

Review of Health Services for Children Looked After and Safeguarding in Salford

Children Looked After and Safeguarding

The role of health services in Salford

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Summary of the review

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

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

About the review

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

- The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.
- The focus was on the experiences of looked after children and children and their families who receive safeguarding services.
- We looked at:
 - the role of healthcare providers and commissioners.
 - the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
 - the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.
- We also checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, *Working Together to Safeguard Children 2013*.

How we carried out the review

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

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

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

In total we took into account the experiences of 64 children and young people.

Context of the review

The city of Salford is part of Greater Manchester, lying to the west of the conurbation. Its neighbourhoods include Irlam, Swinton, Broughton, Eccles, Ordsall, Claremont, Little Hulton and Walkden. Approximately 236,597 people live in Salford, including 45,705 children aged 0-16 years. Salford is becoming increasingly diverse, with about 14% of the population estimated to be from an ethnic group other than white.

Salford contains areas of significant deprivation. It is the 13th most deprived district in England. Approximately a third of localities fall within the 10% most deprived areas in England. The health and well-being of children in Salford is generally worse and infant and child mortality rates are higher than the England averages. It is estimated that 29.3% of children aged less than 16 years are currently living in poverty. The rate of family homelessness is also worse than the England average. Salford has the highest number of accident and emergency attendances due to self-harm in Greater Manchester, particularly among young people between the ages of 14 and 19. Hospital admissions of young people under 18, alcohol-specific admissions, teenage pregnancy and smoking in pregnancy are all higher than the England average. Salford has significantly higher Chlamydia rates for 15-19yr olds than England and its statistical neighbours. Levels of breast feeding and GCSE attainment are lower than the England average.

Commissioning and planning of most health services for children is carried out by NHS Salford CCG. NHS England's Greater Manchester Area Team commissions primary care and local health visiting services. There are 48 GP practices in Salford.

Acute hospital services for children are provided by Salford Royal NHS Foundation Trust (SRFT) through PANDA (Paediatric Assessment and Decision Area) and consultant-led outpatients services in locality settings. Children who attend the PANDA Unit and require admission to a secondary inpatient bed are now routinely admitted to Royal Bolton NHS Foundation Trust (RBHT) with required follow up appointments being provided by SRFT. Tertiary in and outpatient services are also provided by Central Manchester University Hospitals NHS Foundation Trust (CMFT).

Midwifery Services are provided by CMFT, RBHT, North Manchester General Hospital and Warrington and Halton Hospital Trust, with each providing community midwifery services serving designated geographic zones covering all of Salford. Consultant led and inpatient services are provided at the respective acute trust site, however there is an early pregnancy service, consultant-led antenatal clinics, and a midwife led unit within Salford on the Salford Royal site.

Community based clinical services, including community paediatrics, health visitors, school nurses and allied professionals are provided by Salford Royal NHS Foundation Trust (SRFT). This includes a Vulnerable Young People's Nursing Service that works with older young people who are looked after and others with complex needs.

Child and Adolescent Mental Health Services (CAMHS) are provided by CMFT, based in a locality setting in Salford. CAMHS services include a 0-16, 16-17, and a specialist learning disability service. Salford CAMHS provision for looked after and adopted children comprises STARLAC (Salford Therapeutic Advisory and Referral service for Looked After Children), SAFSS (Salford Adoptive Families Support Service), and support to Specialist Fostering teams (3D and Focus).

CAMHS within Youth Offending and Children involved with Child Protection and Outreach Social Services are jointly commissioned with the Local Authority and provided by CMFT. Inpatient (Tier 4) mental health services are commissioned by NHS England (Cheshire, Warrington and Wirral Area Team) and delivered by Greater Manchester West (GMW) Mental Health NHS Foundation Trust (at Junction 17) and CMFT (at Galaxy House). GMW also provides adult mental health and substance misuse services.

Salford has relatively high numbers of vulnerable children compared to national figures. On 31st March 2013 there were 349 children and young people on child protection plans. On the 31st March 2013, 540 children and young people were looked after, 211 were placed outside the area. In addition there were 106 looked after children and young people placed in Salford by other local authorities.

The last inspection of health services for Salford's children took place in June 2010 as a joint inspection, with Ofsted, of safeguarding and looked after children's services. Overall effectiveness of the safeguarding services was judged as inadequate. Health outcomes for looked after children and young people were judged to be good. Recommendations from that inspection are covered in this review. A re-inspection by Ofsted in November 2012 judged safeguarding arrangements to be adequate.

The report

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

What people told us

Young people and their families attending the PANDA unit at Salford Royal said:

"They treat me like an adult in a children's area- it's nice."

"The doctors and nurses are brilliant- the care they provide is excellent."

"Staff are very reassuring- they are good at keeping us informed- they reassure you, keep you up to date and tell you what is happening. The play therapist has been great- entertaining, chatting and helping. Our child is usually nervous about blood tests, but with her help, he has not been upset."

Young people said very positive things about their school nurses:

"It was only when I talked to the school nurse and she saw me a few times that I decided I needed to talk about my illness. She asked my permission to refer me to CAMHS and I am also now seeing a counsellor from the NSPCC. I can talk about my illness to my friends as well. She (the school nurse) has been brilliant and I don't think I could have done it without her".

“The school nurse referred me to CAMHS and I was seen pretty quickly. I was given five appointments to talk about my anxiety, but they told me that if I had any more problems they would see me again. They even met my mum and we now have coping skills in place at home and here (at school) to help me if I am feeling stressed or sick. CAMHS were really nice and the coping skills have really helped my attendance at school.”

“She’s the only person that understands me and what I have been through, when I need something she will get it, and will sort things out for me.”

A parent told us their child’s school nurse is very good in helping to sort out a lot of problems as their child has a number of needs. It seemed to them that other health specialists were not making much progress in identifying the causes of problems.

Support from the Vulnerable Young Person’s midwife (CMFT) was also valued. One young person told us:

“She’s good, she’s down to earth and is a good role model for a teenager. She speaks to me on an equal basis”.

We spoke to a new mother at Royal Bolton hospital whose baby had been born 5 weeks early. She told us that the community midwives had been very supportive and that she and her baby had been well looked after by the staff on the post natal ward. However, on arrival at the hospital in labour there had been a significant delay of over four hours before midwives were able to get a doctor to see her. This has been reported as a serious incident in line with the Trust’s protocol.

