NHS
Bury
Clinical Commissioning Group

Report into the current position of the Bury health economy action plan following the CQC Children Looked After and Safeguarding inspection in September 2018

Author

Maxine Lomax

Designated Nurse for Children Protection & Looked after Children

Deputy Director of Nursing

Contributions from all health providers

Pennine Acute Trust (PAT)

Pennine Care Foundation Trust (PCFT)

One Recovery

Virgin Health Care

May 2019

Background

In September 2018, NHS Bury Clinical Commissioning Group (CCG), coordinated a Children Looked After and Safeguarding (CLAS) inspection of the local health economy, following a notification of inspection from the Care Quality Commission (CQC). The inspection was extensive with a range of services being reviewed. The services inspected are commissioned by both the CCG and Public Health.

An action plan was devised and agreed with the lead inspector from CQC and has been implemented over the last 8 months. The plan was monitored via the NHS Bury CCG internal Safeguarding Assurance and Governance meetings and via one to one sessions between the Designated Nurse for Child Protection & Looked after Children with the safeguarding leads in the providers. Additionally, there have been a number of visits and short audits completed to assess on-going improvements.

The report outlines the current position against the recommendation with some narrative on the journey. Further details are available on request.

An important note to include is that Pennine Care Foundation Trust Board made a decision in December 2018 to divest themselves of their community services. This has led to considerable activity around due diligence as Bury Community Services will transfer and be hosted by Salford Royal Foundation Trust from the 1st July, as part of the Local Care Organisation arrangements

The actions that remain in progress will be reviewed and monitored via the Bury CCG Safeguarding Assurance and Governance meeting on a quarterly basis and additionally via the contract meetings which review the action plans against the safeguarding contractual standards

RAG outcomes

Achieved		26
Partially achieved		18
Not achieved		1

1.1

Review the capacity of the designated safeguarding professionals to address gaps in strategic capacity and ensure the sustainability of local arrangements to drive forward its significant continuous improvement and transformation agenda.

The CCG Governing Body agreed funding for a WTE 1.0 Deputy Designated Nurse for Child Protection and Looked after Children (LAC). The post was recruited to and the post holder commenced in post on the 1st May 2019. Additionally, the CCG safeguarding team has benefited from the return of the band 7 specialist nurse who works predominantly around the work with LAC.

Pennine Acute Trust (PAT) has increased the capacity of the Designated Doctor for LAC to two sessions per week and this is now reflected in their job description.

The impact of this additional resource is not yet embedded, however, within the CCG, the deputy Designated Nurse is beginning to attend meetings that previously had apologies sent. An example would be the newly formed threshold review meeting and the neglect strategy.

The Designated Doctor for LAC is beginning to implement audit and is working more closely with both the CCG and PCFT Community Service LAC team.

2.1

Devise effective and efficient methods for ensuring community health practitioners are promptly informed about children and young people presenting at ED.

Joint process mapping has been undertaken between Pennine Acute Hospitals Trust (PAHT) and Pennine Care Foundation Trust (PCFT). Existing information sharing procedures relating to attendance of children and young people to the Emergency Department have been reviewed, updated and communicated across the organisations. This process captures all children who attend the Emergency department and is completed

automatically via Child health. In addition, all attendance by children and young people under 18 years of age is reviewed by a senior paediatric nurse within 24 hours of attendance. The provision of senior nurse oversight aims to ensure where concerns are identified that have not been effectively escalated by the clinician at the time of attendance this is addressed immediately and the relevant clinician informed.

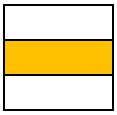
Work is continuing in the Emergency Department to monitor the timeliness of information leaving the emergency department and its receipt by community health practitioners. This is supported by the safeguarding team who conduct a weekly department visit by a safeguarding practitioner.

The increased departmental focus on safeguarding children has seen a positive change in the quality of referrals through to Childrens Social Care. The change requires constant attention and oversight from senior staff within the department and care organisation alongside a more focused approach and increase in visibility of the safeguarding team.

The safeguarding team report on a quarterly basis to the Bury and Rochdale Care Organisation Executive Quality and Patient Experience committee. Progress on the actions within the CQC inspection is included in the quarterly report ensuring that actions and progress is considered effectively within the organisations governance structure.

2.2

Ensure initial and review health assessments provide appropriate detail about children's heritage and parental health history, including their faith, culture and language to provide a clear picture of children's identity and of their experiences, including those who are unaccompanied children seeking asylum.



An audit was completed by the CCG Specialist Nurse for Child Protection and LAC, this audit built on the previous three audits

Health assessments were reviewed over a 3 month period from November 2018 to January 2019. Seven RHAs were sent to the Specialist Nurse for Child Protection and Looked after Children within Bury CCG for each month of the review period, totalling 21 assessments. Each RHA was audited using the Greater Manchester (GM) *"Looked after Children Health Assessment – Practitioner Checklist"* as adapted from the 2015 intercollegiate role framework**.** The assessments were completed by Health Visitors, School Nurses and the Specialist Nurse for Looked after Children and Care Leavers.

The audit showed considerable improvement from previous audits and provided evidence of good internal QA process within PCFT. A number of recommendations were developed and will be tracked by the CCG. These are documented overleaf.

1. All health care professionals should discuss oral health and hygiene when completing health assessments and this should be documented clearly within the assessment, particularly in Part B and summarised in Part C.
2. All health care professionals should document clearly that parents/ carers/ young people have been offered a time and venue for completion of their health assessment.
3. Information should be gathered from other allied health professionals or social care if relevant to contribute to the RHA.
4. Evidence of immunisation history including dates should be provided by either including a printed copy or screenshot within the assessment. Practitioners should also ensure these are reviewed an analysed for error or missed immunisations.
5. Practitioners should create child focussed rather than condition focussed health recommendations on the action plan

The audits show improvement in the understanding and recording of children and young people's health needs their history and their own unique circumstances which in turn should ensure that there is a focus in meeting their needs in an informed manner via comprehensive health plans.

