

Review of health services for Children Looked-after and Safeguarding in Manchester

Children Looked-after and Safeguarding The role of health services in Manchester

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Provider services included:	<ul style="list-style-type: none"> • Manchester University NHS Foundation Trust - at the time of the inspection this single provider was two separate bodies known as: <ul style="list-style-type: none"> ○ Central Manchester University Hospitals NHS Foundation Trust ○ University Hospital of South Manchester NHS Foundation Trust • Pennine Acute Hospitals NHS Trust • Greater Manchester Mental Health NHS Foundation Trust • Change Grow Live
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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 Manchester. 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 NHS England regional teams.

Where the findings relate to children and families in local authority areas other than Manchester, 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 2015.

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. It also included some cases where children and families were not referred, but where they were assessed as needing early help that they received from health services. We also sampled a number 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 161 children and young people.

Context of the review

The latest published information from the Child and Maternal Health Observatory are those from March 2017. These figures are published by Public Health England and are used to set the context for the area.

The data shows that children and young people under the age of 20 make up 25.6% of the population of Manchester, with 60.9% of school age children from a minority ethnic group. Generally, the data indicates that the health of children in Manchester is not as good as the rest of England with most of the attributes measured being significantly worse than England; some of these are summarised below. For example, the rates of immunisations for all children are lower for both the MMR and the 5-in-1 vaccinations at 88.4% (compared with the England rate of 91.9%) and 94.3% (compared with 95.2%) respectively. However the rate of immunisations for children in care is significantly better at 91.3% as compared with 87.2% for England.

Family homelessness is significantly higher than the rest of England at 2.6, as opposed to 1.9 for every 1,000 families. The proportion of children living in low income families is also significantly higher, at 35.6%, than the England average at 20%. The number of children in care is also significantly greater than England with 105, as opposed to 60 per 10,000.

The infant (aged 0 to 1 year) mortality rate is greater than the England average with 5.1 per 1,000 live births. The child (aged 1 to 17 years) mortality rate is slightly higher than the rest of England at 15.9 per 100,000.

More babies in Manchester have low birth weights than in the rest of England (3.3% compared with 2.8%) and there are more children aged 4-5 years with obesity (11.4% compared with 9.3%). This data is more pronounced for children with obesity aged 10-11 years where the rate is 25.1% compared with 19.8%.

Children's dental health is also significantly worse than the rest of England with 32.7% of children having one or more decayed, missing or filled teeth compared to 24.8% for England. There are around one-and-a-half times the number of hospital admission of children aged 0-4 with dental caries that in the rest of England.

Under 18 conceptions are higher than average at 28.8 for every 1,000 pregnancies as opposed to 20.8 for England whilst the rate of teenaged mothers is also higher at 1.1% compared with 0.9%. There are 11.6% of new mothers who smoke at the time of delivery compared with 10.6% on average elsewhere.

Hospital admissions for young people under 18 with alcohol related conditions are around 48 for every 100,000 compared to around 37 for England. This figure is less pronounced but still higher for young people aged 15-24 admitted due to substance misuse where 106 for 100,000 admissions compares with 95 for England.

Hospital emergency department (ED) attendances for young children aged 0-4 years is worse than England at 825, as opposed to 588 for every 1,000 attendances. This is also the case for attendances of children aged 0-14 with injuries at 175 for every 10,000 compared with 104 for England. However, admissions for young people aged 15-24 with injuries are fewer at 106 for every 10,000 compared with 134 for England.

There are fewer young people admitted to hospital with mental health conditions; this is at 80 for every 100,000 compared with 86 for England. Whereas those admissions for young people aged over 10 years through self-harm are significantly less than England at 296 for every 100,000 compared with 430 for England.

The Department for Education (DfE) provide annual statistics derived from outcomes for children continuously looked-after. As at March 2016, Manchester had 975 children who had been continuously looked-after for more than 12 months (excluding those children in respite care), 95 of whom were aged under five.

The DfE data indicates that a greater proportion of Manchester's looked-after children (91.3%) had an annual health assessment than the rest of England (90%). The data also shows that 91.3% of looked-after children were up-to-date with their immunisations, better than England with 87%. There were 98.5% of looked after children who had received a dental check compared with 84% in England as a whole. Further, 94.7% of the looked-after children aged under five had received an up-to-date development assessment, better than the 83% for the rest of England.

The commissioning of health services for children and young people in Manchester, including children looked after, at the time of our inspection was straightforward with most services commissioned by one integrated body known as Manchester Health and Care Commissioning (MHCC), an amalgamation of NHS Manchester CCG and Manchester City Council public health and social care commissioners.

Acute services are provided in the north of the city at North Manchester General Hospital by Pennine Acute Hospital NHS Trust (PAT).

At the time of our inspection acute services in most of the south and central Manchester were provided by two separate providers, Central Manchester University Hospitals NHS Foundation Trust and University Hospital of South Manchester NHS Foundation Trust. However, since that time these providers have merged to form a single entity, Manchester University NHS Foundation Trust (MFT). For the purposes of this report, and to avoid confusion, we will refer to the names of the hospital sites where we carried out visits; Wythenshawe Hospital, Manchester Royal Infirmary, St Mary's Hospital and Royal Manchester Children's Hospital. Our recommendations at the end of this report reflect the name of the newly formed acute provider, MFT.

Specialist health services for looked after children and community health services for children and families (health visiting and school nursing), were provided by Central Manchester University Hospitals NHS Foundation Trust at the time of our inspection but are now provided by the newly formed provider, MFT.

Child and adolescent mental health services (CAMHS), including those for looked after children, were also provided by Central Manchester University Hospitals NHS Foundation Trust but are now provided by the newly formed provider, MFT. There are also a number of independent and voluntary providers that deliver interventions for young people that we did not visit as part of our review.

Mental health services for adults are provided by Greater Manchester Mental Health Foundation Trust (GMMH) and a range of third sector, voluntary sector and independent providers that we did not visit during our review.

Integrated contraception and sexual health services are provided by MFT. Both the adult substance misuse service and the children's substance misuse service are provided by Change Grow Live (CGL).

The last inspection of safeguarding and looked-after children's services for Manchester involving health services took place in November 2010; a joint inspection with Ofsted. Then, the effectiveness of arrangements for safeguarding children were judged to be 'adequate' as were those for looked-after children, with an overall capacity of the council and its partners to improve rated as 'good'. Provider recommendations from that inspection were considered during this review.

Ofsted carried out an inspection of the local authority and the safeguarding children board in June 2014. Both were judged to be inadequate.

Greater Manchester Mental Health NHS Foundation Trust was inspected by the CQC in February 2016. The trust was given an overall rating of good.

Pennine Acute NHS Trust was inspected by the CQC in August 2016 and was rated as inadequate. Specifically the North Manchester General Hospital which serves the northern area of the city of Manchester was rated as inadequate overall with both the maternity and emergency department also rated as inadequate.

University Hospital of South Manchester NHS Foundation Trust was inspected by the CQC in January 2016 and was rated overall as requires improvement. The maternity and emergency departments were also rated as requires improvement.

Central Manchester University Hospitals NHS Foundation Trust was inspected by the CQC in November 2015. The trust was rated overall as good. The child and adolescent mental health wards and specialist community mental health services for children and young people were both given an outstanding rating; community health services for children, young people and families was rated as requires improvement. The urgent and emergency services (which include both the adult ED at Manchester Royal Infirmary and children's ED at the Royal Manchester Children's Hospital) were rated collectively as requires improvement whilst maternity and gynaecology services (including St Mary's Maternity Hospital) were rated as good.

Health services in Manchester follow the Manchester Safeguarding Children Board (MSCB) procedures. These are part of the procedures produced through the Greater Manchester Safeguarding Partnership (GMSP), a collaboration with other local authorities in Greater Manchester.

Referrals are made for children and young people according to their level of need. There are five, overlapping levels described by the MSCB guidance (Multi-Agency Levels of Need and Response Framework) where needs are met by:

- universal services;
- additional services provided by a single agency;
- a co-ordinated, multi-agency programme of support;
- intensive and co-ordinated support for complex issues;
- more acute intervention for high need or significant harm.

For children who require support that cannot be delivered on a single agency basis, referrals are made on a 'Request for Early Help Support' form direct to one of the three Early Help hubs. Where more complex or significant concerns are identified, referrals are made to Manchester's multi-agency safeguarding hub (MASH) using a 'Request for Social Work Support' form. Both forms use the well-established 'Signs of Safety' model to help practitioners think about and present their concerns. We have used the term 'referral' interchangeably throughout this report to describe the processes used by health practitioners to request additional help and support.

This final contextual note reflects the fact that this inspection took place just over two months after the terrorist incident at Manchester Arena on 22 May 2017 when 22 people were killed, 10 of them children and young people under 20. The three hospital sites involved in this inspection were at the forefront of the city's major incident response on that day and staff received, and treated many people for serious, traumatic injuries and dealt with many enquiries from grieving or distressed relatives. Some of those injured patients have remained in hospital for an extended period whilst others will continue to receive ongoing care. This unprecedented level of trauma has had significant emotional impact on children, families and staff. Much has been publicised about the professionalism, dedication and humanity of front line health staff. The inspection team concurs fully with those sentiments and wishes to formally acknowledge the good grace and courtesy in which the inspection team were received at a time when staff were still feeling the impact of this event.

The report

This report follows the child's journey reflecting the experiences of children and young people or parents or 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

We spoke with a number of young people and parents or carers.

The father of a five year old patient on the paediatric ward at North Manchester General Hospital told us he was happy with the care given and had felt involved in care planning. The family's experience of the admission process had been positive.

The mother of a boy who had had repeated admissions to the children's ward at North Manchester General Hospital due to a long term condition said:

"I definitely feel listened to. I have built up good relationships with the staff and they trust what I am saying, which is important to us... the new management are definitely improving things here."

A young female patient on the paediatric ward at Wythenshawe Hospital who needed some high dependency care due to a long term condition told us:

"They listen and sort things out quickly... the nurses make me feel welcome ... they are starting to talk about my transition, it's a bit scary but I feel involved."

A mother and maternal grandmother of a 12 week old baby reported:

"The quality and speed of treatment and care is very good... I have been kept informed of what's going on... People should know how much they care here."

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 Commonly, throughout our visits to services in Manchester, we saw a strong focus on preventative and early intervention work. This is enhanced by consistent and effective use of a model of assessment and planning that enables practitioners to build on strengths to plan interventions. This 'Signs of Safety' model, supports staff to be child focussed and outcome driven in their work and is in use in most services we visited. Cases we looked at demonstrated that health interventions for early help are relevant, meaningful and have a greater chance of success. This is a systemic strength in the city's health services' approach to early help.

