms and conditions, 33% Persona terms and conditions and 5% other terms and conditions (due to the TUPE in of a small service from another employer and an NHS service).

3.5 Opportunities

Persona is currently engaged in work to explore opportunities for further growth and development in partnership with the Council. This presents the opportunity to develop a more flexible and mutually supportive partnership

approach. A business case is currently in development and will report back to Cabinet in October 2019.

3.6 Growth

The Escape service, launched in 2018 as a specific service for young people with learning disabilities is growing and fast approaching full capacity. Strong partnerships with Bury College have resulted in the service providing 33 days of support per week to a number of young people. This year we have also adapted the service to offer a summer attendance option for college students which has resulted in provision of 44 places per week during the summer period. It is clear there is a need for services which support young people with additional needs and this will be an area for development in future months.

3.7 Local Care Organisation

Persona is now a partner in the Local Care Organisation and is delighted to be able to play a role in transforming health and social care through innovative and integrated models of care.

4.0 WHAT NEEDS TO WORK BETTER AND WHAT ACTION IS IN PLACE TO ADDRESS THIS?

4.1 Quality ratings

The organisation has experienced some challenges in some areas in respect of consistency in quality. This was identified in 2017 and is evidenced through the CQC ratings:

Regulated Service	Oct 15	Jun 16	June 17	Aug 17	Oct 17	Oct 18	Jan 19	Feb 19
Spurr House	Good		Requires Improvement		Good	Requires Improvement		
Elmhurst	Requires Improvement	Good					Good	
Woodbury /Shared Lives	Good			Requires Improvement				Good
Supported Living	Good			Good				

The latest inspection of of Woodbury/Shared Lives resulted in a Good rating. Three out of the four registered services are now rated as Good on all five Key Lines of Enquiry. Inspections of Spurr House and Supported Living are expected in the coming months.

4.2 Quality Management

In response to issues around consistency, work commenced in 2018 to develop a quality assurance framework. This includes a comprehensive daily, weekly and monthly set of audits and inspections, recruitment of a Compliance Manager whose duties include quality assurance checks, and external periodic mock inspection. This framework is now embedded in Elmhurst and Spurr House and is beginning to be adapted and rolled out in to Woodbury and Supported Living. This internal quality management framework is in addition to the external regulatory framework and the regular inspections undertaken by

the Councils QA and Infection Prevention Control teams.

4.3 Sickness

As described in the last report to Health Scrutiny, sickness levels within Persona are higher than we would like to see and this can have a negative impact on continuity and quality of care. During 2018/19 consideration was given to a number of ideas and feedback on how we could improve this was gathered from staff teams. As a result of this a revised sickness benefit scheme was launched to staff in July 2019 and staff had the opportunity to sign up voluntarily. The new scheme is as follows:

- 3 days basic sickness pay per annum
- SSP between day 4 and day 48
- 75% basic pay from 13 weeks and up to 2 years of absence

In addition, any employee who signs up to the scheme receives a funded health cash plan which enables them to access a range of health benefits including claiming back dental treatment, physiotherapy, opticians, access to counselling etc. There is also an agreement to annual leave being used more flexibly.

This scheme is designed to encourage employees to be more proactive about managing their health and wellbeing. It has been launched alongside access to a range of free wellbeing intiatives including stretching and meditation sessions and access to mental wellbeing support and resources.

All new starters to Persona will automatically have this sickness benefit scheme in place. In addition, 40 existing members have staff have already transferred across to the new benefit scheme. Monitoring of attendance of those on each benefit scheme will take place from August 2019 and will be reported back to Board to identify the impact of this investment.

4.4 Medication Management

Management, administration and recording of medication has become a significant task within all of our services. This is in line with the experience of many other providers and is outlined in the recent CQC report Medicines in Health and Social Care (June 2019). In short stay services in particular, the volume, turnover and complexity of customers that are supported involves 5 medication rounds per day and administration of hundreds of different medications. In 2018 our monitoring systems indicated that error rates on medication, particularly in short stay were higher than we would like them to be. As a result we have taken a number of actions to address this including:

- Changing our supplying pharmacy
- Implementing electronic medication administration systems
- Moving to medication being kept in individual customer's bedrooms
- Training all care staff in short stay to administer medication to make the process more person centred to the customer and less arduous to the staff
- Improving our training
- Increasing our competency checks and observations
- Implementing audit systems as part of the QA framework
- Implementing a range of tools such as stock labels to help manage different parts of the process
- Weekly error reporting to Persona Leadership Team

A cross service piece of work is currently underway to review and redesign the Medication Policy and procedures to make them more consistent between

services and simpler for staff to understand and therefore get them right.

5.0 CONCLUSION

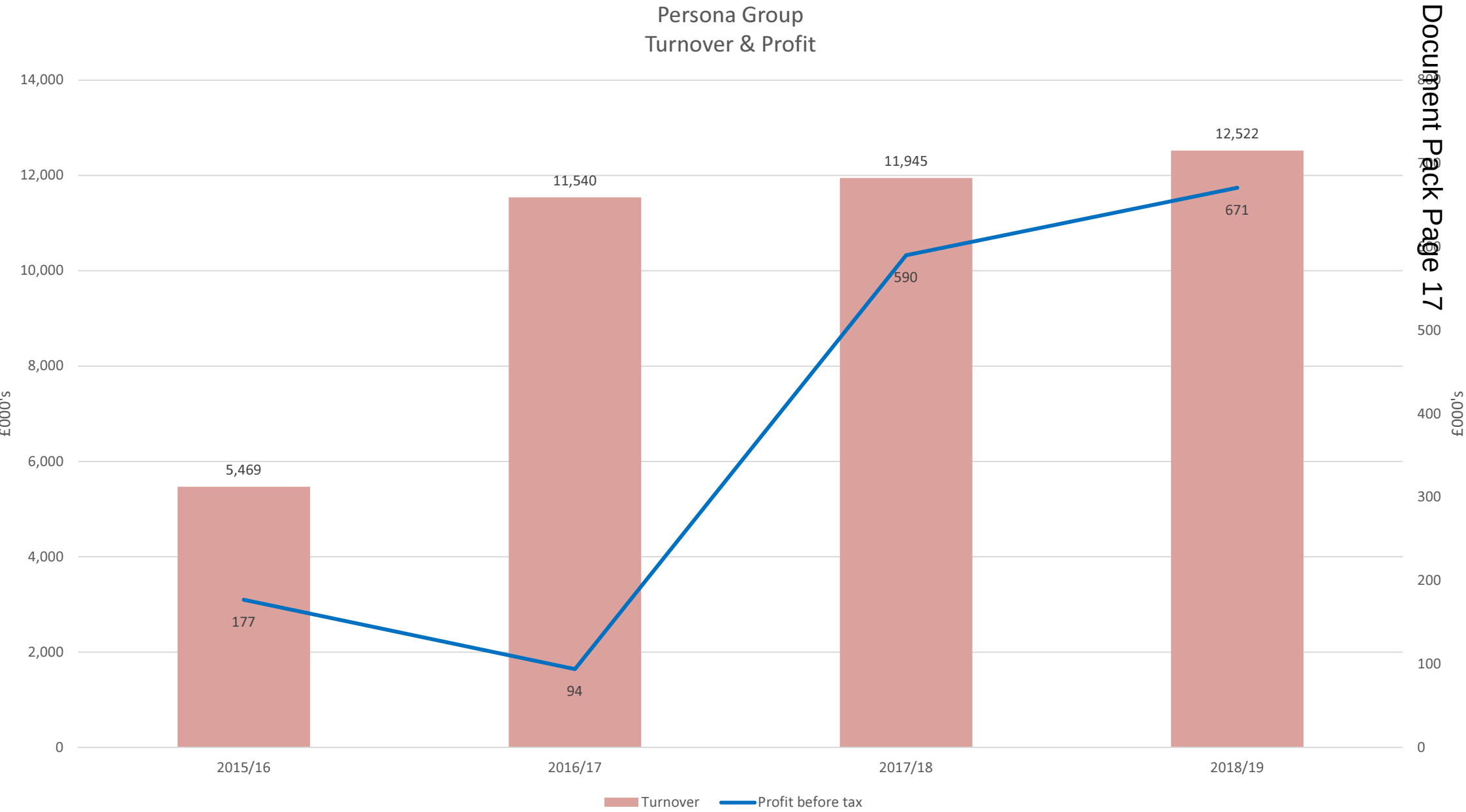
The creation of Persona in October 2015 was the start of a journey. Organisations are not created overnight and over the past years and months the organisation has begun to develop and evolve. Establishing strong governance arrangements and a value base has been a key foundation in this. The development of the organisation has not been without its challenges and this will continue to be the case. However, Persona has developed the expertise and agility to take it forward to develop as a sustainable organisation for the future.

List of Background Papers:-

Appendix 1: Business Plan
Appendix 2: Financial Position

Contact Details:-

Kat Sowden, Managing Director


Persona Group
Turnover & Profit
£000's
£000's
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
800
700
600
500
400
300
200
100
0
5,469
11,540
11,945
12,522
177
94
590
671
2015/16
2016/17
2017/18
2018/19
Turnover
Profit before tax

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Persona
We're all about you

Our Business Plan 2019 - 2021

Our Mission

We believe that people deserve social care, which improves their quality of life. We know that it's unique to every individual.

Our Vision

is to be the leading provider of adult social care, delivering excellent service all the time, every time.

Our Values

Growth

Developing and growing our business

- Lead and facilitate the development of a business case for the transfer of services from the Council, and implement any decisions to progress this
- Identify and implement creative and innovative solutions in our service delivery.
- Develop current services to be fit for future
- Replace Head Office accommodation with appropriate space fit for future

Governance

Building Effective Governance

- Grow and develop the impact of Employee Forum and Friends of Persona
- Establish and embed a compliance and quality management framework across Persona
- Development of new partnership relationship with Shareholder and LCO
- Develop more refined methods of evidencing impact and outcomes

Quality

Maintaining high quality, efficient services

- Achieve and maintain a CQC Good rating on all 5 KLOEs in each regulated service and strive to achieve Outstanding
- Develop the workforce to be our greatest asset, fit for the future
- Develop the culture of the organisation in line with the agreed values
- Develop a culture of continuous improvement and co-production which has customer experience at its heart
- Maintain the financial sustainability of the organisation

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Agenda Item 7

SCRUTINY REPORT

MEETING: **Health Scrutiny Committee**

DATE: **18th September 2019**

SUBJECT: **Health Visitors**

REPORT FROM: **Lesley Jones**

CONTACT OFFICER: **Rachel Davis**

1.0 INTRODUCTION

This report provides an overview of the development and achievements of the Health Visiting service since the commissioning became the responsibility of Public Health in October 2015.

Health Visiting is the only Universal service for children under school age commissioned in Bury. As such, the service is a key contributor to identifying barriers to good child development and a child being school ready, delivering and referring to appropriate interventions and crucial to ensuring no child slips through the net.

2.0 BACKGROUND

Responsibility for public health passed from the NHS to local authorities in April 2013. The responsibility for 0-5 aged services remained with NHS England for them to oversee the fulfilment of the Prime Minister's 2010 challenge to increase the health visiting workforce and transferred in local authorities in October 2015.

The 0-5 Public Health Service for Bury consisted of Health Visiting and Family Nurse Partnership services.

Following a workshop with key stakeholders on 3rd August 2017 the decision was made to decommission Family Nurse Partnership (FNP) in Bury and implement a new model of delivery within Health Visiting. This was due the restrictions placed on the service by the FNP licence with regard to referral criteria and delivery of the programme.

Following a period of review and redesign, an extended version of the Health Visiting Service was agreed and contracted with the provider from 1st July 2019. This model includes additional capacity within the service to deliver more intensive support for those families who require it.

The Health Visiting service is for all families who have a pre-school aged child and are resident in the Borough of Bury. Health visitors are qualified nurses or midwives who have completed further education to degree level to become specialist community public health nurses (health visitors).

Health Visitors follow the nationally mandated Healthy Child Programme providing a wide range of care, advice and support. This includes advice on health and minor illness, feeding, weaning, dental health, developmental checks and support for parents such as post-natal depression.

All children are offered a core set of visits with those requiring additional support having a tailored service around these needs. They deliver care in people's homes, health centres, children's centres and other community-based locations and work closely with a wide range of other professionals, community groups and 3rd sector organisations.

Bury's core offer aligns with stages 1-5 of the Greater Manchester Early Years Delivery Model (EYDM). The EYDM comprises of 4 key elements:

1. High Quality Universal Services
2. 8-stage New Delivery Model assessment pathway
3. A range of multi-agency pathways
4. A suite of evidence based assessment tools and targeted interventions

Stages 1-5 of the pathway, refer to assessment stages which are universally offered to all Bury children. The stages are as follows:

Stage 1 Health Visitor antenatal visit	• promotional contact • information given about infant development, feeding, parenting and the Healthy Start Programme. • provide contact details and advise how they will/can support following birth
Stage 2 New Birth Visit 10-14 days	• the Health Visitor is to provide support with feeding and caring for baby • Health Visitor to undertake Newborn Behavioural Observation
Stage 3 2 month/ 6-8 week assessment	• the Health Visitor may weigh the baby, review their general health and discuss their immunisations. • they will also give the family contacts for their well baby clinic or children's centre where they can get their baby weighed and access a range of advice and support. • EYDM requires assessment of baby against ASQ3 and offer mental health screening using a variety of tool including GAD2, GAD7 (General Anxiety Disorder) and EPNDS (Edinburgh Postnatal Depression Scale assessment) of parents • Health Visitor to undertake Newborn Behavioural Observation
Stage 4 8-12 month assessment	• This contact includes advice, such as child's diet, dental health and safety issues. • As part of the visit, the health visitor may weigh and measure the child and discuss their immunisations. • If a parent wishes, the health visitor can also put them in touch with local parent/carer and baby groups, children's centres or activities in their area. • EYDM requires assessment of baby against ASQ3
Stage 5 24 month/ 2-2½ year assessment	• This visit is an opportunity to talk about any issues a parent may have regarding their child's health. This may include their hearing and vision, language development, behaviour, sleeping or toilet training. • The child will also be weighed and measured, and the parent can discuss their immunisations and the various options for childcare and early years education. • EYDM requires an integrated assessment / shared information and assessment against either ASQ3 or EYFS

Children are screened through an Ages and Stages Questionnaire (ASQ) assessment, which assesses the expected levels of development at the developmental stage during which it is completed.

ASQ3 screens: - Communication skills - Gross motor skills - Fine motor skills - Problem solving skills - Personal-social skills	ASQ SE (Social Emotional) screens: - Self regulation - Compliance - Social-communication - Adaptive functioning - Autonomy - Affect - Interaction with people

At each of the assessment stages, numerous other assessments and interventions are delivered as appropriate, such as perinatal mental health assessment, breastfeeding support, Newborn Behavioural Observation (to promote parental sensitivity and secure infant attachment), accident reduction and reducing hospital attendance/admissions through advice and early intervention.

In addition to the core offer, the revised service model contracted from 1st April 2019, includes 3 Key Worker Health Visitors. Children and Families who are assessed as Universal Partnership Plus and Safeguarding will be offered additional support, assessment and intervention.

The aim of the revised delivery model is to improve the health and wellbeing of children and young people by responding to identified health needs based on robust public health and evidenced based data. To learn lessons from the FNP programme and ensure the added value is transferred into the new Early Years model and the Health Visiting service.