The Specialist nurses for Looked after Children from PCFT and the CCG have worked with the Designated Doctor at PAT to develop a teaching sessions for the community doctors completing the IHA. This was delivered in March 2019 and a follow up audit on the impact on the quality of IHA will be completed in Quarter 2.

PCFT Children's Safeguarding Board has also produced a 'Safeguarding 'message of the month' in November 2017 around Unaccompanied Asylum Seeking Children and available for information on the intranet.

2.3

Ensure the quality of initial health assessments undertaken by paediatricians provides a comprehensive picture of the impact of neglect and other adverse childhood experiences on their growth and development, health and wellbeing; in line with national guidance. This should provide a clear benchmark to assess progress and help monitor ongoing risk

As stated previously, a bespoke training session was completed in March 2019 by the PCFT LAC Specialist Nurse and the CCG with Paediatrician's at Pennine Acute Hospitals Trust regarding the completion of IHA's and the standards required. A follow up audit on the impact of this on the quality of IHA will be completed in Quarter 2.

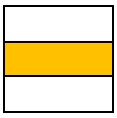
The safeguarding team at PAT are working across the Northern Care Alliance to ensure that the medical staff have the appropriate level of skills to work with the young people.

The Designated Doctor for Looked after Children has accessed the training on line, provided by Kent, on unaccompanied asylum seeking children. The named doctor for Looked after Children has attended L3 safeguarding children training and arranged a session on Female Genital Mutilation for junior colleagues. Neither doctor has attended face to face training on Looked after Children.

The development of knowledge and understanding for the paediatricians is ongoing and is being supported by the CCG, the PCFT CSB Looked after Children team and the Safeguarding team at PAT. For example, a link has been provided to them to the Coram BAAF courses. This is allowing the movement towards a greater understanding of the health needs of the children and young people.

2.4

Ensure health action plans are SMART and outcomes-focused to enable joint scrutiny of the effectiveness of actions taken to address risks to children's health and development.



All new starters are invited to meet with the Specialist LAC nurse at PCFT as part of their induction. In addition, there are twice yearly workshops (12.03.19, 01.10.19) delivered around the completion of RHA's to maintain quality compliance.

The specialist nurses for Looked after Children and Care Leavers at PCFT and the CCG met with the doctors shortly after they commenced into their community rotation to ensure a consistent approach to the application of knowledge in respect of adverse childhood events and the completion of the paperwork following assessment.

The purpose of the session was to support the medics in providing a high quality IHA for the children and capturing the outcomes on the Coram form. A review audit will be completed in quarter 2 to assess the impact of these sessions.

2.5

Ensure children placed in care placements within and outside Bury benefit from comprehensive assessments and health care plans, including recognition of their emotional and mental health needs and of actions being taken to safeguard them.

The audit completed into the quality of RHA notes the following

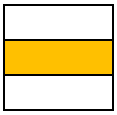
"Within the school health and Specialist Nurse completed reviews the BMI calculator and the Strengths and Difficulties Questionnaire (SDQ) are embedded within the document which enables it to flow and for practitioners to effectively analyse the results.

From the audit there were examples of excellent caption of the voice of the child and it built a very vivid picture of the child/ young person, this was particularly evident in a number of the health assessments completed by the school health practitioners."

This allows the information to be shared with multi agency colleagues as part of the LAC review process.

2.6

Ensure the voice of the child is kept at the centre of looked after children health assessments and care plans; with evidence of choices being given to them about the time and location of the appointment and whether they wish to be seen alone.



The audit referenced in 2.2 explored this point and found that it was not clearly evidenced that choice was being given and this subject to a recommendation as outlined above. PCFT need to give further thought to how they ensure this is captured.

"There continues to be a lack of documented choice of venue for the RHA's. It may be that carers, children and young people are given the option however it is not been documented. It is challenging as within the BAAF form there is not a recognisable section where this information would sit and there is not a prompt to remind practitioners to document this other than the practitioner checklist, which is not completed until after the assessment is completed."

2.7

Ensure children and young people leaving care are equipped with relevant health information about their health histories and actions they can take to continue to promote their personal health and wellbeing.

The Specialist Nurse for Looked after Children and Care Leavers in PCFT has ensured that all young people, leaving care have received a health summary working with the Local Authority Through Care Team to achieve this. For all young people who are now leaving care and have left care since July 2018, the specialist nurse has offered to meet with and review the information with them. The documentation has been consulted on and the young people are happy with the format but have asked that locally it is not called a 'passport', but heath information. Additionally they have asked it is presented via an opaque plastic wallet rather than the A4 folder which was used. The suggestions made during the consultation have been implemented.

3.1

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

There has been much discussion regarding the funding of the additional capacity within the Multi Agency Safeguarding Hub (MASH). The CCG agreed to fully fund the post (WTE 1.0) and the job description which includes a much wider health economy role was developed.

The post was recruited to on the 1st April with a target start date of July 2019. The appointed post holder is very experienced having worked for a number years in a MASH in the North East of England.

4.1

Ensure a clear, well-managed system is in place in MASH to promote timely collection, co-ordination and analysis of information from all relevant child and adult health practitioners. This should provide a full picture of what is known about the lived experiences of children and risks to their health, development and safety

The new job description includes all the expectations in the recommendation. Currently there is an experienced band 7 health visitor covering the role as the previous post holder left The CSB safeguarding team have established a clear pathway to ensure representation at all strategy meetings within the MASH.

Once the new post holder commences she will via her induction establish wider links to mental health, drug and alcohol, sexual health, the acute trust, GP's and the heath visiting and school nursing teams

4.2

Review the quality of information and communications technology (ICT) across the whole system to enable well-co-ordinated, streamlined and efficient transfer of information about children and young people who move between health and care services.