Another new mother on the post natal ward told us that she has always seen the same midwife throughout her ante natal care and that she had appreciated this. She also said it was hard to figure out who to contact for appointments and scans which took place at satellite clinics in Salford. She told us that she had not been offered a choice of maternity units or told whether she could have delivered at the Salford Birthing Centre.

A young woman who had been detained under the Mental Health Act on a young person’s unit and then later was re-admitted to an adult mental health ward told us about their experience of transition:

“I felt let down by the adolescent CAMHS unit, and once I was 18 it was as though I was at the end of the road”.

She told us that she had felt unprepared for discharge as the in-patient stay had taken all her responsibility away. She had been scared about the need for further admissions to an adult mental health ward, but now that she has been re-admitted, she feels more comfortable and cared for.

An experienced foster carer spoke very highly of a number of health professionals involved in supporting her to meet the needs of the children she is looking after. She valued the joint approach from her health visitor:

“The health visitor is lovely, wonderful- between us we are working out how best to tackle a health problem”.

“Our GP at Walkden Medical Centre is absolutely amazing- he goes the extra mile to ensure there are no underlying concerns- he’s always very thorough.”

She also reported very good advice and support with timely follow up by the local CAMHS service in helping her care for children with learning disabilities and mental health problems.

“Local health services have been excellent- no side of the health service has let me down.”

The work of the Vulnerable Young People’s Nursing team was highly regarded by a couple of care leavers we spoke to. They said they could call the team if they had a problem, and if they couldn’t help, they would point them in the right direction. They said:

“I always felt respected as a person not a child, even when I was a child. They (LAC staff) were always interested in my wellbeing overall, not just health.”

“I always used to get excited when the LAC nurse was coming around. When we were alone I used to ask her all sorts of random questions about health. I learned so much.”

Young people spoke about the quality of health information they received on leaving care:

“It was all right, but it was just a copy of my last assessment. It didn’t feel very special, and thinking about it, I would have loved to know where I was born and what I weighed when I was born before I left care. It’s about me and I suppose that’s why I’m here helping to design a new way of getting that information to young people. When you are in care it’s important to know these things.”

One young people told us about their experience of leaving care:

“It was sometimes a bit of a shock having to do things for yourself when you have been used to having things done for you. We’re lucky though because even now we can call our nurse and ask”.

The child's journey

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

1. Early help

1.1 Most health professionals told us the referral and initial assessment (RIAT) and multi-agency safeguarding hub (MASH) teams are effective in strengthening local safeguarding arrangements. Early intervention is increasingly promoted across the wider partnership to prevent risks to children escalating. From case records seen, local arrangements are positively enabling a shared understanding of next steps and of the accountabilities of individual agencies for the delivery of early help. Frontline health staff told us that Salford City Council responds quickly to referrals and that they are generally kept informed of the outcomes of referrals made. One GP practice told us they had not been consistently informed, but that they in turn had not proactively chased up the outcome of referrals. They recognised that they needed to strengthen their systems and accountabilities in this area of practice.

1.2 Information sharing between the MASH and CAMHS and adult mental health has been reviewed and strengthened. An appropriate balance between maintaining confidentiality and disclosing safeguarding concerns was evident on most case records seen.

1.3 Health practitioners demonstrated good awareness of the vulnerability of children of parents and carers who present at Salford Royal Emergency Department (ED) with mental health, self-harm, substance misuse and domestic violence. The numbers of referrals to children's social care continues to increase given improvements in the vigilance of staff, including identifying the "invisible child".¹

1.4 Health professionals have a good understanding of the thresholds for access to children's social care services. Since the last inspection the capacity of the health visitor workforce has significantly increased in line with national requirements. Increasing numbers of health visitors are carrying out the lead professional role or are jointly contributing to '*Team Around the Child*' (TAC) meetings.

¹ Term used in child protection research where parents/caregivers seek to conceal their child care responsibilities or where the impact of their behaviour on their children is not sufficiently explored

1.5 Senior health managers in conjunction with Salford City Council have identified high and increasing pressures on the capacity of the school nurse workforce to undertake early help work given that 68% of the team's activity is currently deployed to high priority child protection work. Where school nurse 'drop-ins' exist they are highly valued by young people, and are well used. They provide an effective means of encouraging some young people to share their anxieties and problems. The school nursing service is currently being reviewed to expand its capacity through further strengthening of joint working arrangements and inclusion of a wider skill mix. However, without additional resourcing, the capacity of the team to undertake early help work will remain challenging.

1.6 Teenage conception rates are steadily reducing, and although rates remain higher than other areas, a range of targeted early help support is available. For example, Brook Salford (a service of Brook Young People) offers a weekly nurse led sexual health clinic to all pupils at Harrop Fold High School, an area with high levels of deprivation, unemployment and teenage conceptions. Rates of teenage pregnancy are now falling as a consequence of young people being helped to make informed choices and have a better understanding of risk.

1.7 Contraception and sexual health (CASH) services are widely available and well used, with evidence of strengthening partnerships between providers to reduce risk to vulnerable young people. Brook Salford has recently strengthened its systems for identifying and referring on safeguarding issues and screening risk. This is resulting in improved scrutiny of young people where risky behaviour is identified or increasing. Further work is required across the wider safeguarding partnership to strengthen pathways to ensure CASH services are appropriately engaged in early help work and safeguarding activity.

1.8 Joint working between CMFT's Vulnerable Young Women's Midwifery Service, SRFT's School Nursing and the Council's Teenage Parent team makes best use of each other's expertise and capacity in supporting young people, including young fathers. We saw examples of how this is helping to prepare young people for parenthood and to safeguard unborn babies. Funding has been agreed to establish a Family Nurse Partnership programme later this year which will further enhance local capacity.

W is a 15 year old girl currently looked after by her extended family. She booked with CMFT's Vulnerable Young Person's specialist midwife when she was 19 weeks pregnant.

W experienced a very difficult childhood, has few friends, misses school a lot and has recently broken up with her boyfriend. She is keen to keep the baby and to be a good parent. Her social worker is working very closely with her and local health professionals. Pre-birth planning assessment work has commenced to build a picture of the 'best interests' of the unborn baby. She has been referred to the Council's '*Strengthening Families*' team to help her build her awareness and parenting capacity in key areas such as developing safe routines and promoting bonding and attachment with her baby. This work is normally undertaken over 6-8 sessions and is carried on post-natally through the '*Incredible Years*' parenting work (an evidence based parenting programme)

The Vulnerable Young Person's specialist midwife will continue to support the young person throughout their pregnancy and for up to 28 days post-natally. The school nurse provides a high level of support visiting W at home, helping to reinforce her knowledge of parenting and parenting skills. She is also being well supported by STARLAC and her local GP.