The model of care for children and families follows the principle of Early Intervention in the early years, supporting and empowering families to reduce reliance on public service with the involvement of the 3rd sector.

This integrated model of care prioritises:

- Early intervention and prevention.
- Self-care/self-management and good parenting.
- Safeguarding – domestic violence/child protection/child in need.
- Mental Health issues.
- Attachment and bonding.
- Bury Early Years Outcomes framework.
- SEND Support for families.

The Health visiting have realigned service delivery to Bury's Neighbourhood Delivery Footprints with defined partnership arrangements in place between the Health Visitor service and voluntary sector providers such as Early Break & First Point Family Support Services.

As of 1st July 2019, the service transferred with all Bury Community Services from Pennine Care Foundation Trust to Bury and Rochdale Care Organisation as part of the Northern Care Alliance.

3.0 ISSUES

There are a number of challenges faced by the service

Reducing budget – we had to compromise on the remodel of the service. Further to decommissioning the Family Nurse Partnership and pressures to achieve financial efficiencies, we were only able to fund 3 Key Worker Health Visitors instead of the 5 the model had described.

Data – paper based records create inefficiencies in recording and reporting.

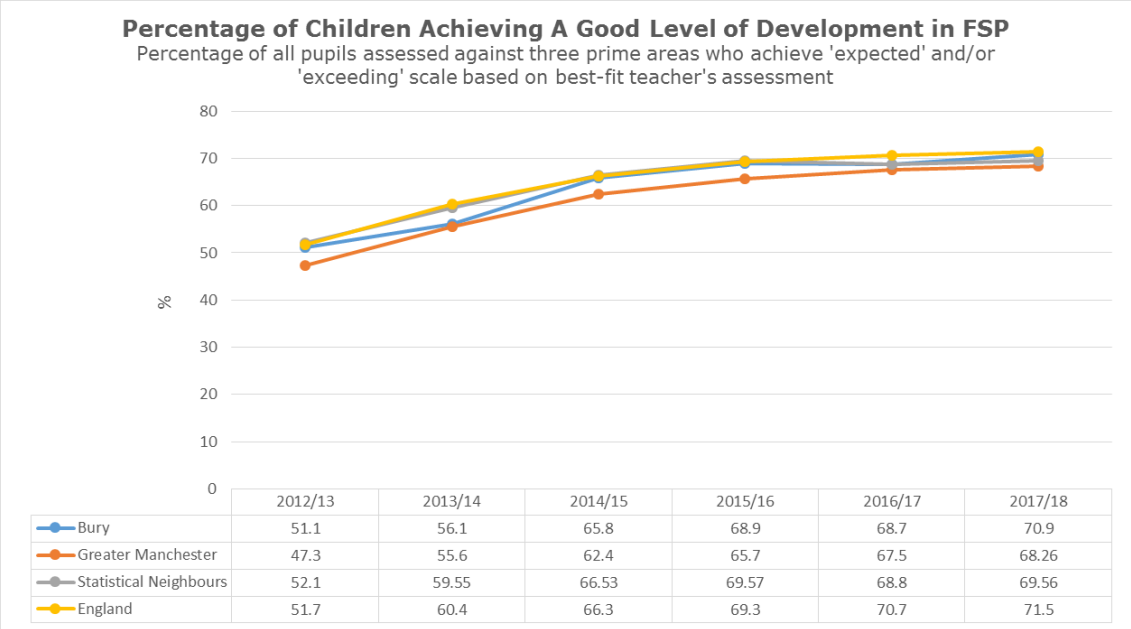
Relationships with maternity services – suitable and consistent pathways aren't in place to ensure timely notification are received and therefore key contacts have been missed.

4.0 WHAT IS WORKING WELL?

The Health Visiting service are a key partner in our work to improve School Readiness in Bury.

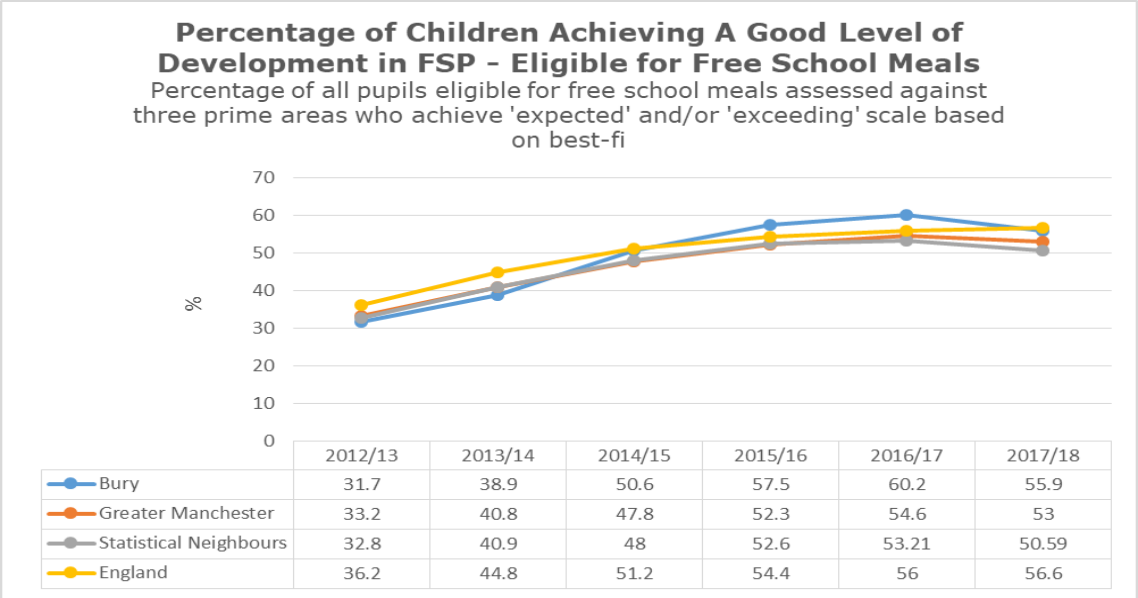
'School readiness' is a term used to describe how ready children are socially, physically and intellectually to start formal schooling. Whilst an end in itself, school readiness should also be seen as a 'way marker' for future life chances. It is an indicator for having had a good start in life i.e. growing up in a nurturing safe environment that enables children to survive and be physically healthy, mentally alert, emotionally secure, socially competent and able to learn.

School readiness is measured through assessment at the end of the early years foundation stage (EYFS) at the end of Reception year and known as the EYFS (Early Years Foundation Stage) profile. This is reported to the Department for Education and informs the Good Level of Development data (GLD).



	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Bury	51.1	56.1	65.8	68.9	68.7	70.9
Greater Manchester	47.3	55.6	62.4	65.7	67.5	68.26
Statistical Neighbours	52.1	59.55	66.53	69.57	68.8	69.56
England	51.7	60.4	66.3	69.3	70.7	71.5

In 2018 Bury closed the gap with the England average from 2% points in 2016/17 to just 0.6% points in 2017/18, we also now have the second highest level of GLD in Greater Manchester behind Trafford and exceed the average of our statistical neighbours.



	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Bury	31.7	38.9	50.6	57.5	60.2	55.9
Greater Manchester	33.2	40.8	47.8	52.3	54.6	53
Statistical Neighbours	32.8	40.9	48	52.6	53.21	50.59
England	36.2	44.8	51.2	54.4	56	56.6

Between 2012 and 2017 there was an excellent rate of improvement in the proportion of children eligible for free school meals from 32% to 60% and whilst still below the whole population average, the gap had reduced. The percentage of Bury children eligible for free school meals achieving good level of development (GLD) was above the national average. However, in 2017/18 there has been a decline in GLD for those children eligible for free school meals in Bury, Greater Manchester and also with our statistical neighbours. England overall has seen a 0.6% increase.

We are unable to explain and determine the nature of this rate of decline, again this is due to a lack of data reported at earlier assessment stages.

Delivery of the Universal offer

In October 2010, Public Health Minister, Anne Milton set out the Government's vision for the future of health visiting in England, repeating the Government's commitment to increase the health visitor workforce by 4,200 by 2015 and launching a new service model for the profession going forward.

Bury's Health Visiting service achieved its target in September 2015 and increased its Health Visitor workforce by 35%. The performance data shows a positive increase in response to the increased capacity.

	2015/16	2016/17	2017/18	2018/19	Month1-3 2019/20
Stage 1 Health Visitor antenatal visit	150	394	322	258	74
Notifications have been delayed due to reporting issues from Maternity Services. Uptake of this contact is problematic. Anecdotally, working women are usually still working when this contact is offered and therefore not available to attend and women who already have a child are less likely to attend.					
Stage 2 New Birth Visit 10-14 days	76.7%	78.9%	79.9%	85.5%	89.5%
The reduced number is because the health visiting service are unable to identify the 'problematic'. These are babies who may still be in hospital or who are not available for the visit. The service do get notified of the majority of births.					
Stage 3 2 month/ 6-8 week	68.11%	74.1%	78.9%	84.2%	89.5%

assessment					
During this same time period, a GP delivers a NIPE screen for all registered babies and promotes relevant immunisations. This impacts on the uptake of the Health Visitor Stage 3 assessment.					
Stage 4 8-12 month assessment	81%	86.7%	84.7%	91.3%	94.1%
Uptake of this assessment stage is consistent and steadily increasing.					
Stage 5 24 month/ 2-2½ year assessment	65.5%	90.9%	89.9%	92.2%	95.1%
Age two is an important time for children. It is a time when problems with both language development and behaviour can start to be identified, and where interventions can be most effective, making a real difference to a child's future. Uptake of this assessment is good and steadily increasing.					

Interventions

Early Years Communication and Language Promotion Service Specification
Work is progressing across Health Visiting and Speech and Language Therapy service, Community Nursery Nurses from within the Health Visiting team received training from Speech and Language Therapy service on implementation of the Wellcomm tool. This is a screening tool used to identify children who are experiencing Speech and Language difficulties at the earliest stage. The use of the Wellcomm Tool is a GL assessment tool for use with all children who have been identified as not achieving the expected outcome on the Communication domain when assessed using the ASQ3. The Wellcomm Clinics are now located in each of the Townships within Bury making them more accessible for some families to attend and some Home Visits have been offered to perform the Wellcomm assessment. From the 1st July 2019 the Wellcomm tool is the universal tool for referral into Speech and Language from the Health Visiting Service.

Breast Feeding Peer Support Group
The Bury Breast feeding Buddies Café continues at Castle Leisure Centre every Thursday from 10am – 12pm providing a great opportunity for breast feeding mums to meet up and chat in a relaxed environment. The breastfeeding peer support group held at Prestwich Hub Children's Centre also continues to run every Monday at the same time as the Well Baby Clinic at the same venue. This is over seen by a member of the Health Visiting team. Bury's Health Visiting Service hold full UNICEF Baby Friendly Initiative accreditation and all Health visitors are trained to give breast feeding advice to UNICEF level 3.

Oral Health
The service supports the improvement of oral health in under 5s by giving out key messages and Brushing for Life packs at key contacts.

Pathways
As a partnership we have focussed on delivery of the Early Years Delivery Model (EYDM) stages since the commissioning of the service transferred to local authority responsibility. Delivery of the assessment stages are now imbedded in Bury and GM and the focus has now shifted to delivery of 6 specific pathways for intervention.

These pathways are:

- Physical Development
- Complex Needs
- Antenatal Early Intervention & Prevention
- Perinatal and Infant Mental Health
- Social, Emotional, Behavioural
- Speech and Language

The pathways are all at differing levels of maturity. Along with Council colleagues, the health visiting service are working locally and with the GM teams to develop and implement the pathways to improve outcomes for our children.

5.0 WHAT NEEDS TO WORK BETTER AND WHAT ACTION IS IN PLACE TO ADDRESS THIS?

Reducing budget – we had to compromise on the remodel of the service. Further to decommissioning the Family Nurse Partnership and pressures to achieve financial efficiencies, we were only able to fund 3 Key Worker Health Visitors instead of the 5 the model had described.

The revised model was contracted on 1st July so the service is currently undertaking a recruitment exercise. The reduction of 5 to 3 key worker roles has meant that 3 staff will work across the 5 localities in Bury rather than one key worker working in each area.

Robust supervision and management is in place and a performance measure plan is in place to enable monitoring of outcomes from the universal workforce and the additional key worker workforce working with targeted families.

Data – paper based records create inefficiencies in recording and reporting.

Data collection and reporting has been identified as a problematic area. The service operates with paper based care records and there is currently no appropriate electronic means to record the full ASQ assessment electronically.

Bury Council and Bury Community Services were successful in their application to be the first early adopter to digitise key assessment tools. This project is being led by the Greater Manchester Combined Authority Digital Team and is working to develop a 'unified architecture' to allow all the difference data systems to 'talk' to each other and push and pull information. They are also developing a system to enable parents and professionals to complete assessments electronically.

Bury staff from across Public Health and Health Visiting are working with the GM Team and technical provider to develop the solution. We are currently working to a deadline of November 2019.

This solution will allow thorough reporting and enable more thorough and reactive identification of population need and appropriate interventions through:

- Digitisation of all Ages & Stages (ASQ3) and SE forms
- Digitisation of WellComm forms to support communication development
- Development of a shared Early Years Outcome Plan that will travel through the 8 stages ensuring that outcomes and support are visible operationally in subsequent stages
- Streaming of supporting and helpful video content incorporated into the citizen app / worker app to support assessment process

- Calculation of assessment scores automatically (with moderation by Health Visiting services)
- Early Years Education Settings (and other professionals) are able to access appropriate information captured by Health Visiting services

Relationships with maternity services – suitable and consistent pathways aren't in place to ensure timely notification are received and therefore key contacts have been missed.

This is a problem across GM and is compounded as we don't have a midwifery service in Bury. Our babies are delivered outside of the Borough, predominately in Bolton (Bolton Foundation Trust) and Manchester (Pennine Acute Hospitals Trust).

There is an acknowledgement across all GM localities that pathways need developing with Midwifery services to improve information sharing and delivery of specific interventions. This work is in the early stages.

Liaison with the antenatal leads with Pennine Acute Hospitals Trust has resulted in a revised process for notifications being confirmed and implemented, whilst this is still being monitored the impact can already be seen. Improving the process for Bolton Foundation Trust is the next priority.

5.0 CONCLUSION

The service have been a key contributor to the improvement of a good level of development in Bury and improving the health and wellbeing of our babies, preschool children and families and continue to work in partnership with us as commissioners and more crucially the Starting Well Partnership Board to deliver national, regional and local priorities.