1.2 We noted some variation at all three hospitals in Manchester in the effectiveness of information sharing between maternity services and other health disciplines or other agencies. For example, maternity cases we looked at in the Wythenshawe Hospital showed regular and effective information sharing with a range of partners such as health visitors, GPs and children's social care in particular. This also included good liaison with the hospital's emergency department (ED) so that mothers who present there are promptly reviewed by the midwifery triage service. These arrangements help to promote a shared approach to the early identification and management of additional needs and risks. Furthermore, midwives check and proactively track women who move between neighbouring council areas and social work teams (Stockport, Trafford and Cheshire East) and this enables good continuity of care.

1.3 Senior managers at North Manchester General Hospital, however, recognise that clinical pathways and joint working between ED and midwifery are an area to strengthen to ensure timely communication between hospital teams when pregnant women present in ED. Work by the midwives to embed early warning scores as routine practice could be shared to help promote joint approaches to the identification of additional needs and risk in such cases. [**Recommendation 2.1**](#).

1.4 Nonetheless, there are good early help opportunities arising from the North Manchester General Hospital maternity offer, with women's pregnancies being routinely booked at home and with good post-natal support. This approach by Pennine Acute Hospitals NHS Trust (PAT) recognises the challenges faced by many local women and enables the development of relationships and easy access to advice and support at all stages of the pregnancy and beyond.

1.5 Midwives in Wythenshawe Hospital and in St Mary's Hospital have read-only access to Manchester City Council's children's social care records. In the case of St Mary's, we noted that midwives can add messages to the system and this encourages good joint work for women with additional needs and unborn babies.

1.6 The timely identification of additional needs and concerns is evident in St Mary's Hospital with clear pathways for mothers who require enhanced support. Care is responsive to the unique needs of each mother and baby and we saw good examples of regular and thorough assessments of maternal mental health, recognition of capacity to consent and reasonable adjustments for mothers with a learning disability. Midwives recognise the importance of good engagement with women and their families and there are appropriate systems in place for prompt follow up of those who do not attend appointments.

Female Genital Mutilation (FGM) – Good practice by Midwives

Arrangements for the identification and support for women and girls who have experienced, or are at risk of, female genital mutilation (FGM) are managed with cultural sensitivity by midwives at all three hospitals. At St Mary's Hospital for example, a clear pathway is in place that describes how to explore, with the woman, information about her cultural customs and the risks to her unborn child and other children within the family. Strong record keeping showed that information is appropriately shared with other relevant agencies and teams.

Good links between St Mary's midwives and social care have resulted in a number of FGM protection orders being successfully sought. Independent Domestic Violence Advisers (IDVA) work closely with midwives to support and advise young women who have been victims of FGM. Joint work with charities, such as AFRUCA (Africans unite against child abuse) helps to raise awareness and to support local families in understanding the need for safeguarding.

For example, a pregnant teenager disclosed that both she and a sister had experienced FGM whilst the youngest girls in the family had not. Through liaison with children's social care and external agencies, early action was taken to work with, and raise awareness among the family and prevent the younger girls in the family being exposed to this.

1.7 We noted generally good examples of information sharing between midwives at all three hospitals and health visitors. However, the ante-natal referral pathway is not always as effective, timely or consistent from St Mary's Hospital or North Manchester General Hospital. The point at which the health visitor becomes aware of a woman's pregnancy can be delayed in a small number of cases and this limits the opportunities for timely assessment of the child and family's health needs. For example, in one case we were tracking across services, a referral was made to children's social care when the woman was 28 weeks pregnant, yet health visitors did not become aware until she had reached 34 weeks. The baby was born at 36 weeks and so there was limited opportunity for health visitors to contribute to any cohesive multi-agency planning in advance of her discharge. Leaders are aware of this and the issue is on the Manchester University NHS Foundation Trust (MFT) risk register; however, the extent of the issue is not well understood because of limited performance data relating to the ante-natal contact. [Recommendation 1.1](#).

1.8 Children’s public health nursing services (health visitors and school health nurses) in Manchester are good contributors to early help assessment, planning and interventions with effective participation in ‘team around the child’ work. Practitioners work well with other agencies, either as providers of particular interventions or as lead professionals. This illustrates a strong focus on preventative and early intervention work that builds on the strengths of the family, supports continuity of care for families who move between different safeguarding thresholds and enables the effectiveness of interventions for families to be better understood. Some examples of this work are set out below.

1.9 Health visitors complete meaningful and holistic ante-natal contacts when made aware of pregnancies. Health visitors use ‘Promotional Guides’ to support clients in recognising their needs during ante-natal contact, which means that assessments can be client led. In one case we looked at, a client was pregnant with her eighth child, the first of her children to be born in the UK. Through the use of promotional guides, she chose to discuss with the health visitor worries about her pregnancy and her relationship with the baby’s father. Her concerns about her significant mental health history were effectively understood and addressed through an affective post-natal plan that was well understood by the client. We saw that the use of the guides at the ante-natal contact also supported father’s inclusion at the birth and allowed him to have a voice and think about life for the new-born child.

Good practice – Early Help for young families

Young children in Manchester benefit from two specialist services that co-ordinate additional support. The ‘vulnerable babies’ service, staffed by midwives and health visitors is aimed at providing support during the ante-natal and post-natal period; the ‘specialist case planning’ service is staffed by health visitors and aimed at older babies and children up to the age of five.

These services provide focused co-ordination of multi-agency staff involved with families, as well as challenge to practitioners if required. As a result, health based early help interventions are less inclined to drift and have clear direction with which to hold practitioners to account. The co-ordination role also frees up health visitors’ time for front line work with families.

Records we reviewed and discussions with health visitors demonstrated strong multi-agency and multi-disciplinary working on an individual case level. This supports appropriate information sharing and the reduction in families having to ‘tell their story’ to different practitioners each time.

1.10 Vulnerable children of school age in Manchester benefit from the vulnerable school children’s team provided as part of the school health nursing service. We have reported on this in more detail under ‘Child Protection’ below. The school health nursing service also successfully operates the ‘chat health’ facility; a text messaging service that provides young people with access to a health practitioner without the need for face-to-face contact. This is frequently used and ensures that young people in Manchester, particularly those who might otherwise be difficult to engage, have access to advice and guidance on a range of health issues.

1.11 MFT employ a dedicated 'specialist nurse community paediatrics' for the whole of Manchester. The nurse supports families of children with complex conditions or disabilities and families from abroad, often acting as lead professional and coordinating 'team around the child' work. There are strong links with specialist health visitors, school health nurses and early help hubs. This ensures vulnerable young people with complex needs get good access to relevant early help services.

1.12 There is a broad CAMHS offer in Manchester covering a range of areas with clear pathways into the service (except see below in relation to GP referrals). There is an effective screening system through a single point of access and 'duty' clinicians with clear, daily sorting and allocation according to urgency, followed by weekly, multi-disciplinary discussion. We highlight the '2 plus 1' facility, which enables up to three short assessment and intervention contacts for children with needs that are not easily identifiable. This careful consideration and emphasis on early intervention means young people are not hastily turned away or signposted to a service that may not meet their needs. We learned that this has been successful in preventing escalation into more specialist services with data showing that 70% of young people using the facility are discharged, requiring no further CAMHS intervention.

Good practice – the 'Child and Parent' service

The 'Child and Parent' service (CAP) offered by the CAMHS enables multi-disciplinary, holistic support for very young children aged 0-5 and their parents.

In one of the cases we were tracking across services, safeguarding concerns were raised about physical chastisement by a parent of a child who was using the services of the CAP team. The parent of the child had been proactive in accessing support from CAP and from her GP for her low mood. A prompt, detailed referral was made to social care and to peri-natal mental health services. Information was also shared with the child's health visitor and head of the children's centre. This enabled professionals to provide the family with holistic, multi-agency wrap-around support through 'team around the child' work.

The child's mother was involved throughout as a partner in decision making so that interventions were meaningful and effective. Consideration was also given to other, older children in the family and to their needs and potential risks and this demonstrated a 'whole family' approach that led to positive outcomes.

1.13 Children and young people up to the age of 18 attending any of the children's or adult's EDs at the three hospital sites with drug or alcohol linked conditions can be referred to 'Eclipse'. This is a local facility provided by Change Grow Live offering a confidential drug and alcohol service for young people under 19 and their families (see also below). If the young person declines a referral a safeguarding alert to children's social care is initiated. This recognises the increased risk to the young person through drug and alcohol misuse.

1.14 The use of templated documentation to support effective safeguarding risk assessment when booking-in patients at the children's and adult's EDs at all three hospital sites is underdeveloped. This is generally the case for records used for children who might have additional, otherwise unidentified needs or risks and for adult patients exhibiting behaviour that might have an impact on children they care for or have contact with. Some examples are below.

1.15 The booking-in documentation for children in the ED at North Manchester General Hospital facilitates the recording of social and family history. However nine of the ten records we looked at did not have this section fully completed and there was little further evidence to suggest the practitioner who saw the child was professionally curious about it. We were advised that there is variability in the extent of the completion of this document between different members of the medical team (see also below in 'Child Protection'). This inhibits the practitioner's ability to consider any additional needs or identify risks arising from the child's social or family situation and there is potential for such needs to be overlooked. [Recommendation 2.2](#).

1.16 This limited professional curiosity was also apparent in the records of adult patients in the North Manchester General Hospital ED. We did not see evidence that practitioners had considered children that might be at risk of a presenting adult's behaviour. The ED documentation does not contain prompts to support practitioners to identify a patient's parental or carer responsibilities. Six of the seven records we looked at showed that the practitioner had not noted any social history, whereas a number of these attendances related to adult behaviour that could impact on children (substance and alcohol misuse and potential violence). [Recommendation 2.3](#).

1.17 The triage room at North Manchester General Hospital does not enable observation of children in the waiting area and is away from the main nurses' station. Observation is intermittent which limits opportunities to check on a deteriorating child or the interaction between children and their parents. [Recommendation 2.7](#).

1.18 Staff at Wythenshawe Hospital ED use separate booking-in documentation for children and adults and the structure and format of the paperwork recognises safeguarding risks. The children's record includes a five question safeguarding screening tool and a section to record the professionals known to the child. The adult record also includes a safeguarding checklist for young people aged 16 and over that are seen within the adult ED.

1.19 Although this recording facility is intended to prompt staff to ask further questions and explore any additional needs or risks, this practice was not consistently evident in the records we looked at in Wythenshawe. Of the ten children's records we sampled during our visit, seven of these did not have the safeguarding prompts completed. Further, in the records of two 17 year-old young people we looked at we found that further exploration ought to have resulted in additional action being taken to ensure their particular additional needs were met and any safeguarding risks identified. This demonstrates that staff are not clear about the importance of considering these aspects of a child's situation; this restricts their ability to assess and respond effectively to needs. [Recommendation 3.1](#).