1.9 Health professionals play a lead role in the joint '*Safe Sleep*'² campaign to reduce the incidence of infant deaths. Further training was provided last year to raise awareness and ensure community midwives, labour ward staff and health visitors actively promote '*Safe Sleep*' education in their work with parents. In cases seen in CMFT this was appropriately recorded in midwifery recording practice.

1.10 The recent maternity review led by NHS Salford CCG identified good practice in a number of areas. However it also highlighted some inconsistencies between the four local NHS providers. A programme of joint work has recently commenced to standardise and improve the use of special circumstances forms to support timely identification of vulnerable women. Communication and information sharing between midwives and health visitors in managing lower level safeguarding concerns, and ensuring good handover of cases and antenatal visits by health visitors have also been identified as areas for further improvement.

1.11 We found CMFT's midwifery staff pay good attention to checking for parental vulnerabilities including mental health, domestic abuse and misuse of drugs and alcohol. St Mary's hospital has an independent domestic abuse adviser who provides easy access to information, advice and support. The Trust's specialist midwifery team also has a specialist midwife who works with people seeking asylum. Her work is effective in strengthening oversight of risk to unborn and new born babies. She is vigilant to women's social isolation including barriers in relation to literacy and language, and cultural practices such as female genital mutilation that are prohibited in the UK. She works closely with local housing providers and charities to ensure all key equipment is in place for the baby's comfort and safety.

² 3 year public health campaign involving Bolton, Salford and Wigan child health and social care professionals

1.12 Cases seen of the work of CMFT midwives demonstrate good joint working with effective communication between midwives, GPs and health visitors. This includes analysis of risks and changes in levels of need, with appropriate review and updating of the care plans of vulnerable women. However, communication is more challenging in relation to women who are accessing different maternity providers for community midwifery support and delivery of their babies. Further review is required to provide assurance of effective joint working and accountabilities across the wider partnerships. (Recommendation 5.1).

1.13 GMW has a clear information sharing protocol to inform health visitors and school nurses about parents or carers who are in treatment for alcohol or substance misuse. The *'Think Child: Good Practice Guidelines'* provide a clear framework for promoting joint working and sharing information about adults with mental health needs who are caring for children. This guidance ensures children's social care and other child health professionals are kept informed about the involvement of adult mental health professionals so that they can offer additional support to children if required. This approach is working to strengthen safeguards in relation to child visiting, home leave and hospital discharge arrangements. It is also enabling a stronger focus on the needs of young carers.

1.14 CAMHS provides early help support through group work to parents of children with Attention Deficit Hyperactivity Disorder (ADHD). This is enabling them to strengthen their approaches to managing children's behaviours. Parents involved reported a reduction in their stress levels given increased confidence in handling situations, learning from the trainers and each other. They also commented that their children were now aware of boundaries and what they needed to do to reduce their frustrations or anxieties.

1.15 NHS Salford CCG has actively engaged young people in giving feedback about their experience of using local health services. Young people said they needed more information and help to deal with issues such as self-harm, bullying and eating disorders. A theatre company has now been commissioned to encourage young people to speak about their concerns and signpost them to local agencies who may be able to help. This approach positively complements local priorities identified in the new Emotional Health and Wellbeing strategy.

1.16 Attention to recording ethnicity and diversity in health records is variable, with weak practice in some areas. We found some good work by health professionals to reach out and deliver culturally appropriate health care, with practice more advanced in relation to the longer established minority ethnic communities. Access to translation and interpreting support is available and is used to support people's understanding and engagement. However further work is required to improve understanding of the health needs of new arrivals who are increasing in number and represent a diversity of faith, culture and language (Recommendation 3.1).

2. Children in Need

2.1 NHS Salford CCG, NHS England Area Team and the LSCB have a strong shared focus on strengthening systems of support to children in need and their families. Improvement actions from the previous serious case review (2010) are becoming more fully embedded in practice, and include actions that require midwives to inform GPs and health visitors as early as possible of socially vulnerable women who are pregnant. This is helping to strengthen communication and promotes regular review of women who are likely to require additional support or where there are safety concerns in relation to the unborn baby. Assessments of unborn babies are generally completed in a timely way and were clearly visible on CMFT's maternity records. Hospital discharge planning meetings are generally held for women where safeguarding issues have been identified.

2.2 Good attention is paid by the PANDA staff to ensuring young people under the age of 16 who present with emotional or mental health needs, including self-harm, are promptly followed up by CAMHS professionals. Children and young people are routinely reviewed by a CAMHS professional prior to the young person being discharged home. No concerns were raised about access to CAMHS services in these instances. Appropriate safeguards are also in place for young people with long term or life threatening conditions who present at the PANDA unit, with clear emergency plans to inform the future management of their care.

2.3 Risk assessments completed by practitioners in the adult Emergency Department (ED) are effective in identifying potential safeguarding concerns. From cases seen this is enabling prompt and effective follow up checks of the whereabouts and safety of dependent children. For example, we tracked outcomes from follow up enquiries and joint working with the police in relation to an assault by a young person on their parent. It was later discovered that the young person was '*at their wits end*' due to their parent's reliance on alcohol, long term mental health problems and a failure to adequately provide for them. In another case where the person presenting was unable to speak English, prompt action was taken involving the police and children's social care to safeguard children given concerns about the controlling nature of a couple living at the same address. In this case, health visitors are now providing more intensive support to ensure the safety of the children known to be living there.

2.4 Adult ED staff are aware of the challenges they face in undertaking a holistic assessment of risks when adults present without their children or where factors such as intoxication or mental ill health impact on their ability to communicate. However, some of the safeguarding referrals made by the adult ED to children's social care are not sufficiently clear or detailed to support effective risk management and decision-making across the wider partnership. If ED staff believe their concerns about children and young people warrant the further involvement of multi-disciplinary safeguarding professionals, their referrals need to clearly indicate the full nature of their concerns and include all relevant detail. (Recommendation 8.1).