List of Background Papers:-

Early Years Delivery Model – Assessment Stages	Early Years assessments.pptx
Early Years Pathway Presentation	Early Years Pathway Presentation (3).ppt:
Health Visiting Service Specification - Bury	Health Visitor Service Specification
Health Visitor KPIs 2015-2019	HV KPIs 2015-2019.xlsx

Contact Details:-

Rachel Davis
Project Lead, Public Health
r.l.davis@bury.gov.uk
0161 253 5370

e 1 - Health Visitor antenatal visit

onal contact
ion given about infant development, feeding, g and the Healthy Start Programme.
contact details and advise how they will/can following birth

clinic or home
ssioner: Local Authority

Stage 2 – New Birth Visit 10-14 days

- the Health Visitor is to provide support with feeding and caring for baby
- Health Visitor to undertake Newborn Behavioural Observation

•Venue: home
•Commissioner: Local Authority

Stage 3 – 2 month assessme

- the Health Visitor may weigh the baby, review general health and discuss their immunisation
- they will also give the family contacts for thei health clinic or children's centre where they ca their baby weighed and access a range of sup
- EYDM requires assessment of baby against AS offer of Edinburgh Postnatal Depression Scale assessment of mother

•Venue: home, clinic, children's centre
•Commissioner: Local Authority

age 4 – 9 month assessment

ntact includes advice, such as child's diet, ealth and safety issues.
of the visit, the health visitor may weigh and e the child and discuss their immunisations.
ent wishes, the health visitor can also put them with local mother and baby groups, children's or activities in their area.
equires assessment of baby against ASQ3

: home, clinic, children's centre
issioner: Local Authority

Stage 4b – 18 month visit

- EYDM requires assessment of child against ASQ3
- Identify need and promote the update of the 2 year old Early Learning Offer

•Venue: home, clinic, children's centre
•Commissioner: Local Authority

Stage 5 – 24 month assessme

- This visit is an opportunity to talk about any is parent may have regarding their child's health may include their hearing and vision, language development, behaviour, sleeping or toilet trai
- The child will also be weighed and measured, parent can discuss their immunisations and th options for childcare and early years education
- EYDM requires an integrated assessment / sha information and assessment against either AS EYFS

•Venue: home, clinic, children's centre
•Commissioner: Local Authority

age 6 – 3-4 year assessment

equires assessment of child against ASQ3 or

home, early years setting, children's centre

Stage 7 – Assessment on entry to Reception in School

- EYDM requires assessment of child against ASQ3 or EYFS

•Venue: School

Stage 8 – EYFS Profile

- EYDM requires EYFS Profile to be undertaken f child within the last term before the child's 5 B (by 30th June)

•Venue: School

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Early Years Pathway Presentation

Petra Hayes-Bower
Children's Services Manager

Kath Beer
Service Manager, Health Visiting

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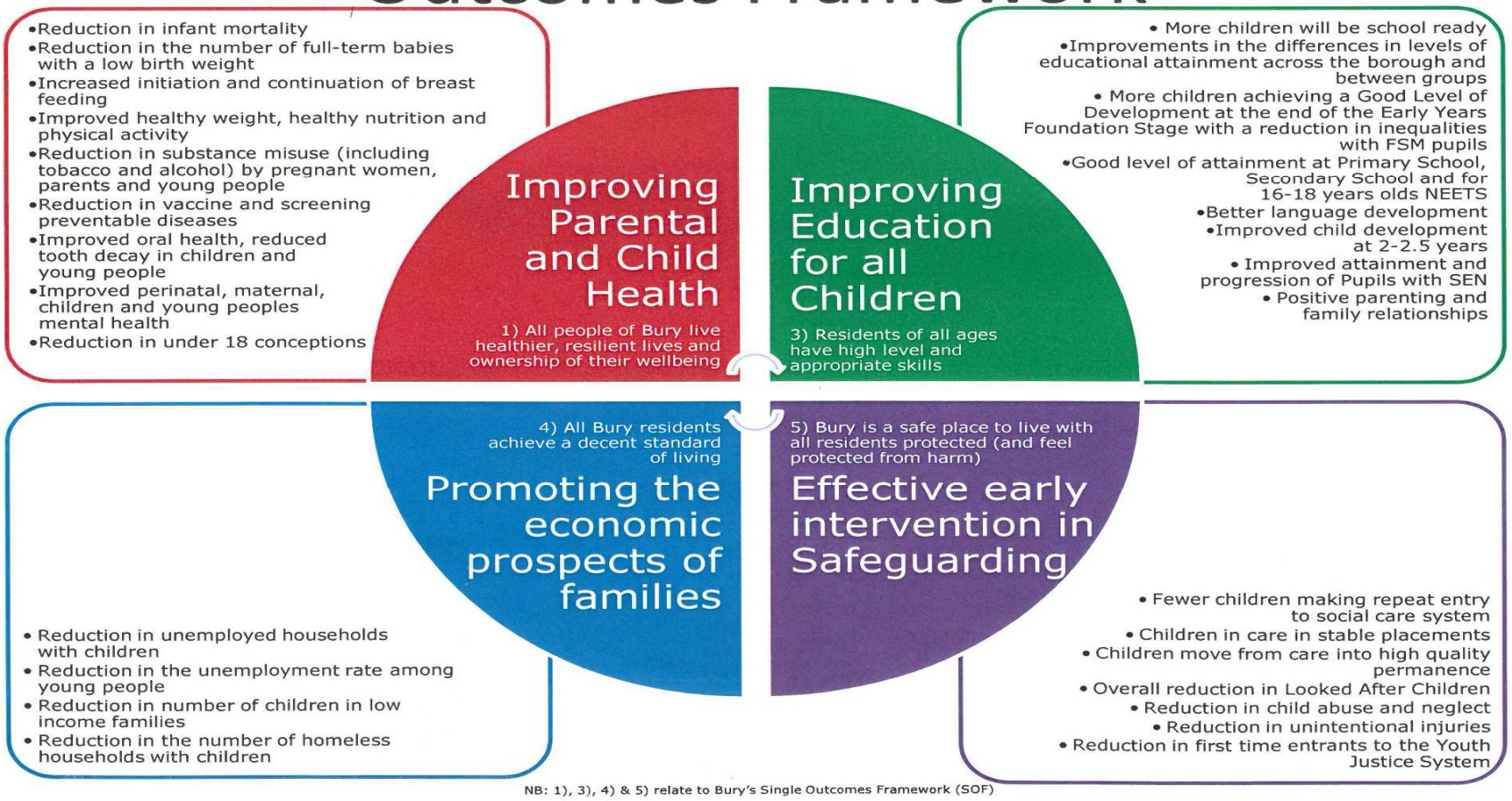
Bury's Children and Young People Outcomes Framework



NB: 1), 3), 4) & 5) relate to Bury's Single Outcomes Framework (SOF)

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Why a new model?

To combine Family Nurse Partnership (FNP) and Health Visiting (HV) experience in one team to improve the outcomes for all Bury Children and families

To work in all age township model to support person centred care neighbourhood approach

To look beyond health teams to understand inter-agency working

Successfully delivered new working model with school nursing

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Support for Complex Families

Drawing on experience from FNP role

Use of FNP tools (unlicensed)

Integrate this specialist role into mainstream HV to provide peer support and share specialist knowledge

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Aim of the new model

The aim of the revised delivery model is to improve the health and wellbeing of children and young people by responding to identified health needs based on robust public health and evidenced based data

To learn lessons from FNP programme and ensure the added value is transferred into the new Early Years model and the Health Visiting service

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Neighbourhood Teams

- Provides a local service that meets the needs of that neighbourhood
- Provides support and care to client / families in a co-ordinated way, with the client at the centre of planning their own care
- A number of agencies within that neighbourhood work in partnership to ensure the right care and support is provided to that individual / family. Reduce duplications, clients not having to re-tell their story
- Agencies will share best practice / education etc
- Working smarter not harder - efficiencies

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AGMA Delivey Model

- Provides a core integrated set of engagement points that all agencies can use to track a child's progress pre-birth – 5 years
- Integrated – no duplication, therefore more cost effective
- Progressive, not repetitive
- Identifies additional needs at earliest opportunity

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AGMA Delivery Model

- Enables comparisons, contracts and impact across GM
- Supports shared outcomes
- Uses the child's NHS number as unique and consistent identification
- Assessments aligned with agreed GM Early Years Outcomes Framework
- A common consistent assessment took to be used

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The 8 Stage Assessment

GMCA GREATER MANCHESTER COMBINED AUTHORITY
AGMA ASSOCIATION OF GREATER MANCHESTER AUTHORITIES

Stage 1 Pre Birth
Midwife
Midwifery Health & Social Assessment

Stage 2 New Birth Visit
10 – 14 days
Health Visitor

Stage 3 2 months
Health Visitor
(EPDS, ASQ3)

Stage 4 9 months
Health Visitor
(ASQ3 & SE)

Stage 4b Targeted 18 months
Targeted Twos pathway
(*ASQ3 & SE*)

Stage 5 24 months
HV & EY provider
(ASQ3, SE and EYFS)

Stage 6
On entry to Nursery (universal 3/4 year old provision)
EY Provider
(ASQ3, SE and EYFS)

Stage 7 On entry to Reception in school
EY Provider and receiving school
(ASQ3, SE and EYFS)

Stage 8
Early Years Foundation Stage Profile and ASQ3 & SE
Undertaken by school within the last term
before the child's 5th birthday (by30/6)
*EYFS profile results derive from this assessment

- All points are already part of Healthy Child Programme or Early Years Foundation Stage apart from Stage 4b, which is for all children identified with needs at stages 2 to 4 and key to ensuring appropriate access to Targeted Twos Daycare.
- Assessments at Stages 2, 3 and 4 to be undertaken within the family home wherever possible
- The engagement points will be expected to be undertaken in line with the ASQ3 timeframe. At every stage parent/s will be asked about their plans for work/education
- ASQ3 is parent led, standardised, retest reliable, and likely to be used as National measure of childhood development at 2/2 ½. EYSF is used throughout within daycare to measure progress.

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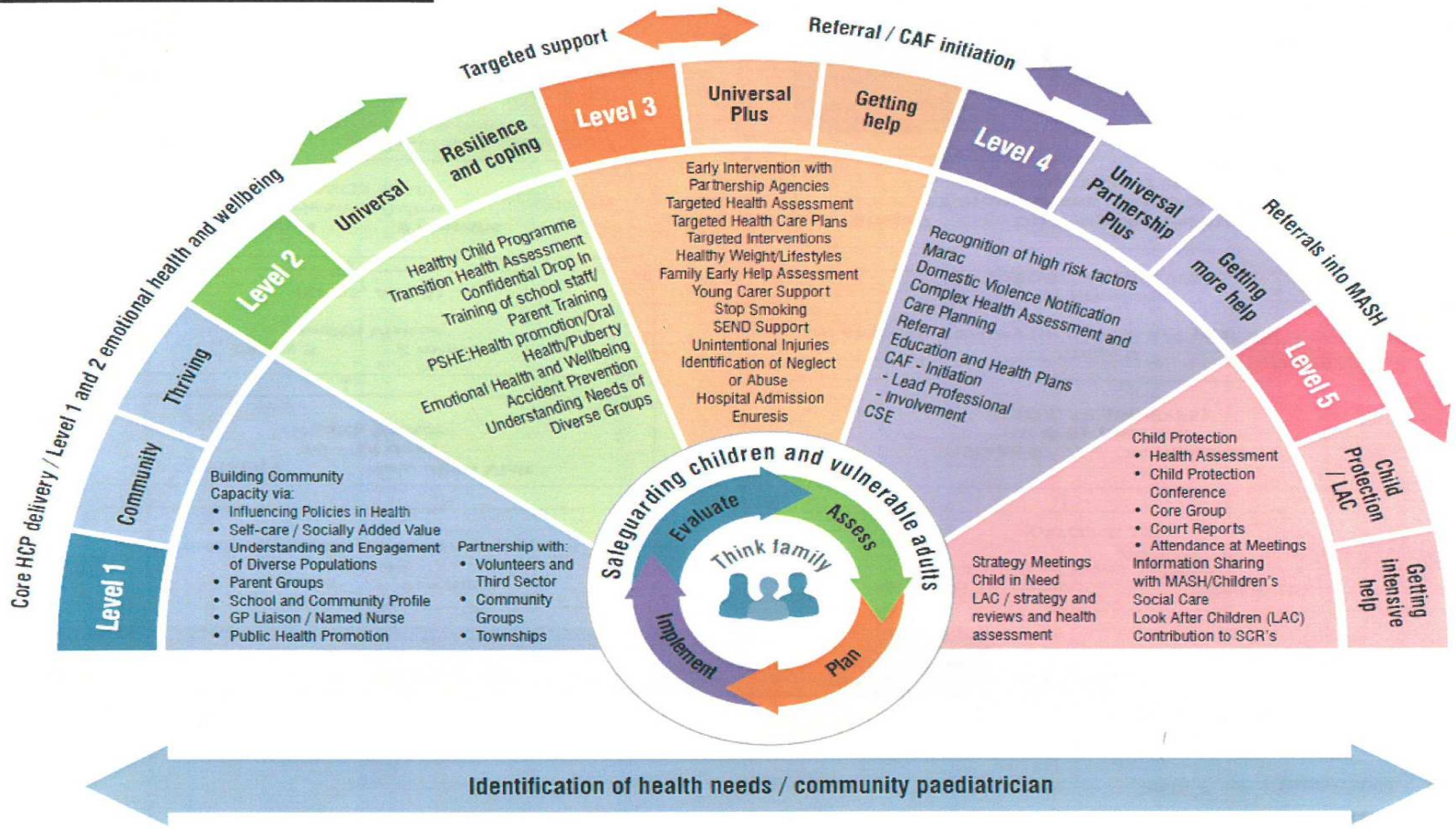
Health Visitor Model



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Early Years Pathway Lead for Children

8a Service Manager	8a Service Manager	8a Service Manager	8a Service Manager	8a Service Manager
Whitefield Band 7 Team Leader 1.0WTE 50:50 Caseload / management	**Radcliffe** Band 7 Team Leader 1.0WTE 50:50 Caseload / management	**Prestwich** Band 7 Team Leader 1.0WTE 50:50 Caseload / management	**Town Centre** Band 7 Team Leader 1.0WTE 50:50 Caseload / management	**Ramsbottom** Band 7 Team Leader 1.0WTE 50:50 Caseload / management

Infant Feeding Co-ordinator 1.0 WTE Band 7
Health Visitor SEND Lead/Champion 1.00 WTE (hrs inclusive in establishment below)

Band 7 CPT – 1.0 wte **Band 6** Health Visitor 4.5 **Band 4** Community Nursery Nurse 0.80 wte **All year round** **Band 2** Health Care Support Worker 0.83 wte Voluntary, Community, Faith Sector	**Band 6** Complex Families Health Visitor 1.0 wte **Band 6** Health Visitor 7.87 wte **Band 4** Community Nursery Nurse 1.00 wte **All year round** **Band 2** Health Care Support Worker 1.0 wte Voluntary, Community, Faith Sector	**Band 7** CPT – 1.0 wte **Band 6** Complex Families Health Visitor 1.0 wte **Band 6** Have 8.17 wte **Band 4** Community Nursery Nurse 1.4 wte **All year round** **Band 2** Health Care Support Worker 1.0 wte Voluntary, Community, Faith Sector	**Band 6** Complex Families Health Visitor 1.0 wte **Band 6** Health Visitor 12.54 wte **Band 4** Community Nursery Nurse 1.7 wte **All year round** **Band 2** Health Care Support Worker 1.80 wte Voluntary, Community, Faith Sector	**Band 6** Health Visitor 4.8 wte **Band 4** Community Nursery Nurse 0.85 wte **All year round** **Band 2** Health Care Support Worker 1.0 wte Voluntary, Community, Faith Sector

Weekly MDT Meeting with Children Centre Outreach Worker, Voluntary, Community, Faith Sector and H.V team

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Partnership working – next steps

Regular MDT meetings with

- Integrated Neighbourhood teams
- Bury Parents Forum
- Children's Centres

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What outcomes will be new model achieve?