The use of Fax has ceased as of the 28th February 2019 at both the Emergency Department (ED) at PAT and the Walk In Centre at Prestwich.

The audit of routine information sharing between the ED at Fairfield General Hospital and community services showed the majority of the time the information is passed in a timely manner. However, on occasions there have been delays and this will be re-audited.

The information is sent securely and electronically.

The initial audit identified that 11 Bury children attended the ED at FGH in January and in the range for the routine information to be shared from the ED to the health visitor via the child health department was two to thirteen days. However, most were shared in less than 7 days with only three being shared over this, one at each of day 9, 12 and 13.

There were five safeguarding information sharing forms, which are shared via the safeguarding team, rather than child health. The range of time from the ED to the heath visiting/school nursing team was one to four day, with mean being 3 days.

4.3

Ensure good levels of involvement and provision of clear reports to child protection conferences by all child and adult health practitioners to provide a comprehensive picture of the experiences of children living in situations of abuse or neglect.

The standard Local Safeguarding Children's Board (LSCB) template for child protection reports has been implemented across the mental health teams of PCFT and a request has been submitted to the audit department for a review as part of the 2019 audit calendar

The impact will be improved information sharing in a standard format that meets the requirements of GDPR.

4.4

Strengthen local arrangements to promote a positive culture of co- production that enables children, young people and their families to shape the design and delivery of services and support ongoing learning from their feedback.

The commissioning teams at the Local Authority, Public Health and the CCG are signed up to the Childrens Trust principles on participation

https://www.bury.gov.uk/CHttpHandler.ashx?id=15992&p=0

Existing examples of co-production in public health include capturing feedback through a range of events around existing services. For example, the circles of influence event, finding out young people's views and perceptions around current services such as sexual health and school nursing services, and working with providers to change or amend services where appropriate to meet needs.

The CCG has been undertaking two key pieces of work where co-production has been central to the development of new services

Sensory Integration:

- A Sensory service was originally proposed by PCFT Occupational Therapists and Community Paediatrics - based on clinical judgement and feedback from parents/carers
- CCG led a workshop in December 2017, pulling together a range of stakeholders from different services including schools as well as patient/carer and family

representatives such as Bury2gether and a young person diagnosed with ASC (and later appointed as the Bury SEND Ambassador).

- The outputs were used to inform a draft pilot service model and this was subsequently revised following further engagement with representatives from Bury2gether and wider stakeholders.
- The pilot model is now complete with final steps being to identify an appropriate site from which to deliver the service and for the CCG to approve the finances. We are targeting go-live in October 2019.
- Following the pilot, we will evaluate including feedback from service users and their parents and carers and will use this information to co-produce a long-term service to go out to tender.

Neurodevelopment pathways

- In response to the SEND inspection Written Statement of Action, the LA and Bury2gether jointly held a borough-wide engagement event attended by many parents and carers. Some of the key findings centred around the neurodevelopmental (ASC and ADHD) assessment and support pathways. Concerns were around wait times, inconsistent patient experience, lack of available support pre and post-diagnosis (including for sensory integration, which supported the priority above).
- In response, the CCG hosted a workshop in December 2018, attended by representatives from Bury2gether and wider stakeholders to agree how best to deliver improvements. We agreed 2 key work streams, which were:
    - Secondary care neurodevelopmental assessment
    - An SEMH Inclusion pilot, which is currently underway The outputs of the pilot, which is in operation for the summer term will support, alongside further engagement, development of the long-term offer of identification and support.

5.1 & 5.2

Equip Walk-in centre staff with appropriate knowledge and assessment documentation to help them to recognise wider risks to children and promotion of child-centred practice

Ensure Walk-in centres benefit from having a stable, well trained workforce with appropriate levels of safeguarding and paediatric expertise.

Considerable work has been completed at both Walk in Centre's (WIC) by the safeguarding teams of PCFT and BARDOC. A visit was completed by the CCG Safeguarding team in November 2018 and although it was clear progress had been made a number of concerns remained with the WIC in Bury. The WIC in Prestwich had made excellent progress and

other than the fact they were still using faxes, due to an IT issue, the staff proved to be knowledgeable and processes tested were sound.

The visit in November identified that a paediatric nurse was employed at Bury WIC and the staff at Prestwich were very focused on the needs of children. Staffing at Prestwich was stable with minimal use of agency staff.

A further visit was completed to the Bury WIC in April. New leadership was in place, the staffing situation was more stable and the clinician spoken to had a good understanding of safeguarding procedures and risk. They were able to share with us where they would find guidance and were clear on out of hours processes, sharing a number of case studies.

There were still some gaps in process and four further recommendations were made. However the CCG team, following their visit, were assured that considerable progress had been made on the day of the visit and there were no concerns raised. The additional recommendations were:

1. Spilt the roles of children and adults at risk lead between two people
2. Ensure all staff attend L3 training within 3 months of the end of April
3. To work with PAT and BARDOC to ensure a SOP in in place for CP-IS by the end of May
4. To establish a process to inform GP when pregnant women attend without notes

Clear progress has been made at both WICs since the September visit and staff are now clearer and more focused on their safeguarding responsibilities. Support has improved and staff are aware of pathways of referral and how access guidance and policy.

6.1

Ensure regular and effective communication between midwives, health visitors, adult health practitioners and GPs to strengthen joint awareness of escalating concerns and embedding of 'Think Family' approaches.

To promote greater understanding of the various roles within health, the terms of reference for the NHS Bury CCG Safeguarding Assurance and Governance group were amended to include colleagues from Sexual health and Drug and Alcohol services. The amendment was completed December 2018. The meeting has been used to support and challenge the implementation of the action plan and has supported broader thinking around "Think Family". A letter was written to the Chair of the Bury LSCB, which requested a Think Family approach is taken in all future training of the Board. This was acknowledged and supported by the Chair.