1.20 The format of children's booking-in documentation at Royal Manchester Children's Hospital does not support practitioners to make a consistent assessment of additional needs or safeguarding risks. The record asks practitioners to signify 'yes' or 'no' at triage stage as to whether any safeguarding concerns have been identified. The rationale for this decision is not part of the document and managers we spoke with acknowledge there could be inconsistencies in the decision making process. In two of the records we reviewed, safeguarding concerns were evident but they had not been recognised as such by practitioners. [Recommendation 3.2.](#)

1.21 Our review of adult's records in the ED at Manchester Royal Infirmary shows that understanding of a patient's parenting responsibilities or significant involvement with children is variable. The templated records do not contain prompts to support this line of enquiry; this level of understanding relies on staff being curious when patients have particular presentations such as substance misuse or mental ill-health. Staff we spoke with showed good understanding of the impact of such behaviours on children but this was not evident in records. There is a risk that needs of children who might be affected might be overlooked. [Recommendation 3.3.](#)

1.22 The arrangements for alerting staff to vulnerable children require strengthening in the electronic patient record systems used in all three children's EDs. For instance, the Child Protection Information System (CP-IS) had not been fully implemented in Manchester at the time of our review. Only North Manchester General Hospital had access to CP-IS but only for children living in other local authority areas. There is currently no other satisfactory means of alerting staff to children subject of a child protection or child in need plan, those who are looked after or children with any other safeguarding concerns. Whilst the providers' safeguarding teams have access to the Manchester City Council's children's social care records system this facility is only available during weekday office hours. Practitioners at all three hospital sites reported that this can be effective but time-consuming.

1.23 The providers are aware of the limitations of their current electronic systems and we have been advised that progress is being made towards improvements in the way such information or alerts are made available to staff at each site. However, practitioners in the three busy children's EDs are currently unsighted on key information that would support effective safeguarding assessment. Currently, such assessment relies on the nursing staff or examining clinician directing questions about social history to adults who accompany children, and as we have explained above, this practice is not well developed. [Recommendation 1.2.](#)

1.24 Arrangements for sharing information with children's public health nursing teams require development at Wythenshawe and Royal Manchester Children's Hospital ED. Community practitioners, including GPs are alerted to a child's attendance at ED by electronic transfer of information. However, the information describing the circumstances of the child's attendance is limited in detail. There is no additional managerial or clinical scrutiny of records of children's attendances at either hospital; this would determine whether information about any child who should have been subject to a formal referral to universal services has been properly passed on.

1.25 At Wythenshawe, for instance, we identified records that would have benefitted from this oversight to ensure early information sharing with community colleagues. At Royal Manchester Children's Hospital the process relies on one of the nurses who saw the child separating the record from others to enable a telephone call to be made the next day to community teams. In one record we looked at we were not assured that information had been shared with community practitioners as a number of 'no response' calls had been made so it was unclear if the child's needs would have effectively been met. [Recommendation 3.4](#).

1.26 GPs told us of variability in discharge notifications received from the children's EDs at all three hospital sites. The named GP told us that ED discharge letters are often standardised and do not clearly set out additional needs and risks and how these were identified. This means that GPs are not in receipt of important information that would enable them to better support young patients who might be at risk or require additional help within the community. [Recommendation 1.3](#).

1.27 In most cases, a 'Think Family' approach is effectively embedded in practice in the adult mental health service. During our review of cases we noted a number of examples where the child was prominent in the thinking of practitioners. This is facilitated by the Manchester Care Assessment Schedule (MANCAS), the tool used to assess a range of social and health aspects of a client's history and presentation, which includes a safeguarding children assessment. Practitioners consider the impact of a person's mental ill-health on any child in the service user's household or with whom they have contact in their social network. Staff are prompted to think about risks, strengths and whether the client is known to other agencies. We noted this was used well in some of the cases we sampled where there was an emphasis on partnership working. This is supported by 'event records' and 'special notes' on the clients electronic record that have key information to alert practitioners to the involvement of other agencies and with their contact details overtly displayed. We found evidence of good multi-agency work at each of the levels of need including attendance at child protection conferences and core groups as well as 'team around the child' meetings. This helps partners to tailor interventions to take account of the mental health of significant adults in a child's life.

1.28 The otherwise good practice and intent in this area is hampered by difficulties in using paper records alongside an electronic system in the adult service. In a number of cases we looked at we saw that paper records, such as referral forms, had not been faithfully copied or uploaded to the electronic record. One of the cases we were tracking across services, a woman with a baby in the mother and baby unit located at Laureate House near Wythenshawe hospital, demonstrates this shortfall. The records were focussed heavily on the mother's assessment and her needs as the patient. The child was not prominent in the very detailed case records with limited evidence of the baby's needs or impact of the mother's mental health. We did not see the mother's and the baby's paper records that were held in the unit but have been assured they have more information to enable staff to manage the child's needs.

1.29 This highlights the issue of reconciling paper and electronic records with staff being unclear about how they should use each. We are advised that this issue is held on the trust's risk register but in the meantime the lack of a single reference point does not support staff to have a clear picture of the impact of an adult's mental ill-health on a child. [Recommendation 4.1](#) and [recommendation 6.1](#).

1.30 There is a well-established substance misuse service that operates from three hubs across the city. The service provider, Change Grow Live, has also recently begun to provide the 'Eclipse' service for young people. This new integrated approach to the adult's and young people's services means that a family's needs can be considered holistically.

1.31 For example, as well as working with young people who misuse substances, the 'Eclipse' service also provides 'hidden harm' one-to-one early intervention support for children who are directly affected by parental substance misuse. The adult service makes regular referrals so that the children of adult service users can access support. This results in such children being provided with a safe space to make safeguarding disclosures and to explore their own attitudes and beliefs to substance misusing behaviour.

1.32 Staff in the substance misuse service carry out home visit risk assessments where it is identified that there are children living with a service user. This is also the case where children are regularly attending the address where the service user resides and this is good practice. A standardised assessment form takes account of the home conditions, the suitability of the environment for children and the safety of storage arrangements for medicines and equipment such as needles. Staff reported that this assessment has enabled them to better understand a family's needs and to consider, for example, when children might be at risk of abuse and neglect.

1.33 There was variation in the extent of record keeping in the substance misuse service. The electronic client record system in the service enables practitioners to record safeguarding concerns through templated data entries. However, in some of the cases we reviewed, the system had not been appropriately utilised to robustly record concerns with many gaps in information about children. The absence of key information does not support practitioners to 'Think Family' and to make good risk based decisions. [Recommendation 8.1](#).

1.34 The cases of young adults who are identified as needing support for substance misuse after the age of 18 are individually reviewed. Their needs, risks and vulnerabilities are assessed, with the involvement of the young adult, and a decision made about where the young person is best placed to receive continuing treatment, whether through the adult part of the service or to continue through 'Eclipse'. Although no transitional pathway is yet in place due to services only recently becoming integrated, this offer enables young people to be routinely treated in a young person appropriate service at age 18 and above. This is beneficial as it supports and safeguards those young people that might be highly vulnerable and at potential risk of exploitation or undue influence from adult service users.

1.35 Children and young people can access a fully integrated contraception and sexual health service in a range of locations across the city. The service has positively used the recent integration of the services to enhance the offer and thereby opportunities to identify young people with particular needs who could benefit from additional support. Dedicated clinics are available for young people under 25, including at weekends. School health nurses work closely with sexual health practitioners to provide clinics in settings outside of the high school. This means that young people are provided with more choice as to how and where to obtain sexual health advice and support. The dedicated outreach team consisting of both clinical and educational practitioners enables harder to reach children and young people to have access to services over and above the mainstream, clinic based, sexual health service.

Good practice – sexual health outreach for homeless young men

The outreach sexual health team work flexibly with individual young people and groups, which improves engagement and better sexual health outcomes.

The team are proactive in engaging with homeless teenaged boys and young male adults through the provision of street football activity. An independent evaluation of this initiative shows evidence of improved outcomes for this vulnerable group of young men.

1.36 The electronic patient record system used in the sexual health service helps practitioners to assess and identify risks to young people under 18 at each presentation. This information is visible and considered by practitioners in all clinics that the person might attend, to ensure they can tailor the consultation accordingly.

1.37 There is a lack of understanding among GPs about the roles and responsibilities of multi-disciplinary and multi-agency partners. GPs we spoke with told us that they were not clear about the thresholds for referral into early help and to CAMHS. The named GP told us that GPs rarely make referrals to the early help hub but that referrals are often made to CAMHS but then declined. This lack of clarity can lead to delay in children and young people receiving the most appropriate support.

[Recommendation 7.1.](#)

1.38 In some GP practices we visited we learned of a bespoke service known as a 'focussed care worker' whose role is to provide additional support to individual children and young people and families where additional risk was identified. This includes support for a range of issues, such as, for example, where there is financial hardship, suspected domestic abuse, known safeguarding concerns, social isolation, vulnerability in pregnancy, transgender or emotional support needs. This is a positive initiative which enables early help interventions to be provided for families who might find it otherwise difficult to seek or access help and support. Where appropriate, the focus care worker signposts vulnerable people and families to other support services but they are also in a good position to identify risk and refer vulnerable children and young people into the MASH if required.

Good practice – focussed care worker

In one of the cases we looked at in a GP practice, the focussed care worker was working closely with a parent who had a child with ongoing behavioural and emotional development issues who had been referred for a CAMHS assessment. Whilst awaiting the assessment, the focussed care worker made arrangements for the young person to attend local youth activities. This enabled the young person to engage with social activities and to support the creation of a frame of reference in advance of the CAMHS assessment.

In addition to this, and because of recognised vulnerabilities and poverty within the family, the focussed care worker enabled the family to access relevant benefits and to source other practical items, such as baby clothes and new-born essentials to support the mother's pregnancy. This created a degree of stability within the family prior to the birth of the child and enabled the expectant mother to manage some of the stressors that were inhibiting the emotional and behavioural development of her older child.

1.39 There is generally good joint working between GPs and other relevant health professionals on an 'issues' basis. However, the area does not have an established, consistent network of regular safeguarding meetings in place within primary care to support proactive joint planning in meeting the needs of children. Although each GP practice has a named link health visitor, and whilst safeguarding meetings take place in some practices (and in one case virtually) this is not the case across the board and liaison with school health nurses is reportedly limited.

[Recommendation 7.2.](#)

2. Child in need

2.1 In records we looked at in Wythenshawe maternity, we saw that multi-agency referral forms are well completed by midwives with detailed information; these are also shared with GPs. We noted good use of the 'Signs of Safety' model to support analysis of current concerns, and an identification of additional needs of unborn babies.