To have a fit for purpose universal offer for our youngest children 0 – 5 years and their families. Based on progressive universalism

Delivery is to be rooted in Neighbourhoods and embedding a integrated approach across agencies, providing responsive effective support

The new model will have at its heart the vision for children, families and communities to be independent, resilient and self-caring. In line with our early Years Strategy.

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On going developments

- Pilot site for GM digitalisation od ASQ
- Focus on the 1001 critical days and integrated working with GM, Public Health and Local Authority
- Perinatal Infant mental Health- Introduction of NBO, NBAS
- Introduction of Wellcomm
- UNICEF accreditation
- SEND- Integrated Health Visitor post within the learning disability team

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Any questions

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Service	Health Visiting for Bury Local Authority area
Commissioner Lead	Bury Council
Associate Commissioners	
Provider Lead	Pennine Care Foundation Trust
Period	April 2019 – March 2022

1 Purpose

These NHS England Greater Manchester particulars support the delivery of National Service Specification no.27 and the National Health Visiting service specification published April 2015, by the provider identified above.

These particulars relate to either additional requirements specific to Greater Manchester, or requirements specific to the area served by this specification.

2 Service Scope

An integrated approach to meet the health needs of young children in the antenatal period and 0-5 years and their families. Health Visitors will lead the delivery of the Healthy Child Programme (HCP) and work in partnership with maternity service, local authority providers/or commissioned services, voluntary private and independent services, primary and secondary care and schools.

The service is to be provided to all eligible residents (permanently or temporarily) within the boundaries of the local authority specified.

The Health Visiting Service workforce

The overarching aim of Specialist Community Public Health (SCPHN) nursing services for children under 5 is to protect and promote the health and wellbeing of children and their families. The Health Visiting Service is underpinned by restorative practice, helping families to deal with conflict and challenge and repair relationships. Responding to the new vision for nursing and the "Six C's", the national nursing strategy, Health Visitors will:

- Show care, compassion and commitment in how they look after families.
- Find the courage to do the right thing, even if it means standing up to senior people to act for the child or parent's/carers best interests, in a complex and pressured environment.
- Communicate well at all times particularly with the children, families and communities they serve and demonstrate competence in all their activities and interventions.

The Health Visiting Service will lead on the delivery of the full HCP 0-5 years with a focus on working across services and organisational boundaries for babies and children 0-5 and their families to improve public health outcomes. The Public Health Outcomes Framework, the Guide to Early Years Profile and the NHS Outcomes Framework include a range of outcomes which will be improved by an effective antenatal and 0-5 years' public health nursing service:

- Improving life expectancy and healthy life expectancy.
- Reducing infant mortality.
- Reducing low birth weight of term babies.
- Reducing smoking at delivery.
- Improving breastfeeding initiation.
- Increasing breastfeeding prevalence at 6-8 weeks.
- Improving child development at 2-2.5 years.
- Reducing the number of children in poverty.
- Improving school readiness.
- Improving Perinatal and Infant Mental Health and Attachment
- Reducing under 18 conceptions.
- Reducing excess weight in 4-5 and 10-11 year olds.
- Reducing hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-5.
- Improving population vaccination coverage.
- Disease prevention through screening and immunisation programmes.
- Reducing tooth decay in children aged 5.

The Early Years model (Appendix 1) has been developed within Pennine Care Foundation Trust, Community Services Bury to support and achieve the NHS Outcomes Framework. The model is inclusive of a Key Worker Health Visitor with a caseload of children and families who have been assessed as Universal Partnership Plus and Safeguarding.

The Key Worker Health Visitor criteria is;

- Children will be pre-birth to fifth birthday and siblings within the age range will be included, older children will be notified to the school health service.
- Where the child is allocated pre-birth or close to birth the expectation is they will remain with the named Key Worker Health Visitor until their 2 birthday at which point if clinically appropriate they will be allocated to their designated Health Visiting team.
- Provide a 'step on step off' approach for older children and their families referred post the antenatal and new birth period, to allow a plan to be put in place for the identified individual needs of the child and family, with appropriate involvement of partnership agencies.

The model of care for children and families follows the principle of Early Intervention in the early years, supporting and empowering families to reduce reliance on public service with the involvement of the 3rd sector.

This integrated model of care prioritises:

- Early intervention and prevention.
- Self-care/self-management and good parenting.
- Safeguarding – domestic violence/child protection/child in need.
- Mental Health issues.
- Attachment and bonding.
- Bury Early Years Outcomes framework.
- SEND Support for families.

The Key Worker role will focusing on the priorities above and providing more frequent visits (appendix 2), assessment and tailored packages of care. This will support the achievement of the public health outcomes framework. The Key Worker Health Visitor will utilise in-depth methods of assessment to support families on the following areas:

- Attachment.
- Relationships.
- Psychological and emotional wellbeing.
- Better parenting.
- Healthier lifestyles.
- Improved attendance for developmental assessments and immunisations.
- Improvements in antenatal health.
- Improved planning of future pregnancies.
- Reducing inappropriate attendances at GP surgeries and A&E departments.
- Improving children's cognitive, emotional and behavioural development.
- Increasing paternal involvement.
- Support with minor ailments / conditions.
- Reducing welfare dependency.

The provider will review benchmarked outcome data for their local areas; guides for effective intervention to improve outcomes can be found on the following links:
http://atlas.chimat.org.uk/IA/dataviews/earlyyearsprofile
https://www2.merton.gov.uk/data_sources_commonly_used_in_public_health_intelligence.pdf

The providers will prepare for collection of service delivery metrics and dashboards at the level of local authority resident population; Public Health Outcome Framework developed; Detailed in the Early Years Model: Performance Measures (Appendix 3)

The providers will utilise the Framework for Personalised Care and Population Health for Nurses, Midwives to ensure high quality, evidenced based care is provided.
Health Visitors and Allied Health Professionals can be found at:
https://www.gov.uk/government/collections/all-our-health-personalised-care-and-population-health

Aims and Purposes of the Health Visiting Service

The Health Visiting Implementation Plan states: "The government believe that strong and stable families are the bedrock of a strong and stable society". It sets out what all families can expect from their local Health Visiting Service under the following service levels:

Community: Health Visitors have a broad knowledge of community needs and resources available e.g. Children's Centres, self-help groups, voluntary and 3rd Sector services. Health Visitors support the development of these services and ensure families know about them.

- **Level 1 Communities Offer**: To empower all families within the local community with children up to school entry age, through maximising family resources and development of community resources via involvement of local agencies and community groups as appropriate. 'Health visitors will signpost and support access to a range of services already available in the community and work with partners to develop services including services communities can provide for themselves and they will make sure families know about them.'
- **Level 2 Universal Offer:** Working in partnership with parents and carers to lead and deliver the full HCP from ante-natal care through to school entry. 'A universal service from health visitors and their teams, providing the full HCP to ensure a healthy start for children and family, support for parents and access to a range of community services/resources.' Ensure every new mother and child have access to a Health Visitor, receive development checks and receive good information about healthy start issues such as parenting and immunisation.
- **Level 3 Universal Plus Offer**: To identify vulnerable families, provide, deliver and co-ordinate evidence based packages of additional care, including maternal mental health & wellbeing, parenting issues, families at risk of poor outcomes. Families can access timely, expert advice from a Health Visitor when they need it, 'Rapid responses from the health visitor team when parents need specific expert help, for example with postnatal depression, a sleepless baby, feeding or answering any concerns about parenting.'
- **Level 4 Universal Partnership Plus and Safeguarding Offer:** To work in partnership with parents and agencies in the provision of intensive multi-agency targeted packages where there are identified complex health needs or safeguarding needs. 'On-going support from the health visiting team, plus a range of local services working together and with families, to deal with more complex issues over a period of time. These include services provided by Children's Centres, other community providers including charities'.

Universal services for all families: will include individual level interventions and programmes that will motivate and support people to;

- Understand the short, medium and longer term consequences of their health related behaviour for themselves and others.
- Feel positive about the benefits of health enhancing behaviours and changing their behaviours.
- Plan change in terms of easy steps over time.

- Recognise how their social context and relationships may affect their behaviour, and identify and plan for situations that might undermine changes they are trying to make.
- Plan explicit 'if/then' coping strategies to prevent relapse.
- Make a personal commitment to adopt health enhancing behaviours by setting and recording goals to undertake clearly defined behaviours in particular contexts over a specified time.
- Share their behaviour change goals with others (NICE 2014).

Additional services as part of Universal Plus and Universal Partnership Plus will include services:

- That any family may need some of the time, for example, care packages for maternal mental health, parenting support and baby/toddler sleep problems – where the Health Visitor may provide, delegate or refer. Intervening early to prevent problems developing or worsening.
- For vulnerable families requiring on-going additional support for a range of special needs, for example families at social disadvantage, families with a child with a disability, teenage mothers, adult mental health problems or substance misuse.

As an overview, core elements of the HCP include:

- Health and development reviews – Assessment of family strengths, needs and risks; providing parents/carers with the opportunity to discuss their concerns and aspirations; assess child growth and development, communication and language, social and emotional development; and detect abnormalities. Health Visitors should use evidence-based assessment tools and must use ASQ for stages 2- 5 as a minimum. See Appendix 4 for the full list of universal assessments.
- Screening: in line with the current and forthcoming updated HCP and the National Screening Committee recommendations.
- Immunisations: Immunisations should be offered to all children and their parents / carers.
- Promotion of social and emotional development: The HCP includes opportunities for parents and practitioners to review a child's social and emotional development using evidence-based tools such as ASQ 3 and ASQ SE and for the practitioner to provide evidence-based advice and guidance and decide when specialist intervention is needed.
- Support for parenting: One of the core functions of the HCP is to support parenting using evidence-based programmes and practitioners who can work across different agencies who are trained and supervised.
- Effective promotion of health and behavioural change: Delivery of population, individual and community-level interventions based on NICE Public Health guidance. Encourage the strengths within the family recognising that families have the solutions within themselves to make changes. Make every contact with the family a health promoting contact Making Every Contact Count.
- Reducing hospital attendance and admissions: Supporting parents to know what to do when their child is ill. This may include prescribing in line with legislation,

providing information about managing childhood conditions and prevention of unintentional injuries.

- Children with additional needs: Early identification, assessment and appropriate support.
- Health visiting teams will provide assessment, care planning and on-going support for babies and children up to school entry with disabilities, long term conditions, sleep or behavioural concerns, other health or developmental issues (Appendix 5).
- Outline of Health Visiting contacts/schedule of visits, and evidence based tools can be seen in Appendix 2.

Health Visiting teams will provide parents and carers with tailored information and support and an opportunity to discuss any concerns. They will check children and young people's immunisation status during health appointments and refer to their GP if unvaccinated. General practices are the provider of immunisations through the section 7A agreement and child health record departments maintain a register of children under 5 years, invite families for immunisations and maintain a record of any adverse reactions in the Child Health Information System (CHIS).

Objective of the Health Visiting Service

The key objectives of the health visiting service inclusive of the Key Worker Health Visitor are to:

- Improve the health and wellbeing of children and reduce inequalities in outcomes as part of an integrated multi-agency approach to supporting and empowering children and families.
- Ensure a strong focus on prevention, health promotion, and early identification of needs, early intervention and clear packages of support.
- Ensure delivery of the HCP to all children and families, including fathers, starting in the antenatal period.
- Reduced inappropriate attendance at unscheduled care of services of the child and other preschool children within the family, if appropriate.
- Promote and improve the uptake of immunisations.
- The child's development is age appropriate using the ASQ assessment tool at stages 2-5.
- Identify and support those who need additional support and targeted interventions, for example, parents who need support with parenting and women suffering from perinatal mental health issues including postnatal depression in accordance with NICE guidance.
- Promote secure attachment, positive parental and infant mental health and parenting skills using evidence based approaches.
- Promote breastfeeding, healthy nutrition, oral health and healthy lifestyles.
- Promote 'school readiness' including working in partnership to improve the speech, communication and language of babies and toddlers and working with parents to improve the home learning environment.

- Work with families to support behaviour change leading to positive lifestyle choices.
- Safeguard babies and children through safe and effective practice in safeguarding and child protection. This will include working with other agencies to intervene effectively in families where there are concerns about parenting capacity, adult mental health, alcohol or substance misuse, domestic abuse or child abuse. Reduce the need of social care involvement.
- Develop on-going relationships and support as part of a multi-agency team where the family has complex needs e.g. a child with special educational needs, disability or safeguarding concerns.
- Deliver services in partnership with local authorities to 'complex families' and be 'lead professional' or 'key worker' for a child or family where appropriate.
- Improve services for children, families and local communities through expanding and strengthening Health Visiting Services to respond to need at individual, community and population level

Remit of the Health Visiting Service

The key remit of the Health Visiting Service is:

- Leading, with local partners in developing, empowering and sustaining families and communities' resilience to support the health and wellbeing of their 0-5 year olds by working with local communities and agencies to improve family and community capacity and champion health promotion and the reduction of health inequalities.
- Working in full partnership with all Early Years services in the local area and wider 0- 19 services to ensure holistic seamless care to children and families.
- Leading delivery of the HCP using a collaborative approach in partnership with children, families and stakeholders.
- Delivery of the Health Visiting elements of the HCP in full.
- Assessing and reviewing in partnership with parents and carers, the health and development of babies at the scheduled visit contacts using ASQ's, National/Local Evidence based assessment tools (Appendix 2) and involving the family in promoting optimum health and development of all children. (See Appendix 3- Performance Measures)

Meeting public health priorities through:

- Health Visitor's use of their knowledge of the evidence base.
- Health Visitors skills as trained public health practitioners - including:
- Providing and developing intelligence about communities' assets in partnership with communities to support the health and wellbeing of 0-5 year olds, to inform the Joint Strategic Needs Assessment (JSNA).
- Use of the benchmarked Child Health Outcome Framework indicators for 0-5s to form a basis for setting shared priorities for action and contributing to the JSNA.
- Advising on best practice in health promotion in the early years of childhood.
- Responding to and supporting delivery of the Joint Health and Wellbeing Strategy.
- Responding to childhood communicable disease outbreaks and health protection incidents as directed by Public Health England (PHE) or other.

- Ensuring immunisations are recommended as per The Green Book.
- Ensuring delivery of the Health Visiting aspects of the new-born screening programmes, for example, ensuring results are recorded and acted upon in line with UK NSC Programme Standards.
- Delivery of evidenced-based assessments and interventions.
- Prescribe medication as an independent/supplementary prescriber in accordance with current legislation (See Appendix 6 for additional information). Where Health Visitors have not undertaken this module in training, it is a requirement of CPD for completion within the first 2 years of practice.
- Promote parent and infant mental health and secure attachment e.g. through use of Neonatal Behavioural Observation (NBO) and Neonatal Behavioural Assessment Scale (NBAS).
- Lead delivery of evidence based antenatal and post natal groups to promote attachment, for example, parenting classes/groups e.g. Preparing for Pregnancy and Beyond, CAN parent quality marked parenting classes, and evidence-based groups for parents.
- Lead delivery in partnership with other agencies of evidence-based parenting programmes for toddlers and pre-school children e.g. Incredible Years Pre-school basic programme and other evidence based programmes.
- Achieve and maintain full accreditation of UNICEF Baby Friendly community initiative.
- Work with parents, using well evidenced, strengths-based approaches e.g. motivational interviewing, Family Partnership Model and Solihull approach to promote positive lifestyle choices and support positive parenting practices to ensure the best start in life for the child.
- Identify early signs of developmental and health needs and signpost and/or refer for investigation, diagnosis, treatment, care and support.
- Provide responsive care when families have problems or need support or preventative interventions in response to predicted, assessed or expressed need (through intervention using new evidence in developmental psychology).
- Ensure a family focus and safe transition into 5-19 services through close partnership working with services meeting the needs of children and young people aged up to 19.
- Ensure a family focus and close partnership working with early intervention services including step up and step down transitions.