7.1

Ensure frontline clinicians and managers are fully aware of their professional accountabilities for checking, following up and recording actions to safeguard children and young people on child protection plans and who were looked after identified on the Child Protection Information System (CP-IS).

Standard Operating Procedures (SOP) have been developed and shared across the Urgent Care System and information sessions delivered. There are two SOPs - one for PCFT and the other PAT. This is likely to change in the near future as the WIC's will become part of the urgent care system managed by PAT ED. The SOP's remain in draft for both organisations.

Child Protection Information Sharing

Updates on the use of Child Protection – Information Sharing (CP-IS) in the ED have been delivered by the safeguarding team via 7 minute briefings during department visits. Due to the increased visibility of the safeguarding team queries are more effectively resolved as and when they arise. It is expected that all qualified staff will have access to CP-IS via a smartcard by the end of June 2019.

The improved use of CP-IS in urgent care should enable staff within the department access to more information on children and young people when making their assessments of potential risk or harm. One example of an impact of the improving use of CP-IS in the emergency department relates to the previous management of LAC. Previously referrals were completed to Children's Social Care for all children who were known to be Looked After. Referrals were completed even when the child had presented appropriately and there were no safeguarding concerns relating to the child's presentation. An improved understanding of CP-IS has allowed a more individualised approach to LAC, with the awareness that when the child care alert is activated an automatic notification is sent to Childrens Social care. This promotes a child focus and reduces the requirement for referrals in every case.

Presently the use of CP-IS remains inconsistent across urgent care settings, consequently the benefits of are still not clearly understood by all frontline staff. Audits of the use of CP-IS have been completed by the safeguarding team in each of the Emergency Departments across the Northern Care Alliance to assess understanding of the purpose and application of CP-IS. Reports are to be submitted to each Care Organisation Exec Governance committees in June 2019. Reports will be provided once approved.

8.1

Ensure the nationally agreed read codes are appropriately maintained and kept up to date to reflect changes in children's legal status or care arrangements.

The Designated Nurse for Child Protection and Looked After Children met with the Information Governance Lead for NHS Bury CCG and developed a Privacy Impact Assessment for the retention of information by GP's once a child ceases to subject to a Child Protection Plan. A pro-forma has been provided to GP in decision making.

The advice to practices is as follows:

"GP practices are the data controller for the information they hold and this is recognised by the Information Commissioner.

A CQC inspection of the health economy, in September 2018, and the way that health manages safeguarding processes and information raised a concern that historic data is retained on GP IT systems, once a child has been removed form a plan.

The main reason from retaining information is that children may present with heath issue that relate to past abuse and neglect. It is recognised that ACE's (Adverse Childhood Experience) continue to impact on children and adults throughout their lives.

If practices are aware of the information, it can be helpful in identifying underlying causes of presenting health issues .Therefore it can be in the best interest of patients to retain the information.

However, it is the responsibility of the data controller within the practice to make a considered decision on each case.

Practices could hold a clinical meeting to decide if they think retaining the information is helpful to ensuring the best care can be provided to the child.

It is advised that unless consent is obtained, when the child reaches the age of 18 years the information should, be archived.

The decision to retain the information in respect of the child protection information following removal from a plan must be clearly documented within the record with a rational for the decision."

Proforma to support decision making in re

Practices now have the tools to make informed decisions about retaining, or not, the information about child protection history.

8.2

Ensure GPs are effectively involved in the assessments and care plans for children who are looked after so that they are able to support joint work to effect change and improve child health outcomes.

The pathway at the time of inspection required the provider of health assessments to obtain GP information for IHA. However, due to changes in the staff of the LAC team this had been lost in the process. This was acknowledged and as a result the process has now been implemented and added to the tracker to ensure the request is made. The return of information from practices was very limited and as a result a letter has been agreed to be sent to practices advising them of the importance of this information within the health assessment process. Additionally, reminders are in place at all GP safeguarding training sessions.

9.1

Ensure dentists are appropriately informed about and contribute to the health care arrangements of children who are looked after.

Initially, the CCG tried to liaise with Wokingham CCG to enable exploration of the process they had established. However, despite numerous attempts by email and phone, a response was not received. Therefore, the Designated Nurse liaised with NHS Public Health England and agreed a briefing note would go out to all dentists in Bury. This action was completed in April 2019.

Briefing to dental colleagues in respect

9.2

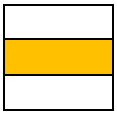
Ensure local specialist children's homes effectively deliver therapeutic support to children with high and complex needs, and ensure appropriate safeguarding arrangements are in place for children under the age of 18 sharing the facilities with young adults.

This action has been a challenge due to the CCG specialist nurse for Looked after Children being on maternity leave. Meet and greet assurance visits have continued. The Designated Nurse attended, as planned, the LA planning meeting and although interesting, this did not progress the recommendation. Currently there is no robust pathway to ensure that the children placed in therapeutic placements and partially funded by the CCG are having their needs met. Therefore we have identified the young people this relates to and a desk top review of health and therapeutic needs will be completed, initially for two of the children. It will be a tri-partate review between Social Care CAMH's, the social worker and the CCG specialist nurse. This will help in planning the transition for the young people and review if their needs are being met in the current placements.

The specialist nurse is also going to develop a pathway for assessment and review of children placed by Bury in therapeutic placements. The timeline is for the pathway to be available for the Health of LAC steering group in Quarter 2.

10.1

Ensure that midwives routinely share all antenatal information with health visitors to enable timely contact and coverage of antenatal visits.



A review of the information sharing process from midwifery services to health visitors highlighted that there were a number of systems within PAHT in which the notifications of pregnancy at 28 weeks and referrals were being sent to the health visitors and that this appeared to contribute to delays in information sharing. The Named Midwife (PAHT) met with senior managers for the health visiting service in Pennine Care and agreed that one system was to be adopted in that all notifications were to be sent to Bury Child Health and that a diary/record of all those sent would be kept by midwifery services in order to monitor those sent and received by child health.