2.2 Midwives at North Manchester General Hospital closely track women who fail to attend ante-natal appointments. A 'serious concerns' form is used to alert other staff when a mother-to-be has not attended on three separate occasions or where there are identified risks. Midwives work closely with health visitors and children's centre staff to provide a joint package of support to vulnerable women and their babies. Regular meetings (in some cases weekly and at least six-weekly) provide good opportunities for handover of complex cases. Health visitors are routinely copied into serious concerns forms completed by midwives. In cases we reviewed we noted good information sharing with health visitors to ensure key concerns were picked up to inform ongoing post-natal care. For example, in one case we noted that a woman had declined to disclose domestic abuse, but the controlling behaviour of the partner observed by the midwife encouraged her to make further checks and ensure the health visitor was alerted.

2.3 The peri-natal mental health pathway in operation in St Mary's Hospital is well embedded with weekly, joint clinics that help to ensure women with a high level of needs arising from their mental health are appropriately supported at all stages from the point at which the pregnancy is booked through to the post-natal period.

2.4 Records we looked at in St Mary's Hospital show that assessment and support provided by midwives to support young parents sensitively recognises the impact of their experience of childhood and of gaps in their parenting capacity that need to be addressed. This enables young and vulnerable new mothers to bond with and safely care for their babies.

2.5 St Mary's midwives are active partners alongside a range of other agencies in working with teenage parents. As such they are instrumental in supporting improved outcomes in complex social circumstances such as homelessness, poverty, mental ill-health, substance misuse and domestic abuse.

2.6 The 'voice of the child' was prominent in records reviewed in the health visiting service including safeguarding reports and referrals; for example to early help and children's social care. This is also the case in records we reviewed in the school health nursing service where an holistic approach enables close work with children and families in school as well as at home. The use of tools and templates enables nurses to capture children's views and those of their parents or carers, and this features strongly in all assessments and plans we looked at. This focus on the voice of children and young people enables intervention to be child focussed rather than parent led and supports better understanding of the child's lived experience.

2.7 School health nurses maintain good working relationships with health visitors. If a child subject of child protection processes or with special educational needs or disabilities is moving into a mainstream school, handover between services takes place according to individual need. A handover sheet is completed by the health visitor highlighting health and personal information that the receiving school health nurse needs to be aware of. Where appropriate, a face-to-face handover takes place between the health visiting and school health nursing services to facilitate a good quality transition for the child.

2.8 The school health nursing service is provided to children from the age of four and-a-half years up to 16 years. Where there are safeguarding concerns school health nurses hold cases up to age 19. This helps to maintain continuity and, where relevant, facilitates additional support for any young person undergoing transition to other adult health services.

2.9 Where a child under 16 presents at an ED in Manchester with mental ill-health concerns, a specialist CAMHS practitioner attends to complete an assessment between the hours of 9am and 5pm, Monday to Friday. This assessment takes place within an hour in most cases, and practitioners do not wait until the child has been assessed as being medically fit, or admitted to a ward to provide this support. This arrangement also applies to young people aged 16 or 17 if they are already known to the CAMHS.

2.10 Where crises occur outside of normal hours, assessments are provided by on call psychiatrists based at Bolton Hospital. We learned that, despite the on call medical team providing an out-of-hours Greater Manchester-wide service, most call out requests are completed well within the trust's four hour target. In each of these situations, the approach reduces delay and means that some young people will not need to be transferred to a paediatric ward to await an assessment.

2.11 At Wythenshawe Hospital and Manchester Royal Infirmary, young people aged 16 or 17 not already known to the CAMHS are seen by practitioners from the adult mental health hospital liaison team. They are available 24 hours-a-day and provide a timely response. Young people are seen quickly, with data showing that, for example, 78% of young people are seen in the adult ED at Wythenshawe within the one hour time-scale. The environment at Wythenshawe is made suitable through the use of dedicated side rooms where young people can wait and this helps to reduce the impact of the anxiety provoking environment of the adult ED.

2.12 During an inspection in June 2016, we identified that the practice of accommodating young people aged 16 and 17 on adult wards at Wythenshawe was an area for further development. The trust established a robust process which identifies young people admitted to adult wards every day. A specialist safeguarding nurse reviews the ED attendance card, initiates contact with the ward and ensures safeguarding considerations are discussed and recorded. The safeguarding nurse has also provided targeted, short training sessions to the wards where young people are most frequently placed. This ensures staff have better insight into the needs of this vulnerable group of patients. Young people with complex needs, learning disabilities or who are under the care of a paediatrician, are directed to the paediatric ward which is the most appropriate setting in which to receive their care.

2.13 Staff in the adult ED at Manchester Royal Infirmary show good awareness of the needs of 16 and 17 year old young people attending the department in distress. The staff proactively identify safe areas for them to wait to be seen away from the adult waiting area. For vulnerable young people, the triage nurse records good information about the young person and their full physical description in case they leave the department before being seen and need to be located.

2.14 The children's ward we visited at the Royal Manchester Children's Hospital does not use a single record for young patients. Nursing notes are held at the child's bedside and clinical notes are stored separately. For example, in one of the clinical records we saw that there was a CAMHS care plan which was not fully reflected in the nursing record. There is the risk that key information by either professional group may not be readily available to each other. [Recommendation 3.6](#).

2.15 Young people aged 16 or 17 attending North Manchester General Hospital are seen in the adult ED. The documentation in use does not prompt practitioners to consider them as a child. Additional information about a person with parental responsibility, the young person's social history or safeguarding vulnerabilities linked to age are not evident. This does not equip practitioners to properly assess and support young people awaiting a mental health assessment. [Recommendation 2.4](#).

2.16 CAMHS practitioners provide advice and consultation to hospital staff in relation to the level of risk associated with children and young people who may need to transfer to a paediatric ward. This advice includes the nature of the observations that are required in order to appropriately safeguard the young person and other patients on the ward. However, there are inconsistencies in the approach to this across the three sites. For example, at Wythenshawe Hospital two mental health nurses that work with the paediatric ward to increase staff knowledge and confidence in supporting young people admitted to the ward with mental health concerns. This increases the safety of the young person in crisis and protects those other children who are admitted to the paediatric ward.

2.17 In the children's ward we visited at Royal Manchester Children's Hospital we found no evidence to provide assurance that a tool or system was used that would facilitate a risk assessment of the environment a child will be admitted to. The absence of a procedure can lead to an inconsistent approach to ensuring the environment is safe for the child. For example, the records of one young people we looked at who had a history of risk taking behaviour and of absconding from medical care did not show how the safety of the ward environment had been assessed. The ward manager was not aware of any tool that would support this. Furthermore the young person's care management plan, including a self-harm behaviours care plan, was not available within the patient's notes. This means that nursing staff who were supporting the young person would be unaware of the steps to take to ensure the person was kept safe. [Recommendation 3.7](#).

2.18 Children admitted to the paediatric ward at North Manchester General Hospital experience considerable delays in discharge from the ward to an appropriate therapeutic setting. Staff make use of a mental health practitioner, commissioned as and when required, to undertake supervision of young people in mental health crisis who are placed on the ward.

2.19 Staff at North Manchester General Hospital recognise the need to consider safeguarding factors when young people are placed on adult wards. All 16 to 18 year-old young people who do not have a learning disability, complex needs or who are not under the care of a paediatrician are admitted to an adult ward. A process has been established for all admissions to be identified by the senior nursing manager each day. This is followed up by their attendance on the ward to speak to the young person and carer, review any safeguarding considerations and agree case management with the ward manager. Operational managers recognise that this is not ideal; however, the individual assessment approach ensures a young person-focussed approach is maintained for that patient.

2.20 The 'Signs of Safety' model is used within the CAMHS service although we are advised it is not yet fully embedded. However, where we saw it in records it was used well to formulate assessment of needs and risk. There is strong active participation in 'team around the child' and child in need process by CAMHS practitioners. In particular, practitioners attend Multi-agency Risk Assessment Management Meetings that provide a good forum for sharing information and sense-checking action taken in risky cases. This ensures that staff who are supporting children and young people with the most complex needs are fully apprised of ongoing concerns. However, external records from all of these processes are not always uploaded to the client's file. This means that key information to inform ongoing care may be missed. [Recommendation 3.5](#).

Good practice – patients with autism at Wythenshawe children's ward

The paediatric department at Wythenshawe Hospital have developed an innovative programme to support patients that are on the autistic spectrum and may have additional needs and communication difficulties. This programme resulted from learning following the death of an autistic patient.

As a result of this learning, and to ensure children and young people with autism can communicate and have their needs met, all children and young people who present with autism and additional needs are assessed upon admission. This includes establishing individual routines for each child and the preferred means of communication. These needs are shared and re-iterated at every handover.

A training package has been co-produced with parents of autistic children and is delivered every six months on a mandatory basis to all staff on the paediatric unit.

We saw evidence of innovative and creative ways of facilitating effective communication with children who are non-verbal, such as flash cards and play therapy. We also saw that children on the autistic spectrum are asked if they would like their own private room to avoid sensory over stimulation, and in most cases this is always possible.

Standard forms such as the admission form, care plan form and pain scale have been adapted so they capture the needs and voice of the child more effectively.

The impact of this innovative practice is that staff have a greater awareness and understanding of how to medically manage children with additional needs or difficulties, and misdiagnosis as a result of communication difficulties is less likely.

2.21 In one GP practice, the focussed care worker, along with staff who had been trained in the IRIS (identification and referral to improve safety¹) domestic abuse programme provide enhanced support to children and their families. This includes those who do not meet the child protection threshold or who have been stepped down to child in need. This ensures ongoing monitoring of risk with prompt feedback to the lead GP about incidents where risks to children are increasing or uncertain. We have reported further on IRIS in 'Child Protection' below.

¹ IRIS is a national initiative aimed at supporting professionals to identify and report domestic abuse and at providing advocacy for women and men affected by domestic violence and abuse. In Manchester, this is provided by trained staff in primary care in collaboration with third sector domestic abuse specialist advocacy services.

3. Child protection

3.1 There is strong focus on safeguarding and protecting mothers-to-be and their babies in Wythenshawe Hospital midwifery as demonstrated in the following paragraphs. Safeguarding case records we looked at were underpinned by detailed chronologies and comprehensive care plans from the point of booking through to the baby's birth and discharge home.

3.2 Good joint working between community and hospital-based midwives at Wythenshawe supports regular monitoring of vulnerable women and their unborn babies. This is also the case for joint working with health visitors, which promotes a shared understanding of risks. There is effective handover and involvement of health visitors in the ante-natal period where concerns about the safety or wellbeing of the mother or baby have been identified.