2.5 The vulnerability of 16–18 year olds presenting at the adult ED is not sufficiently well understood. There are no formal pathways of care for those young people who attend following an incident of self-harm. We saw examples of poor liaison between the attending adult mental health liaison team and CAMHS in arranging follow up community based appointments or in-patient provision. This is recognised as an area for improvement by the Trust and action is now beginning to be taken to address this including the implementation of a clear alert system for flagging 16-18 year olds attending the adult ED. (Recommendation 4.1)

2.6 Data provided to inspectors by GMW indicates that since March 2013, 11 young people aged 16 and 17 were admitted to adult mental health wards because of the unavailability of paediatric mental health placements. One of these cases included a 16 year old boy who was on an adult ward for over 8 days. Such breaches are routinely investigated by the Trust and reported to NHS commissioners. However, further review of the capacity of local services and of the pathways between CAMHS, adult mental health and the adult ED is required as highlighted in this example. (Recommendations 4.1 and 4.2)

Z is a 17 year old who was discharged from an adolescent mental health placement. Follow up CAMHS appointments were offered which he did not attend. The young person then presented at the adult ED where re-admission to an adolescent mental health ward was considered. However, as no bed was available, the decision was made that he would be supported in the community. The young person failed to engage with community mental health services and again presented at ED from where he was admitted to an adult mental health ward. The young person remained there for a total of six days. They were then discharged from the adult mental health ward back to their home.

A 3 day review report found multi-agency failures in this case. Appropriate referrals had not been made, risk assessments had not been updated or completed where necessary. There was no clear pathway followed which could have prevented the young person from being admitted to an adult mental health ward.

3. Child Protection

3.1 The engagement of health professionals in partnership working with children's social care is being continuously strengthened. Health visitor input to the MASH team is effective and enables timely analysis of information held by a wide range of health organisations. This in turn promotes shared decision-making in planning and managing child protection work.

3.2 Health professionals have a good awareness of their accountabilities for safeguarding children. Frontline staff make appropriate use of and value the advice and support of named and designated professionals. The contribution of health professionals to child protection case conferences and core group meetings has been strengthened. The quality of health reports to child protection case conference is good overall, with clear analysis of risk and protective factors on those seen. Priority is given to reflecting the voice and experience of the child.

3.3 Attendance is monitored, and in the school nursing service where capacity and demands are high, a sensible approach has been taken where the health visitor may act as lead health professional for work undertaken by other community health professionals. In these cases we found good collaboration prior to and following attendance at meetings. Although CAMHS professionals are not always able to attend child protection meetings, they will submit reports if requested to do so. In order to achieve higher levels of attendance by GPs, a more flexible approach to the times and locations of child protection case conferences is required.

3.4 GPs have clear alerts on their electronic records to show where children are on a child protection plan or are identified as children in need. Domestic abuse alerts are also in place and details are recorded to enable practice staff to know if a family has been discussed at the Multi-Agency Risk Assessment Conference (MARAC), with appropriate flagging of the perpetrator, victim and children within the household. GPs are strengthening their capacity to work with other community health professionals to ensure child protection is at the centre of their work with vulnerable families. They would welcome stronger joint working with school nurses, however current capacity challenges in relation to the school nurse workforce and their use of IT mean that this is not easy to achieve. These organisational challenges are clearly reflected in the School Nursing Review and children's social care and health commissioners are working to find more sustainable solutions to these issues.

3.5 One practice we visited has a safeguarding action plan to improve liaison with midwifery services. This practice is also starting to strengthen its monitoring of incidents where children do not attend their appointments. Vulnerable families are discussed weekly and there is monthly liaison with the link health visitor. This exemplifies increasing maturity in the role and contribution of GPs to safeguarding children and adults work. However, there remain a few GP practices that have yet to achieve the required standards in the delivery of their safeguarding children arrangements including training coverage, and the quality and timeliness of submission of medical reports to child protection case conferences. It is of concern that these practices are in areas where rates of child protection activity are high. NHS Salford CCG continues to tightly monitor these practices, and sanctions will be applied where performance continues to be poor. (Recommendation 1.3).

3.6 The IT system in use in the ED at Salford Royal does not yet have an integrated flagging system to provide alerts in relation to children on child protection plans or those who are looked after. This is recognised as an organisational risk and is currently being addressed. Named professionals at the hospital are routinely informed of children on child protection plans and are notified when they have been removed so that records can be appropriately updated.

3.7 PANDA staff are vigilant in identifying safeguarding risks to children and young people. Safeguarding screening questions are routinely checked at each attendance. Discharge letters to GPs clearly state whether any safeguarding concerns have been identified. This approach is not only effective in strengthening the focus on children and young people with clearly identifiable risks, but promotes a stronger shared focus on children in need and those who would benefit from early help.

3.8 In one of the core cases selected for review, a PANDA member of staff had not taken appropriate action to fully assess risk in relation to an assault on a young pregnant woman. The clinician did not trigger a safeguarding notification to children's social care in line with Trust procedures. This gap in practice was however quickly identified through the work of the Vulnerable Young People's Nursing team who are responsible for hospital discharge arrangements of older children. Appropriate follow up action was then taken to ensure the mother and unborn baby were safe. The named safeguarding professionals were informed about this incident. This is an example of SRFT's open and accountable culture where learning is strongly promoted.

3.9 Children's presentation and their interactions are well recorded by hospital and community health staff. Young people are spoken to alone with appropriate chaperoning where necessary. We saw comprehensive social histories of what life at home is like from the perspective of young people, with good recording of the voice and wishes of young people on most records. Child sexual exploitation risks are sensitively explored and were well recorded on cases seen, with appropriate management of consent.

3.10 The arrangements for requesting child protection medicals are clear and reports are generally provided in a timely manner. Action is being taken to increase the availability of medical examinations in a suitably equipped community setting to enable the examination to take place in a more confidential young person-friendly environment. Child protection medical reports undertaken by SRFT paediatricians are comprehensive with clear analysis of risk. Effective use is made of body maps and photographs to inform recording. Play therapists in the PANDA unit are sensitively engaged in child protection work and ensure children's experiences, wishes and feelings are used to inform analysis of risk in child protection medical reports.

3.11 Notifications of incidents of domestic abuse are well managed on cases seen, with appropriate information sharing and follow up of concerns. SRFT has a specialist domestic abuse lead nurse who provides the first point of contact for all referrals into MARAC from acute and community health services. The post holder ensures frontline health professionals are appropriately involved in and aware of the outcomes of MARAC work. Arrangements to protect young people experiencing or perpetrating domestic abuse are being strengthened. Incidents of domestic abuse experienced by or perpetrated by young people 16-18 is now beginning to be routinely monitored.

3.12 Salford and Manchester City Councils and their partners are working closely in tracking young people at high risk of being sexually exploited or harmed who frequently move between the two council areas. A recent local serious case is promoting a higher level of vigilance in relation to the trafficking of young people.