Whilst the implementation of a single streamlined process was undertaken soon after the inspection, health visiting services continued to report some delays in receiving these forms.

The named Midwife has identified the points of delay in the new process and agreed a plan to address them with Midwifery and health visiting services and Child Health Bury.

The improved oversight from the Care organisation, the midwifery service and the safeguarding team have allowed the challenges presented whilst embedding a improvements in systems and processes to be quickly identified and addressed. The joint solution based approach to information sharing has created an openness and strength in the local system aimed at improving the transition of care from one service to another.

This approach will need continued senior oversight from both PAHT and PCFT to ensure continued improvements to service provision. This should be further strengthened by the transaction of Community Childrens health Services from PCFT to the Northern Care Alliance in the summer of 2019.

11.1

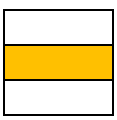
Ensure the emergency department at Fairfield General Hospital has appropriate levels of paediatric doctor and nurse expertise in line with national guidance.

FGH scoped the level of paediatric nurses required and have advertised on a number of occasions. They now have two WTE in post which sits below the national guidance. However, from the 1st July as part of the transaction of PCFT being hosted by SRFT, the Bury Walk in Centre will be managed as part of the ED. This is will increase the capacity to three nurses. The plans are at early stage but it is expected that the rota will be one between both sites.

The increased visibility of the safeguarding team in the Emergency department has allowed greater oversight of case management of safeguarding concerns and will provide specific safeguarding supervision to the paediatric nurses once in post.

11.2

Ensure record-keeping in maternity services is completed in a timely manner to provide a full and up-to-date picture of incidents and risks to mothers and their unborn babies.



A record keeping audit of Special Circumstances forms (SCFs) was completed by the Named Midwife. The audit aimed to identify if SCFs were completed in a timely manner and

were accessible to review to support decision making. The audit findings corroborated the CQC inspection findings as stated. It was agreed that the midwifery records needed to include chronologies of significant events accessible to both community and acute based midwives. All SCF's are reviewed by the safeguarding team to ensure the appropriate safeguarding action is taken when concerns are raised. An audit is required to consider:

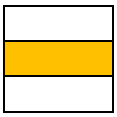
- The quality of SCF's,
- The number of SCFs where the safeguarding team have escalated cases that have not been identified by the midwifery service
- The number of SCFs / referrals that have converted to a safeguarding enquiry (S47) by Childrens social care.

An IT solution has been identified using the existing E3 system. The advantage of this system is that midwives are familiar with it and would require minimal training on the recording of a significant event. This approach has been approved by executive leads for midwifery and dates are to be set to commence implementation by September 2018.

The impact of this improvement is yet to be seen as organisational approval has only recently been agreed. An evaluation will be scheduled 3- 6 months post implementation with quarterly reviews and reports to relevant executive committees thereafter.

11.3

Ensure maternity records clearly identify any concerns about partner's mental health or misuse of drugs or alcohol that could impact on their parenting capacity or availability to support the mother and unborn/new born baby.



Hand held notes should capture this information alongside highlighting specific issues within SCFs. The use of the 'upside down triangle' to identify potential risks related about a partners mental health and /or substance misuse as well as domestic abuse has been under consideration. The upside down triangle is currently used on hand held notes to assist community and acute staff to identify and share risk issues relating to domestic abuse. The current view is that this would not be a practical solution (see 11.4).

The most effective approach is to use the SCFs to document such issues. The introduction of a chronology of significant events will ensure that all midwives have access to this information. As stated in action 11.2 progress is being made on this.

Plans are in progress for SCFs to be sent automatically to GP practices via the DocMan system. A schedule is to be agreed before the end of June 2019.

As in action 11.2, the impact of this improvement is yet to be seen as organisational approval has only recently been agreed. An evaluation will be scheduled 3- 6 months post

implementation with quarterly reviews and reports to relevant executive committees thereafter.

11.4

Equip maternity staff with the knowledge and tools to enable them to strengthen their safeguarding practice in identifying domestic abuse, neglect and exploitation.

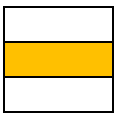
All midwives are mandated to attend level 3 safeguarding children training. Domestic abuse, neglect and exploitation are included in the detailed content of this single agency face to face training. In addition, safeguarding is included in the mandated annual public health days for midwives.

The Northern Care Alliance has a Domestic Abuse Specialist Nurse who is currently focusing recognition and response to domestic abuse training in the emergency departments across the Northern Care Alliance. The Named Midwife and the Domestic abuse specialist nurse have been working together to consider the specific training needs of midwives. Alongside this work a business case is in progress for an Independent Domestic Violence advocate for each of the care organisations across the Northern care Alliance. This replicates a very successful model in other large health providers in Greater Manchester. Whilst the business case is in progress domestic abuse workshops have commenced aimed at improving recognition and response and training frontline staff to complete Domestic Abuse Stalking and Harrassment (DASH) assessments.

The safeguarding team are working with local safeguarding partnerships/ boards and maternity leads to consider the role of midwives in the identification and assessment of neglect using the graded care profile or similar local tools. Progress will be included in future reports.

11.5

Ensure strong emergency department leadership with good recognition, management and review of risks to children. This includes making effective use of safeguarding screening tools to inform judgements about the safety of children, making accurate records in line with professional standards, and sharing relevant information with other agencies, including ensuring prompt referrals to MASH.



The ED is now using Screening tools and clerking document and this is being audited daily There was planned training with Independent Domestic Violence Advocates (IDVAs) but unfortunately the training planned did not go ahead. The Northern Care Alliance group domestic abuse lead is delivering training around recognition and response and the new nurse lead for the ED plans to attend a MARAC for their own personal learning.