3.3 Wythenshawe maternity has effective alert and escalation systems in place for women who fail to attend appointments or who frequently re-schedule. Risks of maternal mental ill-health relapse are clearly considered and recorded, and proactively inform local safeguarding arrangements. The peri-natal mental health service is well-developed and secured by good communication and regular review by all relevant professionals.

3.4 The identification and management of domestic abuse is now well-embedded within the practice of frontline midwives at Wythenshawe; with positive outcomes from joint work with the independent domestic violence adviser (IDVA) to help women to make decisions about their own and their children's safety. Questions about a woman's experience of domestic abuse are routinely asked and recorded at various points throughout the pregnancy and following the baby's birth. This has encouraged increased rates of disclosure, improved screening for levels of risk through use of the domestic abuse and sexual harm (DASH) assessment and the take up of the IDVA service.

3.5 The vulnerability of teenage parents at Wythenshawe is recognised and their parenting capacity is comprehensively assessed in the case records we reviewed. The young person's social history and experience of nurturing, attachment and their preparation and support networks are clearly recorded. These are used to inform wider partnership working, including longer term work provided by the vulnerable babies team. Multi-disciplinary team meetings are convened by the teenage pregnancy midwife to bring relevant partners together to address new or increased risks following the birth of the baby prior to discharge.

3.6 Partner or father's details, and their age, is routinely sought and recorded, with midwives displaying curiosity about others who may be involved in the care of the baby. In one case we discussed with staff, this had resulted in a referral to children's social care where the girl was aged 15 and her partner in his 40s.

3.7 Cases reviewed in the St Mary's Hospital maternity also demonstrate a consistently high standard of safeguarding practice, with prompt notification to the specialist safeguarding midwives of concerns identified by midwives at booking through the use of the maternity information referral form. Key information of concern is shared with children's social care which provides a clear and succinct analysis of risk using the 'Signs of Safety' approach. Safeguarding care plans are promptly developed and incorporated into the mother and baby's case notes through the use of a clearly identifiable 'green sheet'. These are reviewed and updated at each contact and help to ensure a clear plan of care is in place should the woman deliver early. In addition, where there were concerns about the mother's mental health and risks of deterioration, the safeguarding section within the case record provides a clear picture of relapse indicators, and of how additional support could be accessed as required. The effect of this is that staff are well sighted on evolving risk and can support mothers-to-be with up-to-date plans.

3.8 Reports to child protection conference and court reports we looked at in St Mary's maternity were of a consistently high standard, with good attendance by midwives at child protection conferences and core groups. Ongoing records maintained by the midwives demonstrate good understanding and alignment of midwifery practice with the joint child and family plan.

Good Practice – trafficking initiative at St Mary's maternity

The maternity unit at St Mary's hospital have received national recognition from the Royal College of Midwives for their practice in identifying and safeguarding women and their children who have been trafficked; we highlight this work here.

Midwives had observed that, in many cases of pregnant women who had originated from Eastern Europe, the women were unable to communicate with their presumed husbands due to not speaking English, and had declared that their new husbands were not the fathers of their unborn children.

After initially being unable to refer these cases successfully to children's social care due to them individually not reaching a safeguarding threshold, midwives shared their collective intelligence on these women and their partners with the social worker attached to the Greater Manchester Police trafficking operation set up at that time. As a result of ongoing collaboration with the police, four women were rescued, eight men were convicted of trafficking offences and new-born children were protected.

Midwives have collaborated in a further, recently established police operation to protect women and children at similar risk and this work is ongoing. The progressive, multi-agency approach to this issue has enabled the partnership to safeguard vulnerable victims and disrupt the activities of traffickers.

The tenacity of the midwifery team in addressing this has not only led to the development of a robust policy in the trust, but is also now helping to shape national policy.

3.9 We noted a strong intent and capacity to improve safeguarding practice in the maternity unit at North Manchester General Hospital. Currently however, there are some simple systemic issues in relation to assessment and recording that could be strengthened.

3.10 Midwifery safeguarding practice at North Manchester General Hospital is not sufficiently well developed to provide a holistic analysis of risks throughout the pregnancy and we noted some variable standards. For example, the wide use of 'Special Circumstances' forms have enabled midwives to take a structured approach to assessing and managing risks known as SBAR (Situation, Background, Assessment and Recommendation). This form is also used as the referral form to children's social care and cases we looked at showed that these forms were appropriately flagged as 'red' or 'amber'. In the labour ward, one record we reviewed provided a clear picture of current safeguarding issues as they related to the mother and her baby. Good use was made of relevant detail from the special circumstances form to inform care planning and discharge arrangements. However, in other cases we looked at the forms were generally used primarily as alerts for single events. The use of chronologies to support a holistic overview of risks to the mother or her unborn baby is also not well developed. This restricts the opportunity to provide a clear analysis of risk over time and does not support midwives with long term planning. [Recommendation 2.5.](#)

3.11 In many cases, key safeguarding documentation was missing from maternity records we looked at. For example, midwifery reports to child protection conferences, child protection plans and pre-birth plans were not included and so it was difficult to evidence the role of the midwife and the effectiveness of the trust's contribution to wider safeguarding activity. [Recommendation 2.6.](#)

3.12 There are areas of positive practice, however. The appointment of the IDVA in the North Manchester General Hospital maternity unit has enabled the trust to strengthen its identification of women at risk of domestic abuse. In turn, this enables women to be more aware of additional support available to safeguard them and their children and to increase their confidence in taking positive steps to reduce risk.

3.13 The vulnerable school children's team is part of the school health nursing service. School health advisors (SHA) working in the team carry out health assessments for all children who are subject to child protection plans and co-ordinate their package of care where there are unidentified unmet health needs. The SHAs also attend child protection conferences and share information with partners to support decision making. The safeguarding case-holding function means that universal school health nurses do not hold child protection cases which would otherwise have an impact on the proactive, early intervention and healthy child programme work they carry out in schools.

3.14 The team work to a specific protocol that ensures effective liaison between the child's allocated SHA and other health practitioners supporting the child. One of the records we looked at during our visit demonstrated good liaison with a young person's universal school nurse who continued to see the child during routine healthy child programme visits to the school. There are potential risks to a vulnerable young person's emotional resilience at a time when they transfer between allocated school nurses and this is often a feature of our reviews. However, these are outweighed by the continuity of care for those vulnerable children and young people and the benefits of receiving a more targeted and focussed service from a team that are well resourced to provide this.

3.15 Reports are routinely submitted by the vulnerable school children's team to inform initial and the first review child protection conference and attendance is also prioritised. Subsequent review conferences are attended in person when there is appropriate safeguarding information available to share, but a report is always submitted in any event.

3.16 This specialist team completes health assessments for every child and co-ordinates the support provided to the child and family. In the records we looked at, we noted good evidence of the 'voice of the child' in assessments, robust, outcome based health plans, and evidence of strong relationships with other health disciplines. This supports engagement by the children and young people and enables health services to be targeted appropriately.

3.17 The staff at Wythenshawe Hospital use a well-developed process for managing referrals to children's social care. A copy of the report is sent to the safeguarding team for quality assurance, and the administrator contacts the local authority to confirm it has been received and obtain any early feedback. A copy is also sent to the child's GP and health visitor or school nurse. Referrals we looked at were of a good standard and this helps the recipient to get a good understanding of the risk to the child.

3.18 However, safeguarding practice and professional curiosity is variable in the ED at Wythenshawe with a general under-utilisation of the safeguarding screening tools as outlined above in 'Early help'. In one case, a referral had not been made to the substance misuse service despite a young person having a history of alcohol use. In another case, the failure to complete a standard checklist had resulted in risk to a new-born baby not being considered. [Recommendation 3.1.](#)

3.19 The ED and paediatric ward record system at Wythenshawe does not currently support 'flagging' of those children considered most vulnerable, such as those subject of a child protection plan. Practitioners reported that they can contact children's social care to verify information about children independent of the safeguarding team and that this is effective although time-consuming. Although a new electronic patient records system is planned, with a safeguarding 'toolbar' to support recording and alerts about children at risk, this is not yet in place. [Recommendation 1.2.](#)

3.20 There are similar issues in the ED at North Manchester General Hospital, where staff have access to the newly implemented child protection information system (CPIS), in order to help them understand any safeguarding history of a child. However, this is not yet available for children living in the City of Manchester local authority area. Whenever safeguarding information about a Manchester child is received, the ED administrator adds an alert to the hospital's electronic patient record system. This can take up to 48 hours to complete. In order to address this, the trust's safeguarding team can access the Manchester City Council's electronic records system although this is retrospective. As reported above, this is reported to be time-consuming and means that staff in the ED do not have timely access to information about vulnerable children when they attend. [Recommendation 1.2.](#)

3.21 Staff in the EDs at Royal Manchester Children's Hospital and Manchester Royal Infirmary use consistent processes for referring cases of concern to children's social care. All referrals are escalated to a senior nurse on duty who supports the practitioner's referral. Children's social care are alerted to the referral prior to it being sent to minimise any delay in it being reviewed. A copy is also sent to the trust's safeguarding team for quality assurance and, where necessary, to follow up with any additional information. Despite these systemic checkpoints, key information is sometimes missing from ED records, indicating an inconsistent approach to professional curiosity and leading to a variable quality in the information presented within the referral. In the records we looked at in the children's ED, for example, we saw that children were not always asked in detail about risky circumstances in which they attended. The absence of information was carried forward into the picture of risk presented in the referral to children's social care and this does not support effective initial decision making at the safeguarding front door. [Recommendation 3.8.](#)

3.22 The adult ED admission forms are completed inconsistently at North Manchester General Hospital and our review of records indicated that this often relates to the seniority of the medical staff. There was evidence that junior doctors use a templated document to ensure they ask about social and family history and family composition; whereas senior doctors do not complete this. We are advised that senior doctors are expected to rely on their experience to ask these questions although key information was missing in the records we looked at.