Remit of the Health Visiting Service; Child protection and safeguarding children:

The role of Health Visiting in Child Protection and Safeguarding children are essential components of the service. Safeguarding children, which includes child protection and prevention of harm to babies and children is a public health priority.

The remit of the Health Visitor must include:

- Provision of universal services including promotion of attachment and undertaking holistic assessments of children and families.

- Provision of Universal Plus services for example, identifying and intervening with vulnerable babies and children where additional on-going support is required to promote their safety and health and development e.g. CONI, providing interventions to improve maternal mental health.

Provision of Universal Partnership Plus:

- Ensuring early intervention, for example, parenting support and early referral to targeted support. This includes utilising the Early Help Family Support Plan or equivalent and Health visitors undertaking the role of Lead Professional/key worker where appropriate.
- Ensuring appropriate safeguards and interventions are in place to reduce risks and improve health and wellbeing of children for who there are safeguarding and/or child protection concerns (Universal Partnership Plus Offer). This includes maintaining accountability for babies and children for whom there are safeguarding concerns and working in partnership with other agencies to ensure the best outcomes for these children.
- Working with other agencies as part of a multi-agency intensive care package for children and families requiring intensive support, particularly children for whom there are safeguarding or child protection concerns (Universal Partnership Plus Offer).
- This includes the statutory duty to share information and communicate with other health professionals and agencies where there are safeguarding concerns and engagement of the Health Visiting service in multi-agency services e.g. MASH, and MARAC.
- Communicating effectively with other agencies including contributing to initial and review case conferences and other safeguarding meetings as appropriate to the needs of the children.
- Working with the Looked After Children (LAC) nurse to contribute to and support assessments of Looked After babies and children aged 0- 5 with timescales in line with national requirements and contribute to ensuring any action plans are carried out. Ensure provision of the HCP and additional services to meet their health needs.
- Having expert knowledge* about child protection and the skills* and qualities* to intervene to protect children. (*Knowledge needs to include domestic abuse, neglect, child and adult mental health issues, substance and alcohol misuse, physical, sexual and emotional abuse, female genital mutilation, fabricated and induced illness in a child. *Skills and qualities need to include high levels of communication and interpersonal relating, self- awareness, ability to challenge and to be challenged, understanding of barriers to safe practice e.g. collusion, adult focus, fear, burn-out. Health Visitors need to receive expert supervision for child protection and safeguarding work they are involved in).

Remit of the Health Visiting Service; Children with special needs:

The remit of the Health Visitor must include:

- Families with children with special educational needs (SEN). The Children and Families Act (2014) introduces major changes to support for children and young people with SEN, creating education, health and care (EHC) plans to replace SEN statements. The basic goals are to give families a greater involvement in decisions about their support and to encourage social care, education and health services to work together more closely in supporting those with special needs or disabilities. The Act includes the requirement that EHC plans will need to reviewed regularly and cover people up to the age of 25 years old.
- The role of Health Visitor is to work in partnership with other services in supporting the assessment of the education health and care plans for children between 0-5 years through sharing information about the child's and family's needs and reviewing in collaboration with other services what they can do to support the delivery of these plans and making sure the appropriate health visiting services form part of the high intensity multi-agency services for families where there are safeguarding and child protection concerns.

Remit of the Health Visiting Service; Supervision

The remit of the Health Visitor must include:

- The Provider will work with NHS England, HEE and Local Education Training Boards (LETBs) to ensure effective support for trainees and newly qualified Health Visitors. This will be delivered by ensuring the provision of: sufficient practice teachers; support through mentoring and supervision for students and newly qualified staff; and, placement capacity and high quality placements in line with NMC and HEI requirements.
- The provider will develop and maintain a supervision policy and ensure that all Health Visiting staff access supervision in line with the framework below:

Clinical supervision:

- Health Visitors will have clinical supervision according to their needs using emotionally restorative supervision techniques on a regular planned basis and in line with the Trust policies and procedures.

Safeguarding supervision:

- Health Visitors will receive a minimum of 3 monthly (in line with Trust Policy and Procedure) safeguarding supervisions of their work with their most vulnerable babies and children. These are likely to include children on a child protection plan, those who are 'looked after' at home and others for whom the health visitor has a high level of concern. Safeguarding supervision should be provided by colleagues with expert knowledge of child protection to minimise risk. For example, supervision must maintain a focus on the child and consider the impact of fear, sadness and anger on the quality of work with the family.

Management and Clinical supervision:

- Health Visitors will have access to a Health Visitor manager or professional lead to provide one-to-one professional management/clinical supervision of their work, case load, personal & professional learning and development issues, in line with Trust Policy.

Practice Teacher Supervision:

- Health Visitor Practice Teachers will have access to high quality supervision according to the requirements of their role.

All the above forms of supervision will have an emotionally restorative function and will be provided by individuals with the ability to:

- Create a learning environment within which Health Visitors can develop clinical knowledge, skills and strategies to support vulnerable families. This will include experiential and active learning methods.
- Use strengths-based, solution-focused strategies and motivational interviewing skills to enable Health Visitors to work in a consistently safe way utilising the full scope of their authority.
- Provide constructive feedback and challenge to Health Visitors using advanced communication skills to facilitate reflective supervision.
- Manage strong emotions, sensitive issues and undertake courageous conversations.

Record keeping, data collection systems and information sharing

In line with contractual requirements, the Provider will ensure robust systems are in place to meet the legal requirements of the Data Protection Act 1998; 2018 Data Protection Act 2018 and the safeguarding of personal data at all times. Providers should also refer to 'Record Keeping: Guidance for Nurses and Midwives', NMC, up dated 10.10.18. The Code.

In line with the above and following good practice guidance, the Provider has agreed data sharing protocols with partner agencies including other health care providers, children's social care and the police to enable effective services to be provided to children and their families. Providers will ensure that all staff have access to information sharing guidance including sharing information to safeguard or protect children.

The Provider ensures information governance policies and procedures are in place and understood.

The Personal Child Health Record (PCHR) will be completed routinely by professionals supporting parents and carers to use proactively.

Appropriate contact and child development data will be kept in Child Health Information System (CHIS) or similar system to enable high-quality data collection to support the delivery, review and performance management of services.

The provider ensures staff are trained to use paper records (with plan to transfer to a suitable electronic record) and electronic equipment that includes data collection systems to:

- Ensure the Health Visiting service is accessible to all families with young children. This may require the use of appropriate technology e.g. health promoting apps, secure text messaging with clients, secure email facilities with clients and other agencies.
- The use, where necessary to meet needs and make the service accessible of remote access e.g. laptops and tablets, mobile phones, teleconference facilities, videoconferencing facilities.

Assessment of children and families

Initial assessments of children and families must be carried out by the Health Visitor. Certain re- assessments may be delegated according to the professional judgement of the Health Visitor.

Health Visitor's must respond to all referrals.

Referrals, from whatever source, (including families transferring in) the refer will receive a response if appropriate, Child Health Records will be reviewed within 5 working days and contact made with the family within 5 working days.

Urgent referrals, including all safeguarding referrals, must receive a same day or next working day response to the referrer and contact with the family within two working days. While it is preferable that urgent referrals are dealt with by the named Health Visitor for the family involved, to ensure these visits are prioritised, the Provider has a process in place; MASH pathway is utilised when the named Health Visitor is not available.

When a child transfers into an area the Health Visitor must check new-born blood spot status and arrange for urgent screening if necessary.

Providers has their own local area new-born blood spot policies and pathways in partnership with local midwifery, CHIS and GP colleagues.

The Health Visitor must check status of, and record, all screening results including hearing, New-born Infant Physical Examination (NIPE) and Hep B schedule, immunisation status and refer immediately for any follow up necessary.

Caseload holding

As a minimum there must be a named Health Visitor for every family up to 1 year of age and for all children 0-5 years identified as having needs at the Universal Plus/ Partnership Plus levels and above.

Pathway into school nursing service

As a child approaches 4 years of age, transition to the local School Health Service will be initiated in accordance with local and national pathways. The provider ensures each child has an individual health record with all appropriate information recorded. The pathway from Health Visiting to School Nursing should follow the DH published pathway for this transition. The pathway can be accessed via Department of Health pathways.

Children being supported at Universal Partnership Plus must be formally identified to the School Nursing Service as per local procedure in order ensure continued targeted support.

Removals out of area

Where a child moves out of area the Health Visiting Service must ensure that the child's health records are transferred to CHIS for transfer to the receiving Health Visiting Service in the new area within 2 weeks of notification.

Procedures must be in place to trace and risk-assess missing children and those whose address is not known with systems in place to follow up and trace children who do not attend for 9 month and 2 year assessments.

Direct contact must be made to handover all child protection cases.

Integrated working

The provider will establish:

- Excellent working relationships with all stakeholders, including effective joint working at transition points (e.g. midwife/health visitor, health visitor/school nurse, health visitor/midwife/Family Nurse Partnership/Local Authority/GP/5- 19 services/troubled families/early years providers').
- A named Health Visitor on every Children's Centre Management Board.
- Ensure appropriate senior nurse representation in local Health and Wellbeing Boards, Local Children Safeguarding Boards, Children's Trusts, developing and supporting delivery of services in line with the Board/Trust's priorities in the JNSA.
- An area-based geographical Health Visiting Service structured in line with local children's services, working together to deliver integrated, evidence- based services for children and their families, with a focus on prevention, promotion and early intervention.
- Health visitor linked to each GP; the service will provide a named Health Visitor for each GP practice to facilitate liaison, information sharing and joint working in the best interests of families. There will be an agreed schedule of regular contact meetings for collaborative service delivery which must be audited and actioned on a regular basis.

- Health visitor linked to each Children's Centre; a named Health Visitor on each Sure Start Children's Centre management advisory board to work in partnership with children centres to:
  Provide improved access and delivery of the HCP and, through this, the children's centre core offer.
  Integrated working with children's centres in their delivery of evidence based interventions to improve outcomes for families.
  Promote and describe the wide range of early years provision that children and their families are entitled to, and as part of that process encourage all families to register for access to a wider range of provision.
  Work in a collaborative manner with Children's Centre teams to agree joint local children's service priorities based on local JSNA.
  Work in a collaborative manner with Children's Centre teams to agree how both services will work together. An example of this is the development of a Partnership agreement between the Health Visiting Service and Children's Centres.
- Both services will agree a method of data collection that encourages appropriate sharing of information with the families consent.
- The service will develop close links with all local providers of services to children, for example, voluntary sector providers, childminders, early year's settings and schools.
- In addition to the core programme, the HCP schedule includes a number of evidence-based preventive interventions, programmes and services. Providers will work with Commissioners, local authority partners, local safeguarding and children's boards, Health and Wellbeing Boards, Clinical Commissioning Groups (CCGs), to determine which services are offered locally and by whom.

3 Service delivery

Compliance with national service specification

This plan should include the required health visiting developments in line with the roll out of the Greater Manchester Early Years New Delivery Model in Bury. Progress in implementing the transformation plan will be monitored through face to face meetings at 6 weekly intervals with the commissioners.

The Health Visiting Service will work to develop, implement, monitor and review multi-agency care pathways for priority needs for children and their families, ensuring clarity of roles and responsibilities, reducing duplication and eliminating gaps. These will be based on evidenced-based assessments and interventions with a clear role for Health Visitors underpinned by training in the relevant competencies. These will be in line with national pathways and guidance where these have been developed.

Multi-agency, evidence-based pathways expected to be in place are in Appendix 7.

Population covered:

- The Health Visiting Service must be delivered to a defined geographical population in line with Local Authority boundaries and localities. All families with a child aged 0-5 years and all pregnant women currently resident in the local authority area must be offered the HCP. If the intervention is refused this must be recorded and actioned as appropriate depending on the assessment made by the Health Visitor of any risks.
- Data collection should enable reports on activity for both the GP registered and the resident population.
- The service will ensure that any coverage/ boundary issues that may arise will be dealt with proactively in collaboration with neighbouring providers. Delivery of a service that meets the needs (including safeguarding needs) of the child or family must take precedent over any boundary discrepancies or disagreements.

Provider's Premises:

- Parents should be offered a choice of locations and times for visits which best meet their needs, e.g. GP surgeries, children's centres, community health services, the home, health centres, etc. Locations must be easily accessible for all children and families who live in the local vicinity (including access by public transport and at times appropriate to the user), children and young family friendly, suitable for multi-disciplinary delivery of services in both individual and group sessions and be conducive to flexible availability (e.g. 8am-8pm service).
- Specific locations are to be agreed locally following engagement with relevant interested parties and feedback from users. Reviews should be taken periodically to ensure the locations are suitable to local needs.
- Joint contacts should be provided in partnership with other agencies where this is appropriate and reduces inconvenience for families, for example integrated 2-2.5 year review.
- The Health Visiting workforce needs suitable premises for office space and service delivery. The provider organisation must ensure that service delivery is not hampered by inappropriate premises and should work in partnership with local authorities and other providers to ensure that seamless and integrated service delivery is facilitated, for example, co-location of health visiting teams in Children's Centres.

Days/Hours of operation

The core service will operate standard hours of 9am – 5pm Monday to Friday but with flexibility from 8am – 8pm to meet the needs of families. This may be delivered through a range of workforce planning options such as flexible shift times. Other working hours may be considered by local agreement to meet the needs of families.

Acceptance and exclusion criteria

The service must ensure equal access for all children up to school entry and their families, irrespective of age, disability, gender reassignment, marriage and civil partnership and race, this includes ethnic or national origins, colour or nationality, religion, lack of belief, sex or sexual orientation.

The service must ensure it provides appropriate staff allocation according to population need whilst maintaining the universal offer.

The service should provide an equality impact assessment where changes to the existing contract are proposed.

Clinical and Corporate Governance

Client experience is important to the quality of the HCP programme/health visiting service. The views of parents and others should be sought regularly, and taken into account in designing, planning, delivering and improving health care services. The provider to demonstrate staff have mandatory training, clinical and safeguarding supervision.

4 Quality Requirements

Service Transformation Plans

Within the service transformation the provider must:

- Deliver the service as specified.
- Support the roll-out of the AGMA New Delivery model to meet requirements locally. This will include undertaking commissioned relevant training programmes.
- Utilise the Greater Manchester Communications Pathway – Maternity, Health Visiting, Family Nurse Partnership and Children's Centres.
- Be able to evidence when reviews/assessments are delegated by a qualified health visitor to another team member that NMC standards are met and that the recommendations of serious case reviews regarding access to family records are adhered to.

Outcome Measures

The outcome measures are detailed in appendix 3 and concentrate on monitoring the utilisation of health and social care resources, promoting an excellent child and family experience, and for compliance with key health and developmental milestones.