3.13 We found inconsistencies in the standard of recording on some RBHT records for Salford women. Details of fathers are not always completed in the maternity notes. Chronologies were not fully completed for pregnant women receiving support through early intervention or where a referral had been made to children's social care for an initial case conference to protect the unborn child. Copies of the original electronic referrals to children's social care are not kept on file and some files seen did not contain copies of completed reports for child protection conferences or minutes of conferences. This meant that practitioners accessing the records did not have a complete and up to date picture of current concerns. (Recommendation 9.1).

3.14 We also saw that for those pregnant women who crossed NHS provider organisational boundaries there was a lack of clear ownership and delay in the sharing of information with the RBHT Maternity Service. This reinforces the need to ensure that information is appropriately shared and in a timely manner to overcome current challenges given the diversity of maternity providers operating in the area. (Recommendation 5.1)

3.15 RBHT's specialist outreach midwife provides valuable help in ensuring continuity of support to some women who have chaotic and complex social needs. We saw examples of robust safeguarding work undertaken by RBHT midwives in partnership with adult mental health services to ensure pregnant women had timely access to mental health services as highlighted in this case.

The RBHT midwife noted at the booking appointment that pregnant mother A had tried to hide the fact that her previous children were on child protection plans. She also noted that A was living with a lot of stress and was low in mood. It was considered likely that child protection measures would need to be implemented to ensure the safety of the unborn child.

The midwife made a referral to the EDIT team, a primary care psychology service. The EDIT team promptly responded to the referral and completed a comprehensive assessment of her mental health. The EDIT team ensured all relevant professionals were kept informed about risks. Given the severity of her needs, they also made a referral for specialist, more intensive midwifery support.

3.16 We also saw other examples where mental health professionals were working sensitively and creatively with mothers to address to try and reduce levels of anxiety and risk. CMFT has a clear risk traffic light tool to ensure mothers presenting with a range of mental health problems receive timely access to support. In GMW where adult mental health and substance misuse practitioners identify safeguarding risks they complete the Trust's Standard Tool for the Assessment of Risk (STAR). Where the STAR had been completed, these were generally of good quality, were clear in their analysis of risks and how these were being managed. However, the completion of the STAR tool is at the discretion of the practitioner and we found inconsistency and poor practice, with some clinicians not completing the tool when there was clear documented evidence of risk and child protection concerns. (Recommendation 10.1).

4. Looked after Children

4.1 The integration of the LAC nurses into the Vulnerable Young Persons' Nursing Service provides a high level of continuity for young people who move into or out of care or who require intensive support from health professionals at key points in adolescence. Young people value the flexibility of these arrangements. Cases seen demonstrate positive enabling relationships in addressing the needs of vulnerable adolescents, including those who have left care. Examples seen include a nurse working sensitively and at the pace of the young person to address their anxieties about seeing their GP. In another case, support was creatively offered to enable a young pregnant woman to attend her midwifery appointments.

4.2 SRFT has thoughtfully considered the impact of its move away from co-location with Salford City Council. LAC nurses continue to have access to the local authority IT recording systems which facilitate good information sharing. The nurses have named responsibility for each of the 8 local authority children's homes in Salford. This promotes good close relationships with young people and with the staff that support them.

4.3 Children entering care receive timely initial health assessments carried out by paediatricians in dedicated clinics. For those young people that do not wish to see a paediatrician, the LAC specialist nurses will carry out the health assessment which is then reviewed by a paediatrician on completion. This means that the majority of children and young people who become looked after by Salford City Council benefit from an initial assessment of their health needs. We saw evidence of young children beginning to thrive and catch up with their developmental milestones following their placement in care.

4.4 Community paediatricians are effectively engaged in permanence planning for children being placed for adoption. Following a recent audit, action has been taken to strengthen practice including obtaining a comprehensive parental history to inform the initial health assessment. This approach maximises what is often a single opportunity to obtain essential information on the child's birth family. Care is taken to ensure good access to interpreting services for young people and their families whose first language is not English.

4.5 Consent from parents or the local authority was appropriately sought and clearly recorded on most cases seen. However, not all age appropriate young people were being asked to consent to their health reviews. This is a missed opportunity to promote their engagement and to help them to start taking responsibility for their own health care needs. (Recommendation 8.2).

4.6 Good attention is paid to ensuring children and young people are immunised, that they can access dental health and are registered with a GP. Salford performs well against these performance indicators compared to other areas. Foster carers told us that they thought the initial health assessment process was thorough and enabled prompt action to be taken to address risks to children's health. However, we found that practice in investigating a hereditary disorder was slow in one case given information already known about prevalence rates in the wider family.

4.7 GPs and practice staff are yet not sufficiently clear about their roles and responsibilities for children who are looked after. We found a case in one surgery where the legal status of a child was not up to date. Further checks are required to ensure data held by GPs in relation to the status and placement arrangements of children are clear and reflective of their current care arrangements. The contribution of GPs to initial health assessments and health reviews for looked after children registered with their practice is underdeveloped. GPs are not routinely asked to contribute to the initial health assessments and health reviews for looked after children registered with their practice. This means that the assessments and reviews may not always be informed by the most up to date information. (Recommendation 2.1).

4.8 We saw good practice in relation to the work of health visitors who provided a clear picture of the health needs and social and emotional development of young children. Case records demonstrate health visitors are accessible and offer regular support to foster carers to help them provide good care.

4.9 School nurses and social workers work closely in sharing concerns about ongoing health risks to school aged children. In most cases seen, a community health professional attended the child's LAC statutory review. This ensured that the young person, their carers and other professionals had access to further advice as required in relation to the young person's health needs. School nurses are appropriately informed about hospital attendances by children who are looked after and routinely follow up any areas of concern identified.

4.10 Records of young people placed in other council areas generally provide sufficient detail to inform relevant health professionals of any ongoing health needs. Some initial assessments and reviews seen were undertaken outside the statutory timescales for health, but there was usually a clear evidence trail to explain the reason for delays. However, we found an unacceptable delay of over 15 months in one case between an initial health assessment when they were placed out of area, and their next review when they returned to live in the area. Although the review health assessment evidenced the young person's current health issues, it was not clear if previously identified concerns about serious risk in relation to his behaviour had been addressed. In this and a few other cases seen, review health assessments did not sufficiently focus on progress against outcomes identified in previous health care plan (Recommendation 8.4).

4.11 Practice in health assessments and care planning in some cases requires further development to fully identify the range and complexity of young peoples' health needs. The quality of initial health assessment and care plans for some young people who have entered care at a later point in their childhood does not sufficiently detail current risks to their health and wellbeing. Chronologies of significant events are not always in place or used to effectively track the young person's journey through care. (Recommendation 8.3).