The Designated Nurse from the CCG undertook a brief audit of the ED records for children attending. They attended the ED, by prior arrangement with management on the evening of the 6th February 2019 and reviewed the records of children from the previous days. Thirty three children had attended and the sample was generated by taking every third record from the records cards. The cards had already been filed and are filed alphabetically.

Ten records were reviewed and screened against elements of the bench marking tool as the tool includes adult safeguarding. The age range of the children was 8 months to 16 years. The bench marking tool that is used routinely within the department

The Urgent Treatment Centre (UTC), based on the FGH site has been in operation since October 2018 and three of the children were streamed via the ED to the UTC. The UTC works to PAT policies and procedures but uses a different IT system to generate their reports Both the UTC and ED have access to the Child Protection – Information System (CP-IS). Five of the children were seen during the day within the department and two by the night shift.

The outcome of the review identified that processes were well embedded in the ED during the day but less so in the UTC and overnight in the ED

BARDOC, who runs the UTC on behalf of the Locality Care Organisation, has provided an action plan to address the gaps found. A key gap was accessing the CP-IS and this has been addressed by ensuring staff have access via a smart card

The ED at Fairfield GH has also submitted an on-going action plan to address the issues identified in the audit.

11.6

Review the capacity of its named midwife and named nurse to strengthen their visibility alongside frontline practitioners and partner agencies across its whole footprint.

The capacity of the Named Midwife has been reviewed as part of the wider safeguarding service review for the Northern Care Alliance. A business case is currently in progress for 2 additional band 7 safeguarding midwives to support the Named midwife. A secondment band 7 post has been approved and is currently in recruitment as an interim position whilst we await the outcome of the business cases.

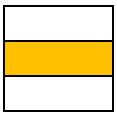
Recruitment has already taken place and staff are now in post to ensure that each care organisation has a band 7 safeguarding children practitioner linked to its services.

The Safeguarding service review continues as the footprint of the Northern Care Alliance (NCA) changes both geographically and in the services it will be providing following transactions of services from Pennine Care to the NCA.

The impact of an increase in resources will enable the safeguarding to increase its visibility across the care organisations. We have already seen improvement in visibility following the recruitment of a new Named Nurse in January 2019 and two new band 7 safeguarding children practitioners. This recruitment has allowed a physical presence in the care organisations to support frontline activities and ad hoc advice, support, supervision and training

11.7

Strengthen recording arrangements for the supervision of midwives to enable tracking of the quality and impact of practice.

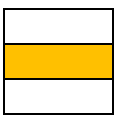


Safeguarding supervision for midwives is conducted by the Named Midwife. A new process is in place for monitoring compliance and where non-compliance is noted this is escalated to the team leader and divisional director of nursing.

The improvements in safeguarding team resource as outlined in 11.6 will enable improved access to safeguarding supervision for midwives. A NCA wide approach to safeguarding supervision is under consideration. The safeguarding team have initiated a safeguarding supervision working group to consider the provision of specialist supervision for case load holders, including midwifery, health visitors and school nurses alongside a range of opportunities for group supervision for Allied health professionals, staff on paediatric wards and Emergency departments.

12.1

Ensure the capacity of its school nursing service effectively meets demand; with good management oversight of the caseloads of frontline practitioners to prevent delays in identifying risks and meeting children and their families' needs



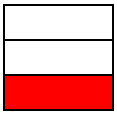
The Director of Public Health sought assurance and this was given as follows:

A review of School Nursing staffing levels completed by the Community Service Manager found the current provision of skill mixed teams to be in line with National Standards as outlined by Choosing Health (2004).

However, a review of the PCFT School Nursing Service is being undertaken by the Children's Community Service Lead with support from the Named Nurse for Safeguarding Adults, Children and LAC. Themes have been identified from local SCR's in relation to safeguarding adolescents, highlighting the need to review school nursing priorities in line with public health commissioning arrangements.

12.2

Address shortfalls in the capabilities of its school nursing electronic case management system to enable prompt retrieval and oversight of key information about children's safety and wellbeing.



This action has been put on hold as part of the PCFT CSB and SRFT transaction.

There is no solution identified. This is further complicated as the proposed IT system (PARIS) belongs to PCFT and PCFT have served notice on Bury community services. From July 2019 Salford Royal Foundation Trust and the Northern Care Alliance will host Community Services Bury. I.T pressures on the School Nursing service is unlikely to be resolved in the near future but has been highlighted as part of the due diligence process. As an interim measure there has been a function identified within Eview (current electronic case management system) that allows a chronology of significant events to be maintained and practitioners have been advised to utilise it as a safeguarding assessment tool.

The recording system is on the risk register at PCFT.

12.3

Ensure the focus on children within adult mental health services assesses the impact of parental mental health on their protective capacity; and that such risks are clearly identified, monitored and recorded throughout the period of care.

Documentation has been reviewed with adult acute in-patient wards across PCFT to include more guidance of safeguarding assessments on admission. The documentation was

discussed at the PCFT Named Professionals Forum in August 2018 and is now live across the trust.

12.4

Strengthen Healthy Young Minds approach to assessment and safety planning to provide a comprehensive picture of the impact of children's social circumstances and previous adverse experiences to ensure ongoing recognition of their resilience and risks.

A quality assurance tool developed and shared with the Health Young Minds (HYM) service lead on the in November 2018. Quality Assurance of ten young people's records was completed by the HYM Manager on 31st December 2018. The results of the audit were positive.

A working group needs to be established to review the HYM assessment framework across the North Sector of PCFT mental health services (Rochdale, Oldham and Bury). A recent action from a local SCR needs to be incorporated into this recommendation with an increased focus on Adverse Childhood Experiences and the impact on child and adolescent mental health. This piece of work has been difficult to progress as the local HYM provision spans a geographical patch beyond Bury. The recommendation has been handed over to the corporate safeguarding team in PCFT to progress with the Associate Director for Specialist Services (including HYM).