5 Appendices

Appendix 1 – Early Years' Service Model	Early Years Service Model
Appendix 2 – Key Worker Roll Schedule of Visits	Key worker Role schedule of visits
Appendix 3 – Performance Measures	Draft Health Visitor Performance Measu

Appendix 4 - Assessments - Universal Offer

Universal Review	Description
Antenatal health promoting visits (EYDM Stage 1)	Promotional narrative listening interview Includes preparation for parenthood This should be done as a face-to-face, 1-2-1 interview in a confidential setting.
New Baby Review (EYDM Stage 2)	Face-to-face review by **14 days** with mother and father to include: - Infant feeding - Promoting sensitive parenting - Promoting development - Assessing maternal mental health - SIDS prevention including promoting safe sleep - Keeping safe - If parents wish or there are professional concerns: 1. An assessment of baby's growth 2. On-going review and monitoring of the baby's health 3. Assessment of safeguarding concerns 4. Assessment of attachment using NBO before 8 weeks 5. Include promotion of immunisations specifically:

	a. Adherence to vaccination schedule for babies born to women who are hepatitis B positive b. Promotion of immunisations for all family members 6. Checking of the status of all screening results and take prompt action to ensure appropriate referral and treatment pathways are followed in line with UK NSC Standards, specifically: 7. Newborn blood spot; ensuring results for all conditions are present 8. Results of New-born Infant Physical Examination (NIPE) examinations 9. Hearing screening outcome.
6 – 8 Week Assessment (EYDM Stage 3)	Includes: - On-going support with breastfeeding involving both parents - Assessing maternal mental health according to NICE guidance 1. The baby's GP (or nominated Primary Care examiner) will have responsibility for ensuring the 6-8 week NIPE screen is completed for all registered babies 2. Include promotion of immunisations specifically: a. Promotion of vaccination schedule for babies born to women who are hepatitis B positive b. Promotion of immunisations for all family members c. Checking of the status of all screening results and take prompt action to ensure appropriate referral and treatment pathways are followed in line with UK NSC Standards as above in initial check.
3 – 4 months	**At three to four months** • Supporting parenting by providing access to parenting and child health information and guidance (telephone helplines, websites, NHS Direct, etc.), and information on Sure Start children's centres and Family Information Services. • Checking the status of Immunisations at three months against diphtheria, tetanus, pertussis, polio, *Haemophilus influenza* type B and meningococcus group C.

	• Checking the status of Immunisations at four months against diphtheria, tetanus, pertussis, polio, *Haemophilus influenza* type B, pneumococcal infection and meningococcus group C. • If parents wish, or if there is or has been professional concern about a baby's growth or risk to normal growth (including obesity), an assessment should be carried out. This involves accurate measurement, interpretation and explanation of the baby's weight in relation to length, to growth potential and to any earlier growth measurements of the baby. **Assessing maternal mental health** Assessment of the mother's mental health at six to eight weeks and three to four months, by asking appropriate questions for the identification of depression, such as those recommended by the NICE 61 guidelines on antenatal and postnatal mental health. **Maintaining infant health** Temperament-based anticipatory guidance – practical guidance on managing crying and healthy sleep practices, bath, book, bed routines and activities, and encouragement of parent– infant interaction using a range of media-based interventions, Apps. Groups **Promoting development** Encouragement to use books, music and interactive activities, groups, Apps etc. to promote development and parent–baby relationship **Keeping safe** Raise awareness of accident prevention in the home and safety in cars. Be alert to risk factors and signs and symptoms of child abuse. Follow local safeguarding procedures where there is cause for concern. https://www.gov.uk/government/uploads/system/uploads/attachment_d ata/file/167998/Health_Child_Programme.pdf https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209907/S9_Happy_Helathy_Familes_First_Community_EISCS_V121210.pdf
9- 12 months (EYDM Stage 4)	Includes: - Assessment of the baby's physical, emotional and social development and needs in the context of their family using

	evidence based tools, for example, Ages and Stages 3 and SE questionnaires; - Supporting parenting, provide parents with information about attachment and developmental and parenting issues; - Monitoring growth; - Health promotion, raise awareness of dental health and prevention (ensuring that all children are accessing primary dental care services for routine preventive care and advice), healthy eating, injury and accident prevention relating to mobility, safety in cars and skin cancer prevention; - Check newborn blood spot status and arrange for urgent offer of screening if child is under 1 year; - Adherence to vaccination schedule and final serology results for babies born to women who are hepatitis B positive; status of MMR vaccination for women non-immune to rubella.
By 2 – 2½ Years (EYDM Stage 5)	Includes: - Review with parents the child's social, emotional, behavioural and language development using ASQ 3 and SE; - Respond to any parental/carers concerns about physical health, growth, development, hearing and vision; - Offer parents guidance on behaviour management and opportunity to share concerns; - Offer parent information on what to do if worried about their child; - Promote language development; - Encourage and support to take up early years education; - Give health information and guidance; - Review immunisation status; - Offer advice on nutrition and physical activity for the family; - Raise awareness of dental care, accident prevention, sleep management, toilet training and sources of parenting advice and family information; - This review should be integrated with the Early Years Foundation Stage two year old summary from 2015 as appropriate to the needs of children and families.
By 4 ½ years	4½ years - Formal handover to School Nursing Service timed to meet the needs of the child e.g. if the HV is lead professional the handover may be delayed where this will improve outcomes for the child Children on Universal Plus or Universal Partnership Plus Offer must have a written handover.

Appendix 5 – Evidence Base, Applicable National Service Standards and Suite of Evidence Based Interventions/Pathways

Evidence Base:

- Healthy Child Programme – Pregnancy and the first five years of life (DH, 2009 – amended August 2010)
- Better health outcomes for children and young people Pledge
- The Children and Young People's Health Outcomes Strategy (DH, 2012)
- Allen, G. (2011a) Early Intervention: The Next Steps. HM Government: London
- Allen, G. (2011b) Early Intervention: Smart Investment, Massive Savings. HM Government: London
- Field, F.(2010) The Foundation Years: Preventing poor children becoming poor adults HM Government: London.
- The National Health Visitor Plan: progress to date and implementation 2013 onwards(DH, 2013)
- The Operating Framework for the NHS in England 2012/13 (DH, 2011)
- NHS Shared Planning Guidance 2018/19
- NHS Outcomes Framework 2014 to 2015 (DH,2011)2015
- Public Health Outcomes Framework 2013 to 16 (DH, 2014)
- The Marmot Review (2010) Strategic Review of Health Inequalities in England, post 2010
- Dame Clare Tickell (2011) The Early Years: Foundations for life, health and learning – An Independent Report on the Early Years Foundation Stage to Her Majesty's Government
- Hall D and Elliman D (2006) Health for All Children (revised 4th edition). Oxford: Oxford University Press. (Please note: this link opens to the bookstore for purchase of copies of this edition).
- Equity and excellence: Liberating the NHS (DH, 2010) and Liberating the NHS: Legislative framework and next steps DH, 2011)
- Achieving equity and excellence for children. How liberating the NHS will help us meet the needs of children and young people (DH, 2010)
- Getting it right for children and young people: Overcoming cultural barriers in the NHS so as to meet their needs (DH, 2010)
- Healthy lives, healthy people: our strategy for public health in England (DH, 2010) and Healthy lives, healthy people: update and way forward (DH, 2011)
- Healthy lives, healthy people: a call to action on obesity in England (DH, 2011)
- UK physical activity guidelines (DH, 2011)
- Working Together to Safeguard Children:
- Conception to Age two: The Age of Opportunity. WAVE Trust and DfE
- Chief Medical Officer annual Report 2018
- UNICEF UK Baby Friendly Initiative

Applicable National Standards:

CQC Essential Standards of Quality and Safety 2010

UK National Screening Committee Standards and Guidelines

- Newborn Bloodspot Screening
- Newborn Hearing Screening
- Newborn Infant & Physical Examination
- The Green Book- (Imms)

Key NICE public health guidance includes:

NICE guidance summary for public health outcome domain (PHE 2013)
https://www.gov.uk/government/publications/nice-guidance-summary-for-public-health-outcome-domain

Please note: For all reference see the NICE website.

- PH3 Prevention of sexually transmitted infections and under 18 conceptions
- PH6 - Behavior change at population, community and individual level
- PH11 - Maternal and child nutrition
- PH12 - Social and emotional wellbeing in primary education
- PH14 Preventing the uptake of smoking by children and young people
- PH17 - Promoting physical activity for children and young people
- PH21 - Differences in uptake in immunisations
- PH24 Alcohol-use disorders: preventing harmful drinking
- PH26 - Stopping in smoking in pregnancy and following childbirth)
- PH28 - Looked-after children and young people: Promoting the quality of life of looked- after children and young people
- PH29 - Strategies to prevent unintentional injuries among children and young people aged under 15 Issued
- PH30 Preventing unintentional injuries among the under-15s in the home
- PH31 Preventing unintentional road injuries among under-15s
- QS107 Preventing unintentional injuries in under 15's
- PH40 Social and emotional wellbeing – early years: NICE public health guidance
- PH42- Obesity working with local communities
- PH44 Physical activity: brief advice for adults in primary care
- PH46 Assessing body mass index and waits circumference thresholds for intervening to prevent ill heath a premature death among adults from black, Asian and other minority ethnic groups in the UK.
- PH48 Smoking cessation: acute, maternity and mental health services
- PH50 Domestic violence and abuse
- CG189 Obesity: identification, assessment and management
- CG192 - Antenatal and postnatal mental health: clinical management and service guidance
- CG62 - Antenatal care: routine for uncomplicated pregnancies
- CG89 - When to Suspect Child Maltreatment
- CG93- Donor milk banks: service operation
- CG110- Pregnancy and complex social factors**:** A model for service prevision for pregnant women with complex social factors

- CG142 -Autism: autism spectrum disorder in adults diagnosis and management
- CG170- Autism: autism spectrum disorder in under 19's: support and management
- QS22 -Antenatal care
- QS31 -Looked-after children and young people
- QS37 -Postnatal Care
- QS59 -Antisocial behaviour and conduct disorders in children and young people
- CG158 -Antisocial behaviour and conduct disorders in children and young people: recognition and management
- QS43- Smoking: supporting people to stop smoking
- QS46- Multiple pregnancies: twin and triplet pregnancies
- CG129- Multiple pregnancies: antenatal care of twin and triplet pregnancies
- QS48- Depression in children and young people
- QS51- Autism

Appendix 6 – Nurse Prescribing

Nurse prescribing enhances the clinician's ability to deliver high impact area on minor illness and reducing hospital admissions, not only from the point of view of managing symptoms but also from the medication knowledge that also enhances advice and support. There is a strong clinician view that health visitors welcome the ability to use their prescribing skills and that this is an important element of practice.

- Nurse prescribing has been shown to have a number of benefits ranging from increased compliance to reduced hospital and GP attendances
- Health visitors are in an ideal position to respond to common health concerns, discuss treatment options and wider management of conditions and then to prescribe as part of a holistic approach.

While prescribing is included as a deliverable within the Core Specification, it is understood that not all HVs will have taken this module as part of their training. Therefore where HVs have not undertaken this module in training, it is a requirement of CPD for completion within the first 2 years of practice.

For more information visit
Standards for prescribing-proficiency
The Misuse of drugs

Appendix 7 – Integrated Pathways

- Safeguarding children including a focus on prevention, early help, targeted support, early intervention and sharing of information. (See Working Together to Safeguard Children HM Gov 2013).
- Post natal maternal mental health (NICE CG 37).
- Substance misuse and alcohol
- Domestic Abuse
- Parental and infant perinatal mental health and early attachment Perinatal mental health
- Parenting Programme Pathway (Social and Emotional Development

- Breastfeeding (UNICEF)
- Nutrition and healthy weight including failure to thrive (NCMP and PHE via www.noo.org.uk)
- Children with additional needs and disabilities
- Transitions between midwifery, FNP and health visiting (DH)
- Transition from health visiting to school nursing (DH)
- Transition from HV to School Nurse (see DH website 2013)
- Seldom heard communities including families with young children from traveler, asylum seeker and refugee communities and homeless families.
- Families with complex and multiple needs including 'troubled families'
- Newborn Blood Spot
- Programme: http://newbornbloodspot.screening.nhs.uk/professionals
- Newborn Hearing Screening Programme
- Newborn Infant Physical Examination Programme
- Nurse Prescribing guidance: http://www.nmc-

	2015/16
C1 - Antenatal First Appointments By HV Team: ANTENATAL - FIRST TIME MUM	0
C1 - Antenatal First Appointments By HV Team: ANTENATAL - SPECIAL CIRCUMSTANCE	0
C1 - Antenatal First Appointments By HV Team: ANTENATAL CARE	150
Grand Total	150
C2 - # No Outcome Recorded	409
C2 - # Total Number Of Infants Who Turned 30 Days	2540
C2 - # NBV <= 14 Days	1949
C2 - # NBV > 14 Days	182
C2 - % NBV <= 14 Days	76.73%
C2 - % NBV > 14 Days	7.17%
C2 - % No Outcome Recorded	16.10%
C4 - # No Outcome Recorded	329
C4 - # Total Number Of Infants Who Turned 12 Months	2446
C4 - # 12 Month Review <= 12 Months	1981
C4 - # 12 Month Review > 12 Months	136
C4 - % 12 Month Review <= 12 Months	80.99%
C4 - % 12 Month Review > 12 Months	5.56%
C4 - % No Outcome Recorded	13.45%
C5 - # No Outcome Recorded	382
C5 - # Total Number Of Infants Who Turned 15 Months	2424
C5 - # 12 Month Review <= 15 Months	2027
C5 - # 12 Month Review > 15 Months	15
C5 - % 12 Month Review <= 15 Months	83.62%
C5 - % 12 Month Review > 15 Months	0.62%
C5 - % No Outcome Recorded	15.76%
C6 - # No Outcome Recorded	83
C6 - # Total Number Of Infants Who Turned 30 Months	388
C6 - # 2-2.5 Year Review <= 30 Months	254
C6 - # 2-2.5 Year Review > 30 Months	51
C6 - % 2-2.5 Year Review <= 30 Months	65.46%
C6 - % 2-2.5 Year Review > 30 Months	13.14%
C6 - % No Outcome Recorded	21.39%
C8 - # No Outcome Recorded	468
C8 - # Total Number Of Infants Who Turned 8 Weeks	2515
C8 - # 6-8 Week Review <= 8 Weeks	1713
C8 - # 6-8 Week Review > 8 Weeks	334
C8 - % 6-8 Week Review <= 8 Weeks	68.11%
C8 - % 6-8 Week Review > 8 Weeks	13.28%
C8 - % No Outcome Recorded	18.61%

Caveats

Not cross referenced all data with previous quarterly returns from 2018/19 and 2019/20 however have done

Unable to look at anything pre 2018 due to:

a) restrictions in the documents I can access since we moved from Pennine Care to SRFT

b) the Performance Team that has submitted the PHE Report in recent years only came in to being on 3rd