3.23 For example, a woman was admitted to ED in relation to domestic abuse perpetrated by her former partner. There was mention in her records that she had a nine year old child but the family history form had not been completed. The triage notes stated that the ambulance crew had 'referred for safeguarding' but it was not clear if this was about the mother (the patient) or the child. There was no record of whether this had been followed up, or if further referrals had been made by the ED staff. It was also unclear if they had checked on the safety of the child. In such cases, the lack of information means that some safeguarding risks would be overlooked. [Recommendation 2.3.](#)

3.24 There is a variable standard of referrals to children's social care made by CAMHS staff. In one case we looked at, a verbal referral for alleged grooming behaviour by an adult had been made but there was no written referral in support of the telephone call. Another child was known to be part of the family but there were no details of that child shown in the first child's record. Furthermore, the referral's outcome had not been followed up despite opportunities for the practitioner to do so. Although we have been assured that children's social care have progressed the matter, the CAMHS practitioner did not take account of the alleged grooming when formulating a risk assessment in relation to the child's family situation. The absence of proper records of referral in cases such as this leads to drift and a lack of a clear understanding of how progress is to be made. [Recommendation 3.9.](#)

3.25 The approach to CSE is underdeveloped in CAMHS. Although some training has been given to newly appointed CSE champions the practice has yet to properly develop with risk assessments for CSE not being routinely considered. [Recommendation 3.10.](#)

Good Practice – professional curiosity in adult substance misuse services

We described the home visit arrangements of the adult substance misuse service above in 'Early Help' as a means of assessing additional needs in a family. We also saw that this, together with strong partnership working, was effective in protecting children in more acute situations. In one case we reviewed, a home visit had been undertaken following a service user with particularly chaotic substance misuse disclosing that she had young children. As a result of the home visit and a further joint visit with the social worker, further, significant concerns about domestic abuse were highlighted. As a result the children were safeguarded due to being removed under an Emergency Protection Order.

3.26 In the adult mental health service there is good evidence of effective use of the MANCAS risk assessment template. We also saw that the 'events records' and 'special notes' on clients' records are used consistently to present a clear picture of risks. As we have set out above in 'Early Help', there is a strong emphasis on partnership working with mental health practitioners attending and contributing information for child protection conferences. This helps the conference to understand and take account of the mental health of significant adults in a child's life.

3.27 The integrated sexual health service has recently adopted an electronic client records system that has enabled efficient and timely oversight of high risk cases.

Good Practice – risk assessment and referral by the sexual health service

Practitioners in the sexual health service are effective at identifying risks to children and young people who are clients as well as to children of adult clients. We noted good professional curiosity and use of established tools to help practitioners to formulate risk assessments. Referrals made to children's social care and to other agencies are timely and clearly articulate risk.

For example, a woman who was known to have a history of being trafficked and exploited whilst young and with a history of being looked after, disclosed that she was pregnant. Practitioners used information they knew about the client to understand her current risks and those to her unborn baby. Good quality referrals were made to St Mary's Hospital Early Pregnancy Unit, to the adult safeguarding team and also to children's social care to ensure that both she and her unborn baby were protected.

In another case, concerns about the exposure of a young child to significant domestic abuse were identified in relation to an adult client of the HIV clinic. In that case, a comprehensive risk assessment led to referrals made to both children's social care and to the Multi-Agency Risk Assessment Conference (MARAC) process.

3.28 Most GPs in Manchester use the same electronic patient record system. In the majority of cases we examined we saw that children, young people and families are appropriately 'coded' when risk is identified so that practitioners are immediately informed by way of dialogue alerts that there are concerns they need to be aware of. This supports GPs when undertaking consultations with children who are vulnerable or at risk. However, in other cases we looked at we saw that records of siblings and parents of children who are subject of a child protection plan were not always appropriately linked. This means that practitioners accessing other family member records might not be aware of child protection measures in place within the family. [Recommendation 5.1.](#)

3.29 The named GP for Manchester has developed a 'was not bought' policy for GPs to follow when a child or young person is not brought to an appointment, either at the GP or at the hospital, and there are concerns about vulnerability. In one case we reviewed in one of the practices we visited, we saw that this had resulted in good liaison between a hospital surgery unit and the GP to identify suspicions of abuse of the child's prescribed medication by the parent.

3.30 GPs across Manchester refer cases of suspected domestic abuse to the IRIS service. However, GPs we spoke with told us that they are not routinely informed of the outcomes when cases referred to IRIS then go on to a MARAC referral. We are advised by commissioners that there is currently no primary care representative on the MARAC although some feedback is provided by MFT representatives in some instances. This means that GPs are not in possession of the most up-to-date information about the potential impact on children in some cases of domestic abuse. [Recommendation 5.2.](#)

3.31 Furthermore, GPs told us that they are not routinely informed of the outcomes of child protection meetings where they have provided information and they are not advised when a child or young person becomes a 'child in need'. These are significant shortfalls in the arrangements for providing feedback to GPs and means that GPs are unaware of key information that would guide their consultations with vulnerable children and young people. [Recommendation 5.3.](#)

Good Practice – Ashcroft Surgery

There is an agreed template in place to support GPs to make written reports to child protection conferences. The quality of work undertaken by the lead GP in one of the practices we visited is of a very high standard. We noted clear and accessible records showing previous events and tracking of escalating risks. In one case we looked at in this practice, the approach enabled a comprehensive assessment of the young child, a description of parental and wider family needs, and an analysis of the impact for the child. This provided a very clear picture to support decisions made by the conference.

4. Looked after children

4.1 The looked after children health service is provided by Manchester University NHS Foundation Trust. As well as a named doctor and a named nurse, who provide operational oversight of the work of the service, there is also a nurse with a specific quality assurance role. A team of specialist looked after children nurses are responsible for review health assessments (RHA) of young people aged 16 and 17, children who are not in education, children in residential placements and unaccompanied asylum seeking children and young people. Health visitors and school nurses are responsible for all other RHAs according to the child's age. We noted generally good practice in the arrangements for assessing and meeting the health needs looked after children, with some good links with other services. We also noted some risks in relation to timeliness of initial health assessments and records as set out below.

4.2 IHAs are currently undertaken at two clinic locations across Manchester with some flexibility according to individual need. There are plans to undertake all IHAs at a single, central location in the future, which is easily accessible by public transport. The new site will include sibling support provided by a nursery nurse while the assessment takes place, although this was not in place at the time of our review. RHAs are generally undertaken at schools or at home, but there is flexibility for these to take place at health locations according to the child's need. This ensures that looked after children do not have to travel and is a good arrangement.

4.3 The timeliness of initial health assessments (IHA) and review health assessments (RHA) is variable month-by-month, with many IHAs falling just outside the period that would allow the local authority to carry out its 20 day statutory review. Cases where there is a shortfall have been reviewed and the service is aware of the reasons for the delay for assessments on an individual case basis. At the time of our review, 56% of children looked after by Manchester were placed out of the city and this has exacerbated the timeliness of some assessments, albeit that most of these children are still placed within the Greater Manchester area.

4.4 We also saw that there is a strong commitment from the multi-agency partnership to address these challenges and to operationally manage any delays in notifications from the local authority. For example, a common delay has been identified in relation to the timescale between a child coming into care and the relevant request being made and consent obtained for the health assessment. In order to offset this, as soon as the specialist nurse team become aware of a child who is new to care, an offer of a health assessment is made even though consent has not formally been obtained at that point. Nonetheless, the variability in timescales means that some children new to care will not receive a health assessment or health recommendations in time for their initial review, and this is an area for development. [Recommendation 3.11](#).

4.5 The quality assurance process for health assessments is robust even if maintaining the timeliness of those assessments is challenging. All (100%) of the IHAs and RHAs are subject of a formal quality assurance process to ensure they are of a sufficiently high standard, clearly identify health needs and any additional risks identify how those needs will be met. This is a solid arrangement that keeps the standard of practice high and ensures children's needs are accurately assessed and planned for.

4.6 We noted that the quality of all health assessments is very good with a strong voice of the child, or a depiction of the child's lived experience in younger children. This was evident in all initial and review health assessments we looked at. Health action plans are outcome focussed with SMART actions describing how outcomes would be achieved. All health action plans faithfully reflect the assessments and this represents consistently effective practice in the cases we looked at.

4.7 Where possible and appropriate, health assessments are not repeated when a child protection health assessment or education, health and care assessment has been conducted within a reasonable timescale and remains relevant to the child's needs. This supports the 'tell it once' approach and means that children and young people do not always have to repeat their 'story' or undergo the same process in a short period of time. This is particularly relevant where the young person has special educational needs and disabilities when repeated assessments for similar outcomes can be frustrating.

Looked after children – good practice and oversight of a child's needs

Looked after children nurses in Manchester often maintain oversight of children, even when they are permanently placed out of area.

In one case we reviewed, a young person was permanently placed outside Manchester but it was known that he would frequently abscond from his placement and return to the city where he would abuse substances. He was considered at high risk as a result of his absconding and substance misuse. The looked after children named nurse agreed to maintain oversight of the case to facilitate co-ordination and health service liaison.

The nurse has contributed to discussion at the multi-agency CSE forum in relation to his being frequently missing and potentially at risk; has liaised directly with CAMHS due to a diagnosis of autism and ADHD; and has ensured his engagement with the Eclipse young person's substance misuse services. An Education Health and Care Plan (EHCP) is in place due to his identified additional needs which has helped his improved engagement with school.

As a result of continued multi-agency information sharing and planning, much of which has been driven by the young person's health needs, a more local placement has now been secured and he has begun to engage well with those services appropriate to him.

Missing from home episodes have reduced and, as a result of multi-agency good practice, personal risk to him is recognised as having significantly reduced.

4.8 The Strengths and Difficulties Questionnaires (SDQ) completed by young people and their carers are provided to the team by the local authority and used by the nurses to better understand a young person's emotional health needs. However, there have been some historical issues in relation to the timing of the completion of these SDQs and the proximity and relevance to the health assessment. A revised pathway for submitting SDQs has been introduced; we are advised that this has led to the SDQs being received in a timeframe that enables them to be meaningfully used in the health assessments although this is a new process and we have not seen any data to assess its impact.

4.9 'CAMHS LAAC' (looked after and adopted children) is an emotional health and wellbeing service that supports looked after and adopted children. The service is provided to all Manchester looked after and adopted children who are placed within the city. The service will continue to provide support to children and young people for up to three years from adoption. This ensures continuity for young people who are no longer looked after by the local authority but who might have enduring mental health problems requiring additional care and support. This is a good example of family centred commissioning.

4.10 For those Manchester children placed outside the city the service is provided if it is appropriate and the child lives within a reasonable travelling distance from Manchester, including those placed within the Greater Manchester area. Where children are placed further away, assessment and consultation is provided for professionals in the receiving area.

4.11 The CAMHS LAAC practitioners also work closely with foster carers, providing training and additional support to promote placement stability. For example, we learned of an intensive training and support programme offered to carers over a 12 week period known as 'Attachment Focussed Caregiving'. This supports young people as it enables foster carers to be better equipped to meet the emotional wellbeing and resilience needs of those young people in their care.

4.12 There is a dedicated looked after children nurse for unaccompanied asylum seeking children in Manchester who maintains oversight of the health needs of all such children in the city. Whilst IHAs for this group of children and young people are still undertaken by a paediatrician, the specialist nurse often carries out some initial, or triage assessment work prior to the IHA taking place. This leads to better, more timely and accurate assessments and ensures that all barriers to communication have been overcome or addressed by the time the IHA is carried out.