12.5

Ensure an effective system of quality assurance of all referrals to MASH. This should promote wider understanding of factors that lead to escalation and tracking of the impact of safeguarding work undertaken and review of the outcomes for the child/children.

The PCFT Safeguarding Team established a quality assurance process for health referrals into local authority children's social care (MASH) as per recommendation. The agreed action was to introduce a data collection exercise as part of the PCFT safeguarding team's annual activity over quarter.

In total, 10 multi-agency referrals were shared with the safeguarding team between 1st January 2019 and 31st March 2019. In general, the quality of referrals from Specialist Community Public Health Practitioners (Health Visitors / School Nurses) was of a good

quality. This supports the findings from the CQC inspection and should be expected given the specific role Health Visitors and School Nurses have as universal safeguarding practitioners working with children and young people. Additional support is required when referrals are made from adult mental health services and this again supports on-going pieces of work between the safeguarding team and those services.

Training needs have been identified in relation to how practitioners articulate risk so that it can be easily identified by the MASH. Bespoke training around risk analysis has been delivered by the PCFT safeguarding team as part of a monthly lunch and learn programme in May 2019.

12.6

Ensure adult mental health practitioners make effective use of their electronic case management system; including routine use of alerts and uploading of child protection documentation to inform their case work. Records should provide a complete picture of the ongoing challenges and risks within the family, and the impact of support given.

The initial plan was to create a tab within the PARIS recording system; however, the PARIS leads identified a 'crucial information' function on the system that formulates a chronology of significant events related to the person, not the service. The new information is to be included in all PARIS training in 2019. Therefore it was not necessary to create a new tab but the training is now underway to ensure all staff are aware of the functionality.

12.7

Ensure adult mental health practitioners provide clear and succinct written reports to child protection conferences that provide appropriate analysis of the impact of parental mental health difficulties on care provided; and ensure their reports are routinely shared and discussed with parents in advance of the conference.

In October 2018 the safeguarding team at PCFT shared the LSCB template for Case Conference, used by school nurses and health visitors with Adult Community Service Lead and Community Mental Health Team Service Manager for use by adult mental health practitioners.

Although this is RAG Green, at a later date, an audit will be requested to assess the level of implementation.

12.8

Ensure adult mental health practitioners benefit from regular safeguarding supervision to support their work, ensuring effective vigilance of children where there are fluctuating risks or complex family circumstances.

Due to the transaction around the separation of community and mental health services the SOP has been put on hold. However, a contingency has been put in place which provides with individual supervision available on request from either the CSB safeguarding team or Trust team

Additionally, the CSB safeguarding team have offered training on safeguarding supervision for managers and practitioners working in the Bury Early Intervention Team and Community Mental Health Teams. This will enable them to deliver group safeguarding supervision autonomously with specialist support as required. Three sessions have been delivered in April/May 2019, totalling 32 practitioners and have been positively evaluated.

12.9

Ensure looked after children's health records provide all essential information about children's care status, parental and sibling details and consent to provide a full and accurate record of each child's personal circumstances.

An audit of 27 records was completed by the Specialist Nurses for Looked after Children within Bury CCG. The records reviewed were a combination of electronic and paper and held by school nurses, health visitors and the Specialist Nurse for Looked after Children at Pennine Care. The audit highlighted some good areas of practice, including, ensuring family details are within the records and gaining young person's consent when deemed competent to do so. This was seen consistently across sets of records and multiple health assessments, suggesting that this is a well embedded within practice and shows evidence of empowering young people to make choices around their health and promoting the voice of the child. Care status was up to date in the majority of cases; however, there was evidence in one case that the delay in sharing information caused a subsequent delay in providing health services. This was highlighted directly with the Specialist Nurse for addressing as a priority.

The overall quality of the records that were reviewed varied. The health visiting records were significantly easier to navigate in comparison to the electronic records used by the School Nursing and Looked after Children's team, however, compliance against the audit tool was

similar across all records. It was acknowledged however, that as the electronic records were so difficult to navigate, due to information being filed in differing sections across sets of records, that this information, could well have been within the records, but unable to be found, due to the current filing system. The electronic records system has been acknowledged within the CQC action plan as a risk. Of the records reviewed, those in which the initial consent from Children's Social Care was found, were all within records from outside of Bury. This has been discussed with the Specialist Nurse at Pennine Care and it appears that consent is received by the Looked after Children's team but not then shared with the record holder for filing in the records. This has been reflected in the recommendations below.

1. The electronic record system used by the Looked after Children's and School Nursing team to remain as a highlighted risk.
2. The Looked after Children's team, in part of reviewing their processes, to include sharing of consent to be filed within children and young people's records.
3. The Looked after Children's team, in part of reviewing their processes, to ensure Initial Health Assessments are shared and filed within the child's records.
4. Professionals to review Looked after Children's record on their caseload, as they are next due their health assessments and/or review and ensure a full and up-to-date record of each child's personal circumstances, including parental responsibilities, initial health assessment and consent is included.

A repeat audit will be completed in 12 months' time to allow the changes to fully embed

12.10

Ensure recording and tracking systems in use within the LAC specialist health team are supported by a case recording system that promotes timely and efficient transfer and management of information.

This recommendation was a surprise to us when it was included. We have confirmed that there are robust systems in place with each child being added to a spread sheet and tracked through the system for timely completion of reviews and reminders being sent to staff 8 weeks before a review is GP. It also captures all requests for information, such as from GP's.

The Looked after Children Administrator is always able to provide information immediately when asked for specifics on a child who is known to PCFT Looked after Children team.

12.11

Ensure stronger management oversight and safeguarding leadership within Bury Walk-in centre; including assurance about the currency of paediatric and safeguarding children training undertaken by agency staff.

The WIC in Bury has employed a 1.0 WTE paediatric nurse since November 2018. The leadership within the walk in centre has become more stable since the inspection but there is currently interim manager due to the permanent manager being on long term sick leave.