2016/17	2017/18	2018/19	Apr-19	May-19	Jun-19	2019/20	Grand Total
5	5	2				0	12
1	0	0				0	1
388	317	256	25	23	26	74	1,185
394	322	258	25	23	26	74	1,198
324	204	65	2	0	7	9	1,011
2432	2249	2289	199	176	162	537	10,047
1918	1797	1964	182	158	136	476	8,104
190	248	260	15	18	19	52	932
78.87%	79.90%	85.80%	91.46%	89.77%	83.95%	88.64%	80.66%
7.81%	11.03%	11.36%	7.54%	10.23%	11.73%	9.68%	9.28%
13.32%	9.07%	2.84%	1.01%	0.00%	4.32%	1.68%	10.06%
187	132	54	8	5	4	17	719
2531	2392	2263	188	190	165	543	10,175
2195	2025	2067	176	177	158	511	8,779
149	235	142	4	8	3	15	677
86.72%	84.66%	91.34%	93.62%	93.16%	95.76%	94.11%	86.28%
5.89%	9.82%	6.27%	2.13%	4.21%	1.82%	2.76%	6.65%
7.39%	5.52%	2.39%	4.26%	2.63%	2.42%	3.13%	7.07%
196	121	83	2	3	5	10	792
2481	2463	2323	178	150	188	516	10,207
2211	2286	2208	175	147	182	504	9,236
74	56	32	1	0	1	2	179
89.12%	92.81%	95.05%	98.31%	98.00%	96.81%	97.67%	90.49%
2.98%	2.27%	1.38%	0.56%	0.00%	0.53%	0.39%	1.75%
7.90%	4.91%	3.57%	1.12%	2.00%	2.66%	1.94%	7.76%
139	163	125	3	4	5	12	522
2412	2501	2517	198	194	201	593	8,411
2193	2248	2320	186	183	195	564	7,579
80	90	72	9	7	1	17	310
90.92%	89.88%	92.17%	93.94%	94.33%	97.01%	95.11%	90.11%
3.32%	3.60%	2.86%	4.55%	3.61%	0.50%	2.87%	3.69%
5.76%	6.52%	4.97%	1.52%	2.06%	2.49%	2.02%	6.21%
356	241	68	3	2	6	11	1,144
2446	2289	2261	185	217	157	559	10,070
1812	1806	1903	159	203	138	500	7,734
278	242	290	23	12	13	48	1,192
74.08%	78.90%	84.17%	85.95%	93.55%	87.90%	89.45%	76.80%
11.37%	10.57%	12.83%	12.43%	5.53%	8.28%	8.59%	11.84%
14.55%	10.53%	3.01%	1.62%	0.92%	3.82%	1.97%	11.36%

a sample check

July 2017 and I am unsure where the reports that pre-date that would be

Agenda Item 8

Agenda Item

Overview & Scrutiny Report

MEETING:	**Health Scrutiny Committee**
DATE:	**19 September 2019**
SUBJECT:	**Annual Complaints Report 2018/19 – Adult Social Care Services – for Information**
REPORT FROM:	**Julie Gonda** **Interim Executive Director – Communities & Wellbeing**
CONTACT OFFICER:	**Marcus Connor** **Corporate Policy Manager**

1.0 Purpose and Introduction

1.1 It is a statutory requirement to produce an Annual Complaints Report relating to Adult Social Care Complaints received by the Department of Communities and Wellbeing.

1.2 This report is to provide members of Health Scrutiny Committee with details of information relating to complaints and compliments received by the department on Bury Adult Care Services.

1.3 The report relates to the period 2018/19, and provides comparisons between the this period and previous years, as well as detailing the nature, scope and scale of some of the complaints received, along with any learning that has resulted.

2.0 Background

2.1 The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 were laid before Parliament on the 27 February 2009 and came into effect on the 1 April 2009. From 1 April 2009, there has been a single approach to dealing with complaints to ensure consistency in complaints handling across health and social care organisations. This procedure is based on the Department of Health's guidance, 'Listening, Responding and Improving' which supports the statutory requirements for the handling and consideration of complaints. Its intention is to allow more flexibility when responding to complaints and to encourage a culture that uses people's experiences of care to improve the services provided by Bury Adult Care Services.

2.2 The complaints mentioned in this report typically relate to issues where customers, their families or carers feel that the service they have received has not met their expectations. In these cases, the Council will always have endeavoured to resolve any concerns or dissatisfaction before a formal complaint has been received. Complaints, therefore, usually arise when the customer does not agree with the Council's interpretation of events or, in some cases, where policy delivers an outcome which they do not agree with.

2.3 Within the regulations which govern the complaints process, the Council adopts a flexible approach which prioritises local resolution. However, where complainants remain dissatisfied, they have the option to take their case to the Local Government Ombudsman.

2.4 Councillors and Members of Parliament cannot make a complaint on behalf of a constituent using the statutory process. However, they can raise a 'Concern' on behalf of a constituent, and these are logged accordingly.

2.5 The Complaint Procedure is not intended for dealing with allegation of serious misconduct by staff. These are covered by and dealt with through the Council's separate disciplinary procedures.

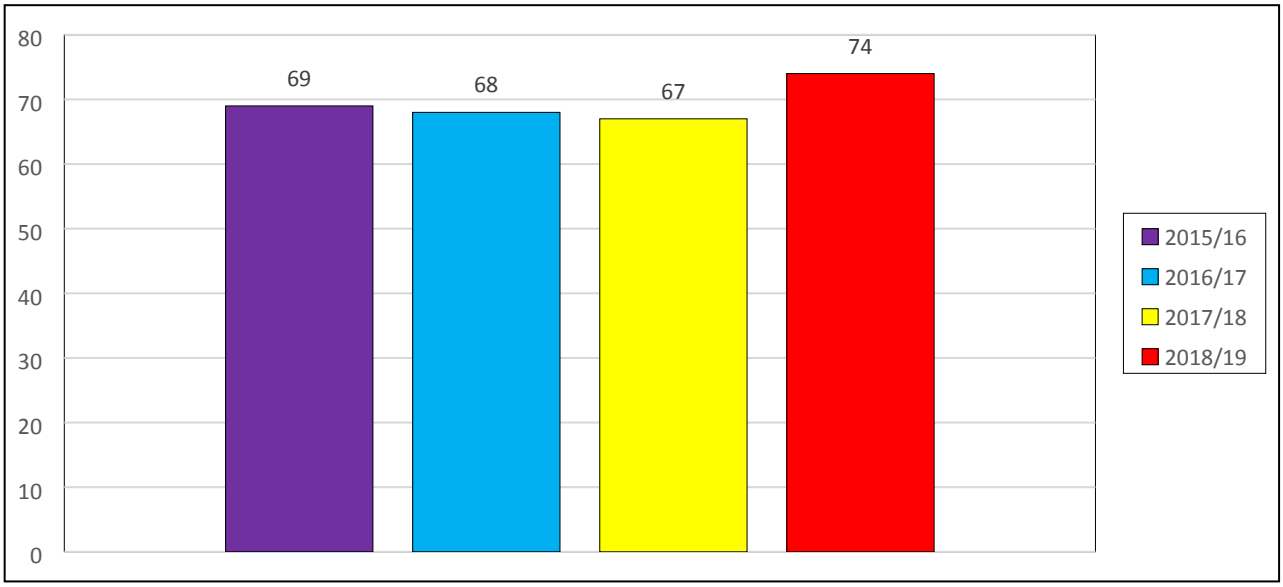
3.0 Data Analysis

Complaints

3.1 As was noted in last year's Annual Complaints Report, the formation of Persona in October 2015 has meant that complaints relating to the services transferred to this organisation and which were previously included in the totals reported, are no longer received by and responded to by the Council. As a result, year-on-year comparisons are only meaningful for years 2016/17 onwards.

3.2 The total number of complaints received over the last year has increased to 74, a more than ten percent increase on the relatively static figure for the last two years. While the report highlights where there might be annual variations in satisfaction with services or teams, there is no overall explanation as to why this increase has happened, other than increased customer demands and expectations placing pressures on services already adversely affected by reductions in funding.

Figure 1 - Number of complaints received for the period 2015/16, 2016/17, 2017/18 and 2018/19

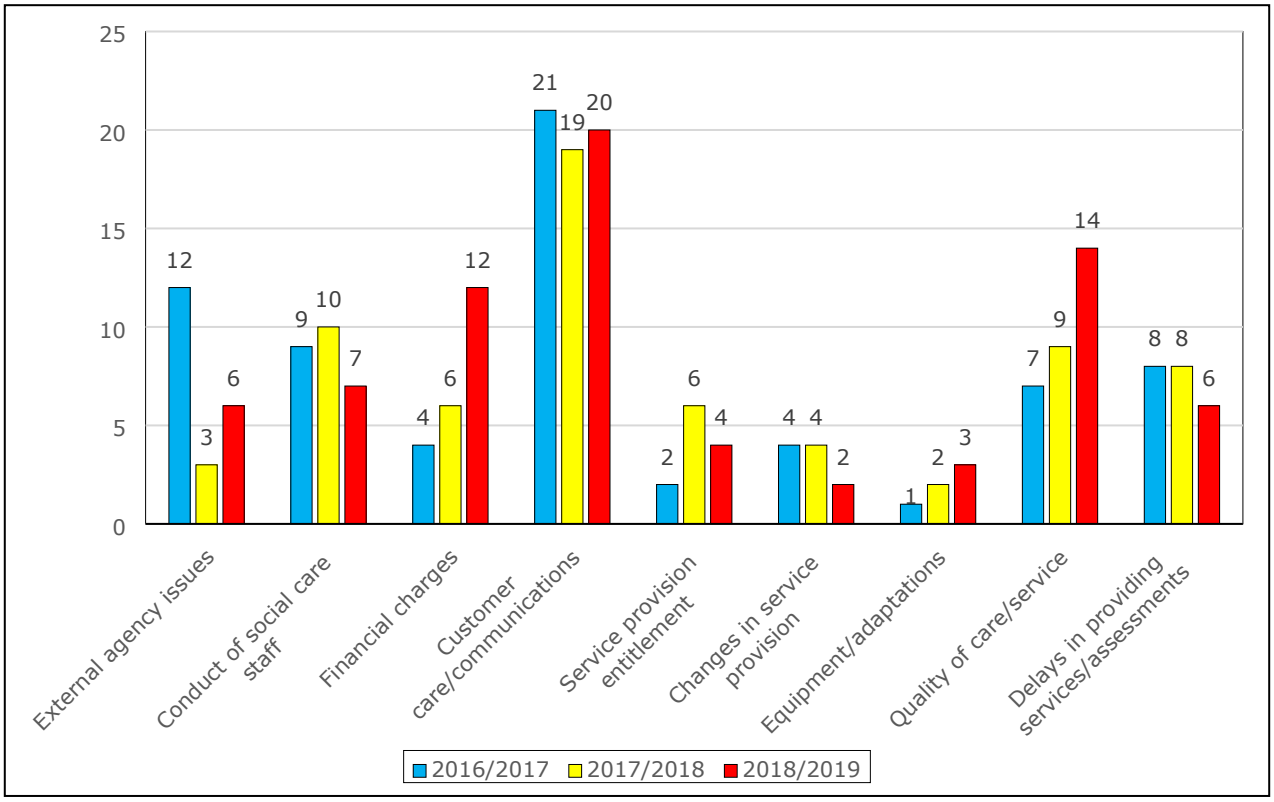


3.3 As would be expected when dealing with complaints from predominantly vulnerable groups, the majority of complaints received are made by a family member, advocate or solicitor of service user, rather than the service user themselves. In 2018/19, this represented 53 (72%) of the 74 complaints received, an increase compared to the 45 (67%) of the 67 complaints received in 2017/18.

3.4 While the nature of the most common type of complaint, 'customer care / communications', received during the last financial year has remained stable over the last three years, it should be noted that there has been a significant increase in complaints relating to 'financial charges' (from 6 to 12) and 'quality of care / service' (9 to 14), representing 100% and 55% increases respectively. The increase in complaints relating to financial charges can be explained by the introduction of the Care Act changing charging policies, something which affected around three and a half thousand customers. The greatest levels of dissatisfaction related to backdating of charges where customers had not told us about changes to their income and changes to day care attendance charges. The increase in the number of complaints about quality of care is harder to explain as this is a very generic heading and could relate to a number of different service areas.

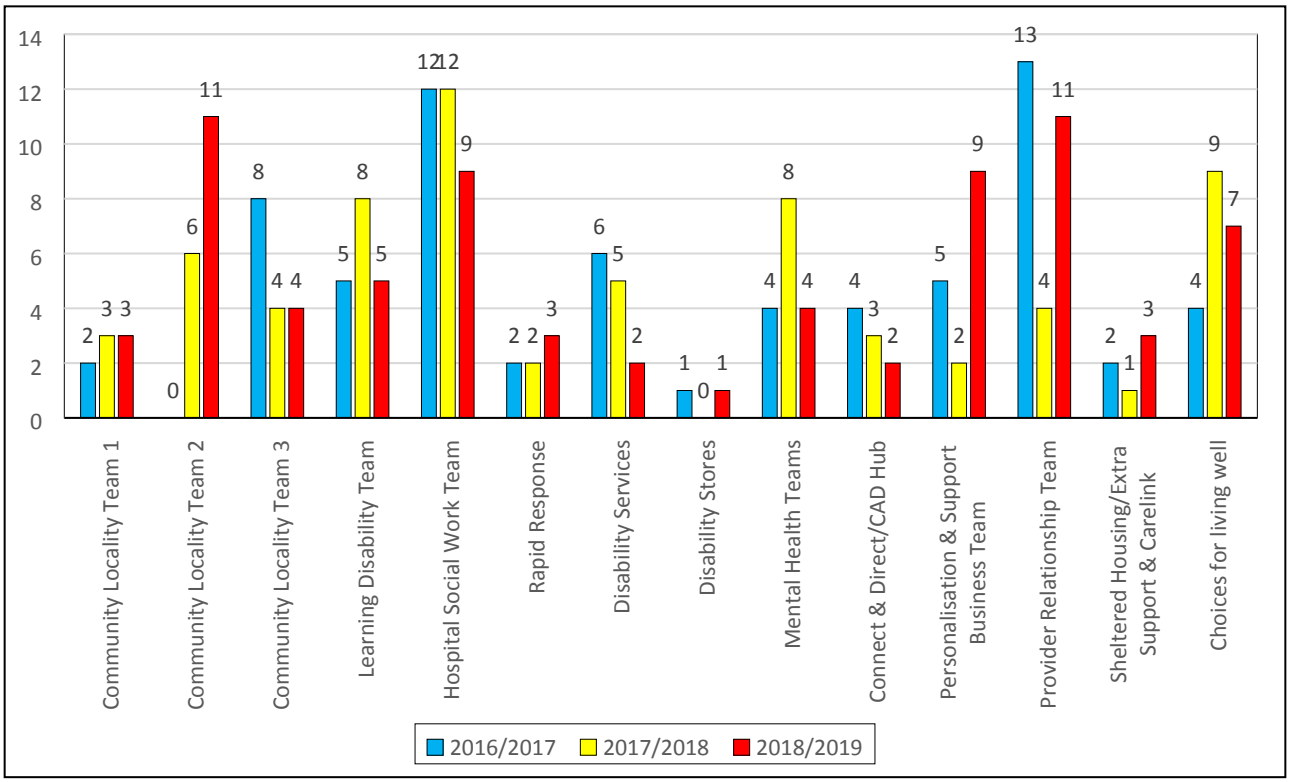
3.5 Although there has been an increase in the complaints received on the two subjects noted above, it should be recognised that not all complaints are upheld. Therefore, the numbers shown against 'nature of complaint' (figure 2) and 'service' (figure 3) should not be seen as failure. In all cases where complaints are received, learning is drawn from the comments received and the subsequent investigation.