4.13 The dedicated nurse also undertakes all RHAs for unaccompanied asylum seeking children and works proactively to ensure that health actions are actioned in a timely way. For example, the nurse ensures that particular diagnostic testing related to conditions prevalent in the young person's county of origin and immunisations take place. This is an important role that helps meet the needs of this vulnerable group of young people who may not be aware of what is available to them to promote their personal health and wellbeing.

4.14 Manchester looked after children nursing team is a 'paper heavy' service with limited IT support. It can sometimes be challenging, therefore, to ensure that information is shared in a timely way between services, especially those from outside the local area. We saw two instances among the cases we looked at where the use of paper records had led to some records containing information that did not belong to the person in question. In one case we saw that specific, detailed information was included in the file that related to the person's sibling and which was not relevant to the subject of the record. In another case we saw that the notes of a CSE strategic meeting were contained within the file. The information had not been redacted and contained confidential information relating to other young people that the meeting had discussed. [Recommendation 3.12.](#)

4.15 The Manchester looked after children health team regularly seek the views of service users to inform service provision. This includes feedback forms following assessment and recent 'open air cafes' in Manchester where information was provided in relation to health assessments. This helps to ensure that the service offered meets the needs of young people. We have reported further on the 'open air cafes' initiative in 'Governance' below.

4.16 Specialist looked after children nurses provide support to care leavers through a variety of means. These include individual one-to-one support, group sessions, and a drop-in service at the Manchester Leaving Care Service provided by Barnardos. Care leavers can also access health advice from the team up to the age of 21. This means that young people have a contact point to help them through any difficulties or uncertainty they might be experiencing about accessing health care independently, although we have not seen any data to indicate how frequently this support is utilised.

4.17 There is currently, no standard mechanism for ensuring young people leaving care are provided with evidence of improvement in their health outcomes or proper consideration of their future needs. For example, in the records of one young male care leaver we looked at in a GP practice, the quality of the report shared with the GP was poor. The health care plan did not articulate well the specific nature and complexity of risks to his future health and wellbeing to be recognised and promoted by the GP. Whilst his non- engagement in eye and dental checks was noted, the care plan did not specifically highlight why his BMI was low. Risks to his mental health were poorly described even though his SDQ indicated he might have some long term difficulties. The approach demonstrated by this example, does not sufficiently support young people who are leaving care and transitioning into independent adult life. We are advised that this process is due to be reviewed and that care leavers themselves are currently being consulted about the format that health information is provided to them on leaving care. This is good, as it will ensure the structure of health summaries, or 'passports', is based on young people's input and more relevant to their needs although the outcome of this consultation is yet to be realised. [Recommendation 3.13.](#)

5. Management

This section records our findings about how well-led the health services are in relation to safeguarding and looked-after children. Although NHS Manchester CCG still exists as an NHS commissioning body, we have used the term 'Manchester Health and Care Commissioning (MHCC)' when referring to commissioners.

5.1 Leadership and management

5.1.1 Throughout our week in Manchester we have noted effective, visible safeguarding leadership in the commissioning body and the providers. We highlight the strong leadership of commissioners at a time of significant challenge due to the transformation of health services. This includes the change in the way health services are commissioned through the recently established integrated commissioning body (in April 2017), the amalgamation of two mental health trusts (January 2017) and the amalgamation of two of the city's three acute hospital trusts (imminent at the time of our review) into a single trust providing acute and community services. At the fore of these challenges is the response to the tragic events of May this year at the Manchester Arena which we have referenced at the beginning of this report and later in this section.

5.1.2 The Manchester Commissioning Strategy, an evolving piece of work governing the transformation of the city's health services, has led to the development of the new commissioning body, MHCC, with five key aims. These aims relate to improving health and wellbeing, ensuring safe, equitable and high quality care, involving communities in service design and assuring sustainability. Safeguarding leaders work together and proactively across organisational boundaries to improve practice, a collaborative approach which is in accord with published MHCC values.

5.1.3 The amalgamation of the two acute trusts in the central and south areas of the city was imminent at the time of our review with completion of the merger occurring since our review. There are plans to develop a single hospital service to incorporate the whole city. This will be through the restructuring of the Pennine Acute NHS Trust and the incorporation of North Manchester General Hospital into MFT although there is no clear date for this as yet.

5.1.4 At the time of our review, strategic leaders and many of the operational managers we spoke with were keen to tell us how they felt the changes would help to address health inequalities in this diverse city. Our overall impression was that staff had generally 'bought into' the strategic changes and were anticipating a more streamlined and effective health landscape as commissioning and provision of services evolves.

5.1.5 There are numerous examples of how health leadership has led to a culture of continuous improvement in safeguarding practice throughout Manchester; this has been evident in our interviews with staff and in the cases we have tracked across services. In the earlier sections of this report, we have already highlighted some of these as good practice examples.

5.1.6 Of significance, however, is the generally good practice in relation to information management and decision making brought about by the Manchester-wide commitment to the use of a single model to support assessment and planning which we have reported in earlier sections. This structured way of thinking has been adopted as a holistic approach across all the services, although not quite fully embedded yet in some. It has had a significant impact on the quality of written work and on the ability of practitioners to formulate plans based on a sound analysis of any situation. It has helped to positively promote and improve recognition of action to take to keep children safe, thus strengthening partnership working.

5.1.7 One of the principal areas for development we have found across services during our review is the prevailing use of paper records. These records are common in many of the services and in some cases they are part of a hybrid system that runs alongside a partially functioning electronic records system. This does not support effective safeguarding practice and we have seen evidence of records being sparsely completed, attachments not being faithfully appended, a limited ability to track and monitor actions, and in particular, an inability to reconcile electronic records with paper records. This is an area that we expect to see develop as the health landscape undergoes its continued transformation over the coming short term but for the present this is a barrier to effective work. [Recommendation 6.1](#).

5.1.8 Safeguarding practitioners from MFT provide the health practitioner coverage in the MASH. However, there is no clear understanding of the role of the health practitioners in decision making, despite the seniority of the staff and the level of expertise that would bring benefit to the process. Although they gather, analyse and share information very well, they are not part of strategy discussions. A practice of taking part in 'multi-agency discussions' that sits somewhere towards the end of the screening and triage process does not enable the health practitioners to play a full part in decision making and planning, evidenced by one of the cases we asked leaders to review further during this week. [Recommendation 7.3](#).

5.1.9 We found clear leadership and accountabilities for safeguarding within Wythenshawe maternity services with effective management oversight of complex cases. For example, midwifery capacity has been strengthened since the previous CQC regulatory inspection and staffing ratios in the department are now within national midwifery staffing guidelines. Additionally, increased levels of need and demand have been identified through routine screening for alcohol abuse at Wythenshawe maternity services. However, the trust (formerly University Hospitals of South Manchester) has identified it needs to further strengthen its specialist safeguarding capacity to promote the development of joint clinics and stronger partnership working with adult substance misuse services to reflect the increased levels and complexity of casework. [Recommendation 3.14](#).

5.1.10 There is improved support and management oversight through the appointment of a new senior leadership team at North Manchester General Hospital midwifery services. The new team have commenced a significant programme of improvement work to raise the standard of maternity care and clinical practice and to strengthen team capacity. For example, the development and expansion of specialist midwifery roles provides additional capacity and expertise in working with women whose needs and circumstances are complex. There is also increased capacity through the recruitment of additional matrons and midwives. Its impact is evident in the notable improvements in staff morale due to better staffing levels at the frontline.

5.1.11 St Mary's Hospital benefits from strong midwifery safeguarding leadership, with a range of specialist midwifery posts to meet the diverse and complex needs of mothers and their unborn or new-born babies. The standard of safeguarding practice is well developed, with midwives in a range of roles continuously striving to achieve the best possible outcomes for women and their babies. The trust promotes a culture of improvement, where the contemporary work of midwives has helped to shape improved safeguarding practice and influence policy, both locally and nationally. The work in relation to human trafficking and FGM are positive examples of this.

5.1.12 Managers in the adult ED at Manchester Royal Infirmary support staff by ensuring safeguarding information and reference material is readily available within the unit. A resource folder of current child protection topics is available and an icon on the desktop ensures easy access to key documents, such as referral forms and contact details. This material provides staff with a ready reference point and adds to the collective pool of knowledge and understanding within the department.

5.1.13 The children's EDs at each of the hospital sites in Manchester are appropriately staffed with paediatric trained nurses, a requirement of national guidance on resourcing such units. In each case, children are assessed and treated by appropriately trained staff.

5.1.14 At North Manchester General Hospital this is a recent development due to a successful recruitment drive, which has also seen some additional senior nursing posts filled. This has helped to consolidate management roles and strengthen the trust's capacity to drive forward its significant change programme. This is borne out by staff who spoke positively of strong leadership, improving standards and a focus on improving children's and families' experiences on the children's ward.

5.1.15 However, the named safeguarding nurse was not highly visible to practitioners within the ED and paediatric ward. An extended period of absence of the named nurse has resulted in reduced capacity. This has led the trust to arrange additional cover by the named midwife with support for advice calls from the nearby Salford Royal NHS Foundation Trust safeguarding team. We are advised that recruitment for additional resources for the safeguarding team is underway but at the time of this review that had not yet been completed.. [Recommendation 2.8.](#)

5.1.16 A well-developed and visible safeguarding team is established in Wythenshawe Hospital. A skill-mix team has been developed to manage the safeguarding workload. This has helped to build capacity and expertise to support better awareness and understanding of the importance of safeguarding practice in front line staff. Staff in the ED and the paediatric ward spoke positively of the team and the visible presence within the two areas. For example, one of the safeguarding specialist nurses attends the paediatric ward daily to offer guidance and support and this helps keep the profile of safeguarding work high.

5.1.17 Health visiting and school health nursing team leads have good oversight and understanding of the caseloads held by their staff which facilitates service planning. A caseload weighting tool currently being trialled in the health visiting service is intended to ensure better, more appropriate resource distribution to meet the needs of each team's population of children and families although this trial is not complete at the time of our review.

5.1.18 The 'Future in Mind' plans for the soon to be implemented crisis pathway are strong with use of an integrated RAID (Rapid Assessment Interface and Discharge) team; a bespoke CAMHS crisis and home and community treatment service; and an integrated rapid response and crisis prevention service. The trust plans to introduce these in a phased approach beginning October 2017 , and so we cannot yet assess the impact of these changes

5.1.19 We found proactive and visible leadership of GPs in Manchester by the named GP and MHCC. The work of GPs is supported through the primary care programme, delivered mainly by the safeguarding link nurses, nurse members of the MHCC safeguarding team with responsibility each for a cohort of practices. This includes twice-yearly visits to every practice and a programme of forums aimed at GP safeguarding leads occurring three times each year. Discussion of serious case reviews and on GP's safeguarding roles ensures that GPs are kept up-to-date on local and national safeguarding issues. This is a supportive arrangement that is highly valued by GPs.