As noted earlier in the report, the model of delivery for urgent care will change from the summer of 2019, with PAT taking the lead across the system.

Quarterly supervision/reflection sessions have been introduced in the WIC with support from a Specialist Safeguarding Practitioner. A Safeguarding Children's Champion has been identified within the workforce to act as a channel of communication between the PCFT Safeguarding Team and the wider staff cohort. All practitioners will be compliant with safeguarding children level 3 training as of 31st July 2019.

13.1

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

The capacity in the service has been increased via recruitment. The service have recruited an education and wellbeing specialist, commenced in post January 2019 and also a nurse who will starts in post in June 2019. The additional capacity will enable the team to engage in child protection and prevention discussions as required

The proposed changes for the Sexual Health Outreach team in the upcoming months will increase the amount of vulnerable young people the service sees in the community and will result in better access to the service.

The Outreach team has also recently become well established in a clinical setting, this means that they can see vulnerable young people who may just want to chat to a member of staff before seeing a Nurse; the team can also do asymptomatic screening including blood taking and pregnancy testing. This has reduced the pressure on the clinical staff who are now able to focus on contraception and treatment for sexually transmitted infections.

13.2

Develop its local safeguarding children assessment processes to ensure appropriate flagging, recognition and recording of the vulnerability of children and young people including those whose care is being managed within child in need and child protection arrangements.

Mandatory fields have been implemented to the assessment process which captures young people whose care is being managed within child in need and child protection, this process does not allow the clinician to progress unless this information is recorded.

The young person pro forma is subject to audit ensuring high standards are met in ensuring young people attending the service have all needs met and are supported if safeguarding is identified.

The addition of the field supports staff exploring with the young person any child in need or protection issues they may be dealing with in their life and adds to the holistic understanding of the young person's lived experience.

13.3

Strengthen its safeguarding leadership assurance processes to enable case audits and regular safeguarding supervision to be provided.

Safeguarding Supervision, supported by the safeguarding team from NHS Bury CCG, has been implemented quarterly and all staff has access to 1:1 supervision as required when dealing with complex cases.

Safeguarding Champions have quarterly meetings with the Safeguarding Lead of ORBISH (Rochdale Integrated Sexual Health Service) and have established a safeguarding forum. The Terms of Reference for the group include the following:

Aim: The overall aim of BU16 Safeguarding Forum is to improve patient safety and the quality of safeguarding delivered within Sexual Health Services. This will be achieved by sharing outcomes and experience, through peer support and networking to share best practice, lessons learnt and discuss updated policies and research. Furthermore to ensure each Service has safeguarding training, support and local and national pathways and policies in place.

The objectives of the network are aligned to the six core principles of our health and care strategy so that everyone feels the difference:

HEARTFELT		STRIVING FOR BETTER		TEAM SPIRIT	
Principle 1 By providing outstanding services	**Principle 2** Putting people at the centre of care	**Principle 3** Be pioneering and transforming care	**Principle 4** Being a trusted partner	**Principle 5** Being the health and social care employer of choice	**Principle 6** Be equipped to do what's needed

There is now a clearer focus on supervision and the pathways for access are clearer. This ensures that staff are supported when working in complex situations and with young people whose lives may be complex. The focus will enable the young person to receive the support they need in a timely and knowledgeable manner.

14.1

Ensure case records contain all relevant information about children within the family and other professionals involved in the delivery of care to promote effective liaison and support for the whole family

Children's details (name, date of birth, social worker) are recorded in the electronic assessment.

A separate children details form is kept for all clients that records child details, school/nursery, first language, social services involvement, GP, any other professionals involved. The safeguarding lead from One Recovery audits each assessment to ensure these have been completed.

All staff have been briefed in team meeting and in supervision on importance of documenting professional details involved with the family and the importance of communication with other professionals involved that must be evidenced in case notes.

Ensuring all case records contain relevant information about children within the family and other professionals involved in the case has led to improved communication/liaison between One Recovery and external agencies/professionals to ensure effective support for the whole family.

14.2

Promote good information-sharing with GP's to enable strong shared vigilance of the care and treatment of adults within the household and recognition of impacts for children.

There is a communication pathway in place.

To support GP's understanding of any current prescribing by One Recovery the following paragraph is mandatory on any communication with them regarding prescribing. The mandatory paragraph states:

"Please could you ensure the medication prescribed by One Recovery Bury as per this letter is added to the patient's record as a drug prescribed by an outside agency (using the same procedure as for adding a RED drug to a patient's record) as this will allow for Vision to check for interactions and maintain an accurate record of what medication the patient is taking."

The impact on case management is that there is:

- Good information sharing with GPs.
- GPs are informed of clients accessing treatment, their treatment plan, any medications prescribed and any concerns we may have to enable shared vigilance regarding the treatment of adults within the household and any implications parental substance misuse and treatment may have for their children.

14.3

Ensure case records contain all relevant child protection information to guide the work of adult substance misuse practitioners and ensure they are actively involved in all relevant child protection planning and review meetings

- One Recovery met with Children's Social Care and agreed that cases will be jointly tracked by One Recovery and Children Social Care.
- The Social Work Practice lead spoke to relevant people to ensure all plans and meeting minutes are shared with One Recovery.

The safeguarding lead from One Recovery attended all social work team meetings to recap on One Recovery, the work it does and parental substance misuse and importance of information sharing between children's social care and One Recovery.

The safeguarding lead from One Recovery is now part of the MASH referral screening process.

All child protection conference invites go to the safeguarding lead at One Recovery so she can ensure practitioners attend all core groups and conferences.

The impact is as follows:

- The changes have led to improved information sharing between all departments in children's social care and One Recovery.
- Improved children's social care teams knowledge and understanding around One Recovery and the impact of parental substance misuse.
- MASH made aware if any referrals include parents known to One Recovery.
- One Recovery practitioners actively involved in all child protection planning, conferences, core groups, looked after review and child in need meetings.