Figure 2 - Nature of complaints received for the period 2016/17, 2017/18 and 2018/19



3.5 Figure 3, below, shows the breakdown of complaints by different teams. The complaints do not necessarily relate to services offered by these teams directly, but the services they are responsible for. For example, complaints received by the Provider Relationship Team will include complaints about external providers contracted by the Council to deliver services and overseen by the Provider Relationship Team. While there can be considerable variation between teams in the number of complaints received, this is expected due to the variation in the number of customer interactions between customers and teams. It should be noted that in previous years complaints for the Reablement/IMC/Raid Response were grouped together, however, for 2018/19 Reablement and IMC were formed into a new service and their complaints are now recorded as 'Choices for Living Well'. To allow comparisons to be made with previous years, the complaints that would have related to the new service have been regrouped. All complaints are considered in terms of the learning that they can provide on how to improve the services delivered (please see points 3.16 and 3.17 below).

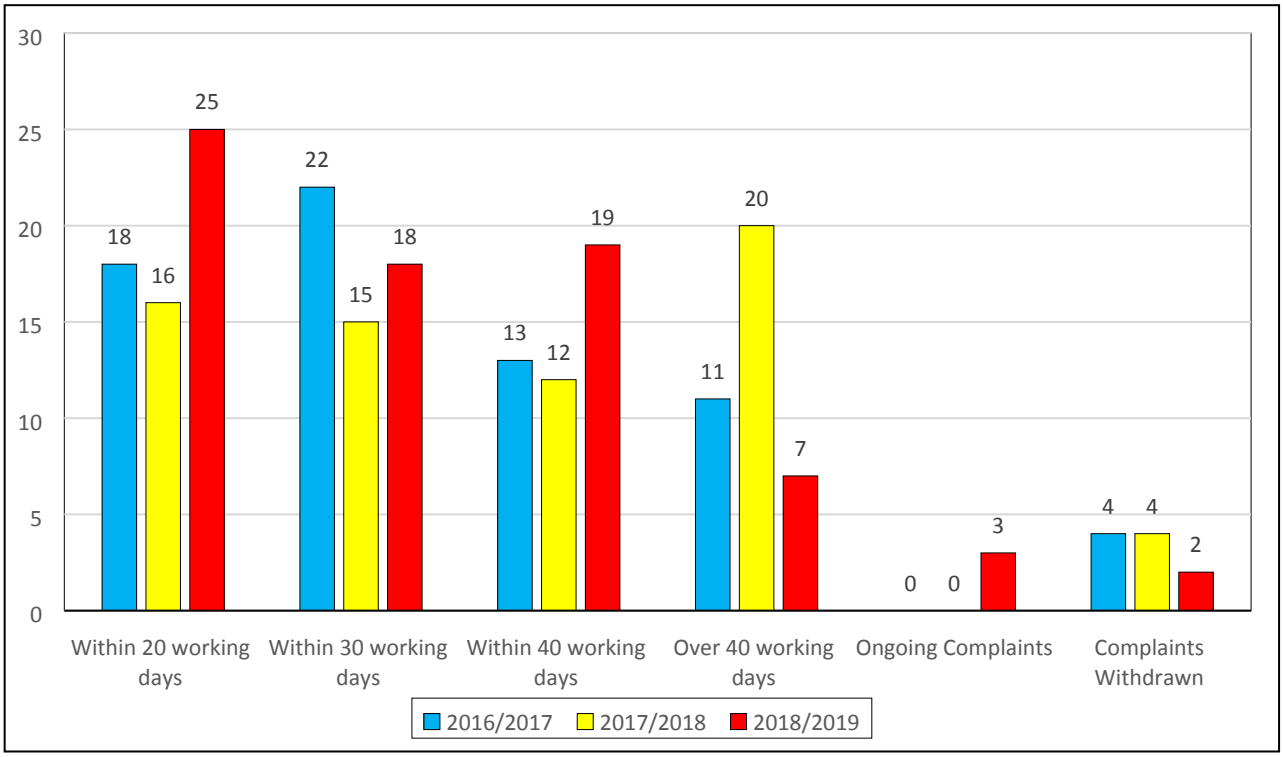
Figure 3 - Number of complaints by team for the period 2016/17, 2017/18 and 2018/19



3.6 It should be noted that the time taken to respond to complaints has increased over the last three years. In 2018/19, 43 (58%) of complaints were responded to within 30 working days; an improvement on the 46% last year. It should be noted that although the number of complaints responded to within 30 and 40 days have both increased compared to the previous year, this will in part be due to a considerable reduction (from 20 to 7) in the number of complaints that took over 40 days to respond to. It is hoped that this positive trend can be maintained in the future.

3.7 The complaints received by the Council are often very complex and involved collation of information and a response from a number of different service areas. These can often result in increased response times.

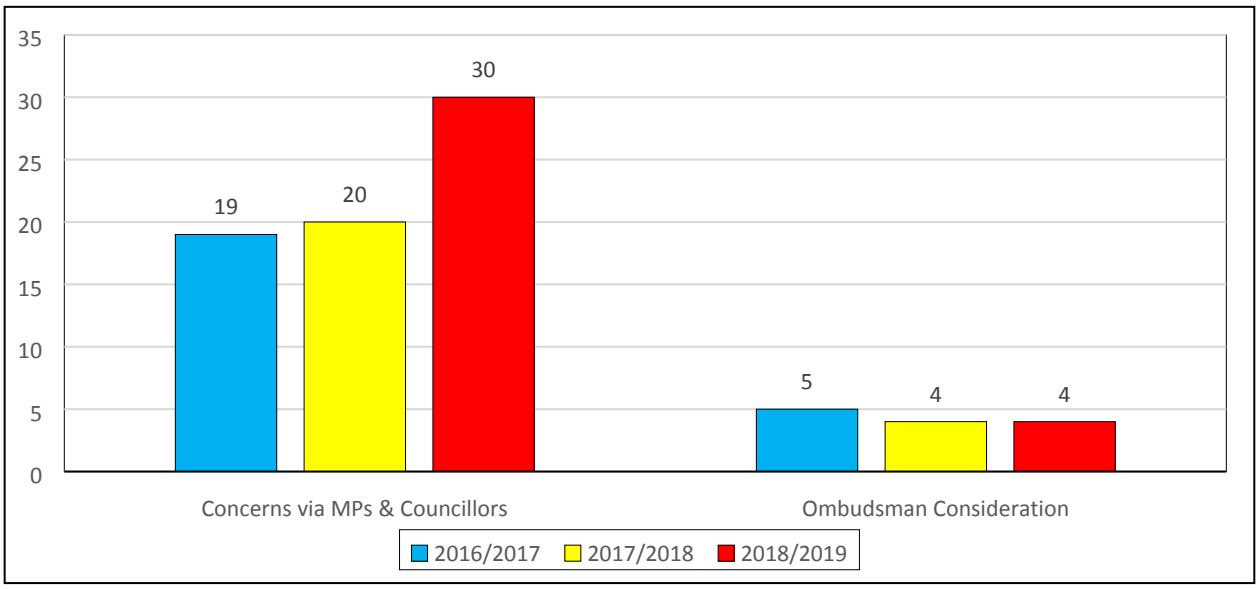
Figure 4 - Timescales for response to complaints for the period 2016/17, 2017/18 and 2018/19



3.7 During 2018/19, 34 (46%) of the 74 complaints received were not upheld. Although, this is a slight decrease in performance on the 36 (54%) in 2017/18, it still compares favourably to the 32% and 38% in 2015/16 and 2016/17 respectively. That around half complaints are not upheld, is testament to the quality of service being provided in initially. The overall increase in response times can also be partly explained by an increase in the number of complainants being dissatisfied with their first response and challenging this, along with providing further complaints which also need to be investigated.

3.8 As has been previously mentioned, concerns raised on behalf of constituents by Members of Parliament and local Councillors are recorded separately. In 2018/19, there was an increase to 30 MP / Councillor concerns, compared to the static levels of the previous two years (Figure 5 below). Of these complaints, 11 were received from Ivan Lewis, 10 from James Frith, 2 from other MPs outside the Borough, and 7 from Bury Councillors.

Figure 5 - Number of MP and Councillors' concerns and Ombudsman considerations / enquiries for the period 2016/17, 2017/18 and 2018/19



3.9 The number of complaints referred to the Local Government Ombudsman (LGO) has remained stable at 4, compared to 5 and 4 over previous years. However, when this is translated into a percentage of 5% of all complaints received, this can be seen to slightly lower than 7% and 6% of all complaints received in previous years and considerably lower than the 14% in 2015/16 demonstrating a positive trend.

3.10 It should be noted, the MP / Councillor complaints do not include enquiries received through the casework system, which tend to be in a more serious nature.

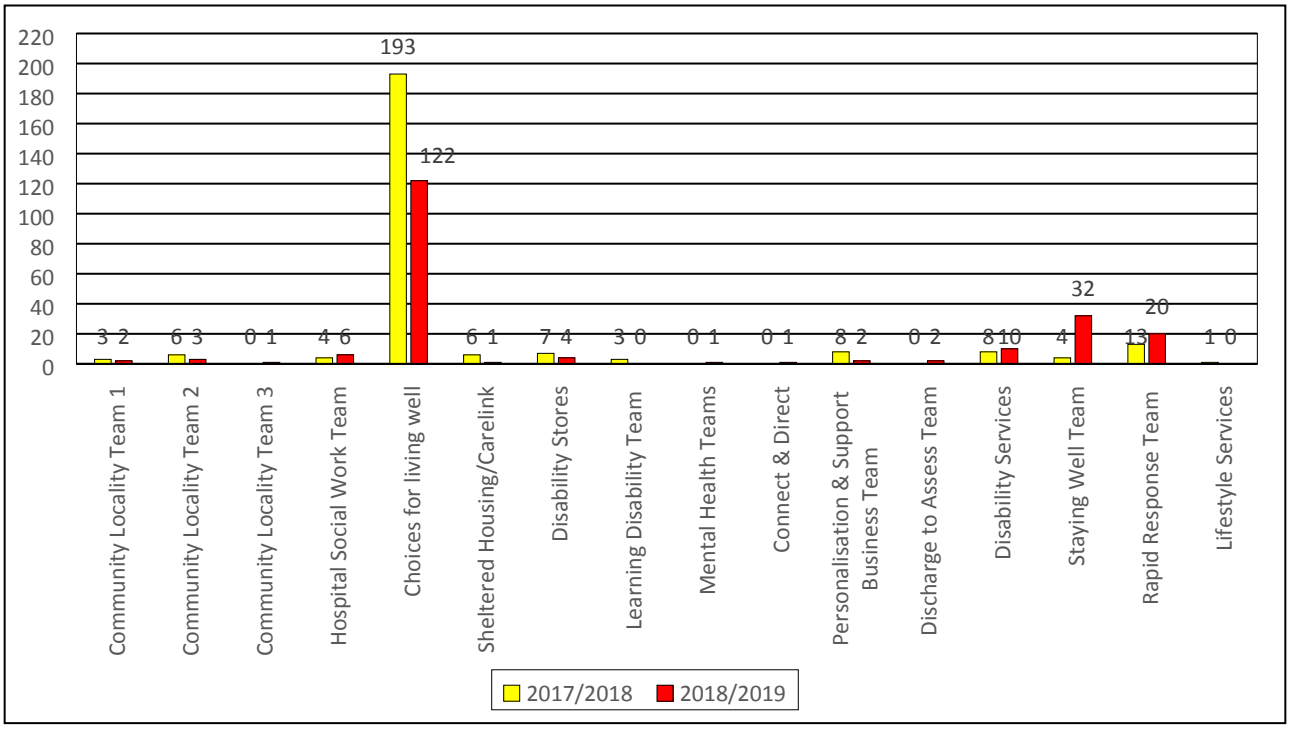
3.11 It should also be noted that of the 4 complaints which were referred to the Local Government Ombudsman, the Council has been deemed to have been at fault in two of the complaints and not at fault in one, with the remaining case still ongoing.

3.12 The number of complaints received should also be considered in context with the number of people actually having direct contact with Adult Social Care Services (excluding their relatives, friends or carers who might make complaints on their behalf). In 2018/19, 7,293 people received a short or long term service or had some form of contact with the Connect and Direct (CAD) hub with a request for support. Overall, and despite increased pressures on services, it is positive that the proportion of people wanting to make a complaint about the services they have received from the department remains low.

Compliments

3.13 In addition to complaints received, the department also records the number of compliments (shown in Figure 6 below).

Figure 6 - The number of compliments received that relate to 2017/18 and 2018/19



3.14 In 2018/19, a total of 207 compliments were received, a reduction on the 256 received in the previous year. The most significant reduction was in the new 'Choices for Living Well' service which combines date previously separately reported as 'Reablement Team' and 'Killelea IMC'; decreasing from 193 in 2017/18 (combined from 162 and 31 respectively) to 122 in 2018/19; this reduction could be partly explained by staff focusing on the establishment of the new service and so not recording all compliments received.

3.15 More positively the Staying Well Team reported an increase from 2 to 32 compliments over the last two years. The low number of compliments in 2017/18 was due to the service only operating for part of the year. Now that the service is fully embedded and operational, it is achieving successes and high levels of customer satisfaction.

3.16 Complaints and compliments can provide valuable information to the department on how well it is performing, where resources need to be used, and where improvements need to be made. Details of all complaints, concerns and compliments are provided to senior officers on a monthly basis, allowing them to identify any trends or issues within the services they are responsible for.

3.17 It should be noted, that the decrease in the number of complaints received is believed to be due to officers concentrating on delivering services at a time of considerable change, and often not sending in compliments for logging.

Learning from Complaints

3.18 As has been stated earlier, while complaints highlight where customers are dissatisfied with the services they have received, they can also be beneficial in helping services to learn and improve services.

3.19 During 2018/19, some of the key learning that has been gained from the complaints received is:

- Need to make sure documentation is up to date – staff have received reminders of this and attended relevant training;
- Need to ensure good communication with customers – staff have been reminded of the importance of keeping customers informed;
- Think about the needs of customers – make sure information provided and processes to be followed are understandable to all, especially those with special needs;
- Problem identified with IT system – this now rectified;
- Reviewing billing processes to give a more accurate representation of the time the customer receives services.

4.0 Summary and Conclusions

4.1 Despite rising demands, pressures and expectations of the services from customers, the number / proportion of complaints received in each of the last two years has remained stable.

4.2 However, the number of concerns escalated to Members of Parliament and local councillors has increased by 40% in the last year.

4.3 Positively, the number of complaints escalated to the LGO has remained static; in only two (half) of these cases, the Council has been deemed to be at fault to date.

4.4 The Council will continue to seek to learn from complaints, concerns and compliments raised with them.

4.5 New ways of working with the formation of Integrated Neighbourhood Teams and other relations with colleagues from the Clinical Commissioning Group (CCG) will also provide new opportunities for service delivery. Future monitoring of complaints and other data will be needed to assess the impact of these new initiatives on the customer experience.

4.6 As a result of the changes in management structures, work will be undertaken to develop an effective joint process for handling complaints. Work will be undertaken this year to review our Complaints Policy and an Appeals process for decisions made on cases relating to the Care Act.

4.7 Work will be undertaken in the coming year to look at improving the way complaints are received, handled and responded to. This will make for a more efficient system and will minimise staff time spent, particularly dealing with complaints which are not upheld.

5.0 Recommendations

5.1 Members of Health Scrutiny Committee are asked to note and comment on the contents of this report.

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