4.12 This case exemplifies good practice in supporting a young person with complex needs.

Y is a 17 year old who became looked after in late adolescence as a result of offending behaviour. Her initial health assessment identifies risks in relation to her learning disabilities, aggressive outbursts and misuse of substances.

CAMHS and speech and language (SALT) professionals are working closely with the vulnerable young person's nursing team and children's social care to explore appropriate strategies for helping her understand and take responsibility for her actions.

The SALT assessment has been effective in 'shining a light' on her capacity to concentrate, understand and recall key actions to keep herself safe and reduce her offending behaviour. Her health care plan is appropriately detailed and provides a clear overview of future actions to address risks and improve health outcomes, including her need for ongoing support from adult mental health services.

4.13 The focus on children's emotional and mental wellbeing was limited in some health assessments/care plans seen. Strengths and Difficulties questionnaires or other tools such as the Mental Health Screening Questionnaire Interview for Adolescents (SQUIFA) are not yet being routinely used to inform a holistic picture of the health needs and risks to the wellbeing of some children and young people. (Recommendation 7.1).

4.14 The STARLAC CAMHS service provides a range of individual therapeutic and group work to children with emotional, mental health and behavioural needs. The team accepts direct referrals and ensures children do not have to wait long before they are seen. Its practitioners communicate well with other agencies to promote a consistent and co-ordinated approach in supporting vulnerable young people. Group work is effective in supporting boys and girls to develop safe relationships with peers and others in the community. Participation in these groups is highly valued by young people and their feedback evidences they feel more assertive, confident and empowered as a consequence.

4.15 Training provided by STARLAC to residential care staff is helping to embed approaches to positive behaviour management and build expertise in supporting young people with mental health or emotional difficulties. Levels of activity and outcomes of their work are closely monitored by local commissioners. Outcomes include a reduction in the breakdown of placements. We also saw positive examples of their work that evidenced improvements in helping children cope with loss and change.

4.16 The vulnerability of young people looked after and risks of child sexual exploitation are appropriately recognised and responded to by the LAC nurses. Their work is secured through strong partnership arrangements that seek to divert, prevent and protect young people from being harmed. The lead nurse for LAC is part of the child sexual exploitation steering group and has good links with local CASH services. In one case seen we found the young person's concerns about forced marriage were well-documented and the legal steps she had been supported to take to protect herself were also clear. This denotes good practice to strengthen safeguarding arrangements for young people who are looked after.

4.17 The risks of substance misuse to young people are routinely discussed in review health assessments. It is positive that the latest data in relation to substance misuse by children who have been in care continuously for at least 12 months indicates that in all 20 cases where this had been identified as a risk, all young people have accessed additional support. Case work seen has a clear focus on health promotion including smoking cessation.

4.18 The focus on equality and diversity in LAC health records is not well developed. A high number of records had missing data in relation to the child's faith, ethnicity and language. Health assessments paid scant attention to the impact of the child's culture and identity on their emotional security and wellbeing. We found limited evidence of health assessments or care plans being adapted to promote the understanding and engagement of young people through the development of accessible and young person friendly documentation. (Recommendation 8.5).

4.19 Care leavers are supported until they are 19 by the LAC health nurses. Healthcare summaries are not provided when a young person leaves care, instead they are given a copy of their last health care plan and an updated list of their immunisation status. The service recognises the limits of this practice. Additional resources have been recently secured through an Innovation Bid to scope out what information should be provided to young people when they leave care. This work is being led by young people who have been in care.

Management

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

5.1 Leadership and management

5.1.1 NHS Salford CCG together with local NHS providers and partners has a clear vision and ambition to achieve the highest possible standards of quality and safety within local services. CCG Innovation Bids are supporting new ways of working to continuously improve the quality and impact of local services in shared work to achieve better outcomes for local children and their families. The Safeguarding Clinical Collaborative led by NHS England Area Team provides strong leadership and direction in raising the quality of safeguarding practice and actively supports work to address organisational risk across Greater Manchester.

5.1.2 The local health economy has taken seriously the lessons from the last joint inspection with Ofsted (2010) and good progress is evident in all areas. Areas of learning have included clearer accountabilities for the management of child protection medicals, strengthened use of escalation procedures, and wider engagement of health professionals in child protection case conferences and associated joint planning and review meetings.

5.1.3 The capacity of designated professionals has been reviewed and strengthened. Designated safeguarding and looked after children health professionals have a high presence and demonstrate strong leadership in working with frontline teams. Designated professionals are actively engaged in the work of the Local Safeguarding Children Board (LSCB) and its sub- groups. Regular attendance at the LSCB by senior managers from NHS England and the CCG has not yet been achieved. New arrangements are in progress to strengthen representation in line with the NHS Accountability and Assurance framework (2013). (Recommendation 1.1)

5.1.4 NHS Salford CCG incorporates the LSCB agenda well into the business of its Governing Body. It gives a high priority to checking progress against its own improvement agenda, including learning from serious case reviews (SCRs), child deaths and other serious or untoward incidents. Opportunities for ongoing learning are identified through 'Case of Concern' reviews for those cases that do not meet the SCR threshold.

5.1.5 The role and capacity of the named safeguarding midwife in RBH merits further review. The senior matron for community midwifery services also undertakes the role of the maternity safeguarding lead. We were advised that there is no specific resource allocation for enabling continuous improvement work in relation to quality assurance. Children's safeguarding supervision is not sufficiently robust in driving forward practitioner reflection, setting SMART objectives and improving quality of practice. (Recommendation 9.2).

5.1.6 Health managers and named professionals in provider organisations give a high priority to safeguarding activity and addressing the health needs of children and young people who are looked after. Health visitors have received additional training in attachment and this is driving improvements in the quality of child centred practice on case records seen. The LAC health team is now working to develop a comprehensive health history in consultation with young people to help address some remaining gaps in current practice.

5.1.7 The numbers of GP reports to initial child protection conferences has significantly increased in the last year, with recent performance achieving an 86% submission rate. The deputy designated nurse has played an active role in driving improvement in this area. Her support is highly valued by GPs we spoke to. However, the area does not yet have a named GP as required by the 'Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework' (2013). This means some gaps remain in local safeguarding leadership capacity. Discussions are ongoing between NHS England's Area Team and NHS Salford CCG to find a mutually acceptable model. (Recommendation 1.2).

5.1.8 SRFT pays good attention to seeking and learning from feedback from young people and their families attending hospital and has a young person's patient experience group. Action is being taken to strengthen systems to hear the voice of young people using its community health services. This includes developing 'Talking Mats' and employing new methods for engaging older young people. Young people's views have been actively sought and are being used to inform the review of school nursing services.

5.1.9 The focus on the health inequalities experienced by local children is growing. Health managers in partnership with Salford City Council Public Health are working to develop a comprehensive health profile of the needs of looked after children. This should enable better awareness of and support to young people who require additional support to address areas of risk to their health and wellbeing throughout their childhood. The health needs of all children and young people on paediatric caseloads are also currently being reviewed to inform strengthening of early help and preventative work.

5.1.10 A new council- wide Emotional Health and Mental Wellbeing Strategy has been developed, but it is too early to assess its impact in tackling the relatively high numbers of young people aged 14-19 self- harming who currently present to ED.

5.1.11 SRFT's electronic case management systems are supporting efficient and timely transfer of information between health teams and GPs. It has radically transformed the time taken and processes for managing hospital discharge work. Practice in this area is ahead of what we routinely find in other areas of England. The PANDA unit and emergency department at Salford Royal are in the final stages of implementing their new system for e-management of clinical records. This will address the current remaining gaps in the management of e-alerts about risks to vulnerable children.

5.2 Governance

5.2.1 Local health commissioners and providers make an effective contribution to the priorities of the LSCB and the Children's Trust. Integrated performance reports ensure a clear shared focus on areas of risk and health inequalities experienced by local children. Data collection has been strengthened to enable tighter local scrutiny of rates of hospital admissions for young people presenting with unintentional and deliberate injuries and of levels of MARAC activity involving 16-18 year olds. Performance management activity includes review of waiting times and access to CAMHS and the availability of local support for teenage parents and young people who misuse alcohol or drugs. The findings of S11 audits are well used by NHS Salford CCG to support continuous improvement in safeguarding children arrangements.

5.2.2 NHS Salford CCG and Greater Manchester Area Team have appropriate performance management systems for identifying and tracking outcomes and learning from serious and untoward incidents. This includes incidents where young people may need to be placed on adult wards, including adult mental health wards. Although demand for tier 4 inpatient CAMHS beds has increased, in most cases, appropriate placements are made for young people in crisis, with relatively few instances of young people being placed on adult mental health wards. However, as seen in an earlier section of this report, we were concerned about the length of stay of some of these. The Area Team has commissioned an additional 2 beds in the GMW Junction 17 service and continues to monitor usage to ensure sufficiency of supply and appropriateness of use.

5.2.3 The Area Team in conjunction with Greater Manchester CCGs is currently developing a Safeguarding '*Heatmap*' to provide early warning of safety or poor quality concerns. This should provide an effective model to benchmark the performance of a wide range of local health services and strengthen analysis of trends and learning from safeguarding incidents.

5.2.4 A safeguarding escalation policy and alert system is in place and working well, with few incidents of cases requiring intervention by designated professionals. CAMHS have implemented Risk Assessment Management Meetings to help progress those complex cases where practitioners have concerns about the effectiveness of multi-agency planning in keeping children and young people safe. These meetings are chaired by a CAMHS senior manager and agencies involved with a young person are invited to attend. The purpose of the meeting is to agree a risk management plan and if consensus is not agreed then the case is escalated to the local authority safeguarding unit. This new approach aims to strengthen professional accountabilities and was an area of practice identified for improvement in the last SCR (2010). CAMHS have now introduced a series of key performance indicators and case file audits implemented through supervision arrangements to further strengthen safeguarding children practice.

5.2.5 All GP practices now have a lead GP responsible for safeguarding children. The two GP practices we visited had good arrangements in place to safeguard children and young people. A significant programme of improvement work has been undertaken and is still ongoing to ensure GPs are trained to the required standard and are routinely providing medical reports to child protection case conferences. As highlighted earlier in this report, there remain a few practices where the required standards are not yet being achieved. The deputy designated nurse continues to provide a high level of support to some practices.

5.2.6 The recent maternity review has been effective in evaluating areas where outcomes are not as good as expected. This is helping to drive improved performance in areas such as early booking, breast feeding and mental health support.

5.2.7 Audits are routinely undertaken by local providers to provide assurance on the quality of local services. CMFT has recently audited midwifery practice against its '*Safeguarding Vulnerable Women and Babies*' pathway and is taking action to address areas where the required standards of practice have not been consistently achieved. Audits of domestic abuse and 'hidden males' are also enabling tighter scrutiny of risk and management actions. GMW has invited external audit of its safeguarding children and vulnerable adult arrangements and is strengthening its focus on domestic abuse in the light of lessons learned from a domestic homicide review.

5.2.8 Learning from audits and inspection is proactively managed with strong leadership from senior clinicians in SRFT. This approach has been effective in continuously driving improvement in the quality and culture of SRFT paediatric services. Action has been taken to improve the quality of child protection medicals and ensure full developmental health checks of all under 5's. Improvements have been made in the dissemination of discharge information to all relevant professionals and parents/young people as appropriate.

5.2.9 Since the last Trust inspection by CQC in October 2013, the paediatric directorate has taken action to review and update all its policies and procedures and ensure information is more accessible to the public. The PANDA unit has enhanced the range of activities and equipment suitable to help occupy older children and adolescents.

5.2.10 However, further work is required to establish a comprehensive quality assurance framework for looked after children and to embed the focus on child health outcomes. Whilst the lead LAC nurse routinely reviews assessments for all children placed out of Salford area, this does not extend to reviewing assessments carried out by practitioners for children living within the Salford City Council area. The health files for the older children transferred to the LAC nurses were difficult to navigate and did not contain chronologies. As identified in an earlier section of this report, some review health assessments were episodic in nature and did not reflect the child's health journey. Issues around emotional health and wellbeing were not always explored thoroughly and from cases seen we found limited progress in embedding SQUIFA or CSE screening tools to inform subsequent reviews or transition planning. (Recommendation 8.6).

5.2.11 The contract specification for SRFT's LAC health service is out of date and does not reflect recent national strategies or evidence based work with children and local health commissioning arrangements. Commissioners are now working to ensure the revised specification provides clearer measures and accountabilities to support evaluation of the effectiveness of local arrangements. (Recommendation 6.1)

5.3 Training and Supervision

5.3.1 Safeguarding children training is recognised as a core element in the delivery of high quality and safe services. Most health staff have the required levels of training in line with inter- collegiate professional standards and keep up to date with changing professional practice.

5.3.2 GMW's safeguarding team has developed bespoke safeguarding training for the substance misuse team and the mental health team to promote the "*Think Family*" agenda when working with adult clients. Although the training is badged at Level 2, the competencies are taken from Level 3 of the intercollegiate guidance. Substance misuse practitioners are also encouraged to attend the Level 3 LSCB training. Training figures provided by GMW on safeguarding children training demonstrated a compliance rate of 84% in Salford Substance Misuse Services and 75% in Salford Adult Mental Health. Coverage of safeguarding children training in adult mental health does not yet meet the 80% target set by CQC. (Recommendation 10.2).

5.3.3 LAC nurses provide training on the health needs of looked after children as part of the mandatory safeguarding children training. This helps to promote understanding of the specific vulnerabilities of children looked after within health services.

5.3.4 PANDA has a comprehensive and proactive approach to individual and team development, including learning from research. The designated doctor for safeguarding children facilitates bi-monthly safeguarding peer review meetings within the paediatric (PANDA) department. Monthly peer review meetings with community paediatric staff have recently been established to further strengthen safeguarding support and learning. These approaches are helping to reinforce practice standards including vigilance in assessing injuries to infants who are not yet mobile.

5.3.5 Attendance by all clinicians involved in safeguarding children work is expected and written into their job plans. Positively these meetings include representation from children's social care which supports strong information sharing and partnership working. However, peer review arrangements within the adult ED take place on an 'ad-hoc' basis rather than via regular, structured, pre-planned meetings. Regular review would enable adult ED staff to share knowledge and experience about cases they work with, and better inform them about how best to protect children and young people who either attend the department or are at risk of remaining invisible at home. (Recommendation 8.8).

5.3.6 Safeguarding supervision in community health services for children on child protection plans is well managed and secured through a clear model of learning from research, analysis of risk and supportive management direction. Records seen provide a clear picture of checks of the quality and impact of interventions and the achievement of professional accountabilities. Newly qualified health visitors are well supported in working with complex families through a programme of peer support, mentoring and assessment of safeguarding competencies. However, the focus on children looked after is not so well developed and would benefit from further scrutiny to address some of the variability in quality of health care assessments and plans and provide a stronger audit trail to evidence outcomes are improving (Recommendation 8.7).

5.3.7 Action has been taken to strengthen supervision arrangements in midwifery services in CMFT and structured group supervision is now in place for community midwives. The Trust also holds a monthly neonatal forum to look at cases that may require escalation to the specialist midwives and supports learning from research. The quality of supervision in RBHT is not sufficiently challenging and its impact in driving improvements in quality is not sufficiently well-evidenced. (Recommendation 9.2).

5.3.8 Substance misuse practitioners receive safeguarding children supervision as part of their line management supervision, though the supervisors have not received accredited or recognised training in delivering child protection supervision (Recommendation 10.3).

Recommendations

1. NHS Salford together with NHS England Area Team should:

- 1.1 Ensure strong attendance from senior NHS commissioning managers to support the work of the LSCB.
- 1.2 Ensure a named GP is appointed to further strengthen primary care leadership capacity in Salford.
- 1.3 Ensure all GP practices achieve the required standards of performance in safeguarding children.

2. NHS Salford and NHS England Area Team together with SRFT should:

- 2.1 Ensure all GP practices are fully aware of their roles and responsibilities in relation to children who are looked after, that they are kept informed about changes to the legal status of children, and that their contact with young people and their carers positively informs health assessments and health care plans.

3. NHS Salford CCG together with SRFT, CMFT, RBHT and GMW should:

- 3.1 Improve their understanding of the health needs of new minority ethnic groups coming to live in the area and ensure they are able to make appropriate use of local health services.

4. NHS Salford and NHS England Area team together with SRFT, CMFT and GMW should:

- 4.1 Ensure clear shared pathways of care underpin support for young people who present at the adult Emergency Department with self-harming behaviours with effective follow up to reduce the risk of further attendances.
- 4.2 Further review the capacity of CAMHS community and inpatient paediatric services to prevent young people being placed on adult mental health wards.

5. NHS Salford CCG together with CMFT and RBHT should:

- 5.1 Ensure joint working arrangements effectively keep women and their babies at the centre of service delivery and that information sharing and inter-agency accountabilities are clear and well-observed in practice.

6. NHS Salford CCG together with SRFT should:

- 6.1 Develop a clear and comprehensive contract specification and standards for the delivery of the LAC health service to support high quality evidenced based work.

7. SRFT together with CMFT should:

- 7.1 Ensure health assessments and care plans are appropriately informed by an awareness of young people's emotional and mental health needs.

8. SRFT should:

- 8.1 Ensure referrals to children's social care made by its adult Emergency Department provide a clear picture of concerns identified in relation to vulnerable young people or families.
- 8.2 Ensure all young people who are looked after are asked for their consent prior to undertaking their health review if they are of age and have capacity to make decisions for themselves.
- 8.3 Ensure initial health assessments of older children provide clear and comprehensive details of the range and complexity of their needs.
- 8.4 Ensure review health assessments fully consider risks to the health and wellbeing of children who are looked after and evaluate the extent to which planned improvements in their health outcomes have been achieved.
- 8.5 Provide clear records of children's faith, ethnicity and language and ensure health assessments for children who are looked after pay good attention to the impact of the child's culture and identity on their emotional security and wellbeing.
- 8.6 Implement a comprehensive quality assurance framework for children who are looked after and care leavers to secure a strong focus on child health outcomes.
- 8.7 Strengthen arrangements for the supervision of staff involved in LAC health work to secure a consistently high standard of practice.

8.8 Ensure its clinicians and nursing staff in the adult Emergency Department have regular access to peer review to support their work in safeguarding vulnerable adults and children.

9. RBHT should:

9.1 Ensure the quality of its maternity records fully achieve Nursing and Midwifery Council standards with effective use made of chronologies and social histories, with retention of child protection documentation to inform ongoing analysis of risk.

9.2 Review the role and capacity of the named safeguarding midwife to support essential continuous improvement work in areas such as quality assurance and safeguarding children supervision.

10. GMW should:

10.1 Ensure its mental health and substance misuse practitioners complete the STAR risk assessment tool in all cases where there are concerns about risk of harm to children.

10.2 Ensure it fully meets CQC safeguarding children training targets.

10.3 Ensure line managers of substance misuse and adult mental health teams receive additional training in safeguarding children.

Next Steps

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

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