5.1.20 Lastly, staff, managers and leaders talked openly of the impact on staff at all levels of the bombing incident in May 2017. In particular, we note that the emergency departments and inpatient wards that have accommodated some of the patients from this incident have coped with unprecedented levels of trauma and the significant emotional impact on children, families and staff. Leaders and operational managers have reflected and have already considered where to implement changes arising from the learning from this incident. Managers consider the learning to be dynamic in nature and remain highly attentive to the needs of staff in supporting them to adjust to their experience of the incident.

5.2 Governance

5.2.1 Safeguarding governance in Manchester's health economy has become comparatively streamlined since the creation of MHCC in April 2017. Manchester's three previous CCG's amalgamated into one single CCG, followed closely by the commencement of the new commissioning body. Embedding the governance processes and lines of accountability for safeguarding has continued to evolve through the first part of this year and up to the point of our inspection in the summer.

5.2.2 There is an integrated safeguarding team within MHCC with lead practitioners for each of the children's and adult's functions. There is a continuous line of accountability for safeguarding performance, with key personnel at different leadership levels. This comprises of executive nurse posts (a Director of Safeguarding and a deputy) and a Head of Safeguarding (lead role for management of the functions of the safeguarding team, including safeguarding adults). There are designated nurses for each of the safeguarding children, looked after children and safeguarding adults functions as well as two specialist safeguarding children nurses, one of whom has a lead role for primary care. The designated doctors for safeguarding and for looked after children are employed by MFT, and, together with the named GP, provide medical leadership on behalf of the commissioners.

5.2.3 The Director of Safeguarding chairs the Safeguarding Governance Group that reports directly to the MHCC executive. Membership of the group includes lead GPs on the CCG board, the designated safeguarding professionals and strategic safeguarding leads in the principal providers. Through the effective use of data, MHCC have a good understanding of the complexities and diverse health and wellbeing needs of Manchester's population. These feature prominently in the strategic vision for health services in the new landscape. MHCC also have a clear picture of the strengths and shortfalls in safeguarding practices. This assurance is monitored through a variety of information sources and notifications that populate the RAG rated safeguarding dashboard and through a robust, rolling audit programme. Through this, the Safeguarding Governance Group has a clear understanding of their priorities at any point in time and this is evidenced by their section 11 self-assessment audit just prior to our visit.

5.2.4 The management processes overseeing the changes in Manchester's health landscape have paid due regard to the sustainability of the safeguarding responsibilities of commissioners. Furthermore, the safeguarding establishment structure enables sufficient governance capacity for ongoing safeguarding improvement initiatives, strategic risk management and provider performance monitoring that has prevailed throughout the period of change. This is evident from our review of strategic papers, risk registers and minutes. We acknowledge that it may be too early to tell if safeguarding performance has been adversely or positively impacted by the changes. However, our visits to services, interviews with staff and managers and our review of cases indicates that safeguarding has remained high on everyone's agenda. The impetus behind the improvement work driven by the commissioners has been maintained through the period of change and safeguarding practice remains at a generally high standard as shown in this report.

5.2.5 MHCC and each of the trusts are properly represented at an appropriate strategic level in the Manchester Safeguarding Children Board and its sub-groups. This includes membership of the Complex Safeguarding sub-group, which has oversight of the development of work on cross-cutting themes (adults and children's safeguarding) such as CSE, FGM, radicalisation, domestic abuse and modern slavery. This ensures that health leaders are fully sighted on, and contribute to major, whole-system issues that affect the delivery of health care in the city.

5.2.6 The MSCB Leadership Group also has senior representatives of the safeguarding leadership in MHCC and each of the providers in Manchester. This enables all health leaders to manage and co-ordinate safeguarding activity across the complex health service landscape and is exemplified in the role of safeguarding in the emerging 'One team approach'. This is the principal strategic vision for the single (acute) hospital service and the single local (community) care organisation which is extensively reported on in the MHCC and the MSCB annual reports.

5.2.7 Health partners have contributed significantly and effectively to the board's response to the Ofsted inspection of 2014. For example, the safeguarding children board and the local authority have begun a significant improvement plan in relation to availability and accessibility of early help services as part of the re-design of the 'Multi-Agency Levels of Need and Response Framework'. The health commissioners' 'integrated early help plan' is part of this improvement agenda. This is a series of measurable activities designed to heighten the profile of early help services among health staff, to strengthen their participation in early help work and to enhance opportunities for early help from other health initiatives (such as the primary care programme). During our week's review we found that the approach to early help is a strength in the Manchester health services as noted in 'Early Help' above.

5.2.8 MHCC also lead on some of the strategic multi-agency developments for the MSCB. For example, the 'Perplexing Presentations' working group, chaired by the designated doctor, has been established to strengthen the multi-agency response to potential cases of fabricated illness. This is a key area of work given the frequency with which such cases feature in serious case reviews. A 'perplexing presentations' pathway is currently being developed which will support practitioners to respond appropriately to such instances and escalate if necessary. This will then require specific training and work to embed this into exiting safeguarding processes.

5.2.9 MHCC and providers seek out the views of children and young people to support service design. This includes proactively engaging with children and young people or by listening to children as part of established consultation process. For example, one of the looked after children designated nurses is a member of the 'Voice and Influence' group run by the local authority to support the Looked After Children and Care Leavers strategy, a group that is chaired by, and made of young people. Additionally, in October 2016, the designated nurses (from the then CCG) and the specialist looked after children nurses (from MFT) assisted the local authority in hosting 'Open Air Cafes' with the purpose of consulting looked after children and care leavers. The nurses sought young people's views on information leaflets about health assessments and about what makes a good looked after children nurse. The trust has used feedback from these young people to define the job description and interview questions for looked after children nurses.

5.2.10 Following the development of Manchester's 'Promise to looked after children', the city's arrangements are directed by the looked after children strategy and governed by the looked after children strategic group. This group reports to Manchester's Corporate Parenting Panel and this provides assurance and accountability to the local partnership.

5.2.11 The designated nurses for looked after children are active members of the strategic group and the corporate parenting panel and are well placed to influence policy, monitor performance and direct improvement in the provision of looked after children health services. Performance of the looked after children service is also monitored through the MHCC Safeguarding Governance Group. The named nurse for looked after children within MFT has also developed good working relationships with multi-agency partners. The named nurse is also a member of the looked after children and care leavers strategy health group. This is an inclusive arrangement and ensures the provider can contribute operational insight to strategic discussions. As we have set out above in 'Looked After Children', leaders are aware of current challenges in relation to the timeliness of initial health assessments, the development of health histories for care leavers and the shortfalls in paper records.

5.2.12 Except where indicated below, each of the hospital trusts (those that were extant at the time of our review) has robust, accountable governance for safeguarding at an executive, clinical level. These are supported by various strategic forums that direct safeguarding activity in the providers.

5.2.13 For instance, in the recently formed GMMH, the Director of Governance has executive responsibility for safeguarding whilst activity is managed through the trust's Safeguarding Practice and Development Group. At PAT the Director of Governance has the executive lead role for safeguarding and chairs the trust's safeguarding committee. In turn this is accountable to the Executive Quality and Patient Experience and Governance Committee. Our review of the GMMH and PAT annual safeguarding reports for 2017 show that both trusts have a clear understanding of the data that describes their safeguarding performance. However, the annual report for PAT is 'data heavy' and whilst factual in nature, does not provide a clear evaluative picture of the trust's safeguarding performance.

5.2.14 We have also reviewed the annual reports for the MFT precursor organisations, Central Manchester University Hospitals NHS Foundation Trust and University Hospital of South Manchester NHS Foundation Trust. Both reports are relatively sophisticated and set out a clear picture of each trust's safeguarding performance. Both trusts had robust lines of safeguarding accountability through an executive lead and a Combined (adults and children's) Trust Safeguarding Group (Central Manchester) or Operational Safeguarding Committee (South Manchester). We are advised that these groups remain in place through the transition period pending the creation of a combined governance forum. Although since our inspection pre-dates the new organisation, we cannot report on the effectiveness of these transitional governance arrangements MFT.

5.2.15 We noted that operational safeguarding governance is strong across the services in Manchester. Some examples of this are set out below.

5.2.16 New approaches in the North Manchester General Hospital maternity, such as practice reviews and safety huddles on the wards, are helping to promote a strong, shared focus on safeguarding and professional accountabilities. This promotes a culture of continuous improvement, challenge and transparency.

5.2.17 Governance of midwifery safeguarding practice in St Mary's hospital is strong with relevant safeguarding leadership and operational groups in place to keep a good focus on safeguarding children and families. Learning from incidents, near misses and from inspections is positively promoted and used to inform continuous improvements in professional practice. For example, following the joint targeted area inspection of Salford in September 2016, the quality of safeguarding practice across the Trust was promptly audited with key actions put in place to address areas for further development. This demonstrates the culture of improvement that we have previously noted in this report.

5.2.18 Strong governance structures in the MFT safeguarding team support timely sharing of information between board level and frontline health visiting staff. Team leads share strategic updates with health visiting staff at monthly meetings and the monthly safeguarding newsletter is discussed at the monthly team meeting. The named nurse, head of service and team leads meet bi-monthly to focus on safeguarding issues that are affecting frontline staff. For example, there was recent discussion regarding staff reporting challenges due to a high turnover of social workers. The named nurse was able to arrange a meeting with social care counterparts to better understand the impact of this issue

5.2.19 There is a widespread use of audits to improve practice by MHCC and all the providers we visited. This is further evidence of the prevailing culture of improvement we found throughout the week. Audits are planned as part of a rolling programme, but are also carried out in response to concerns or inspection findings. For instance, following a CQC inspection report of Wythenshawe hospital in 2016, the safeguarding named nurse for the trust carried out a qualitative audit of nine young people aged 16 and 17 who were placed on the adult ward at the hospital over a two week period. The purpose of this was to ascertain whether the voices of young people were taken into account when deciding how to best meet their needs. The audit found some shortfalls in the way young people were enabled to express a view about their care. This resulted in a series of actions designed to improve staff liaison with young people and an invitation for three of the young people to take part in a focus group to help identify measures that could be taken to improve the service.

5.2.20 Incident reporting is used well by the health visiting service and safeguarding team to understand when there are challenges in multi-agency safeguarding work. For example, if a health visitor cannot attend a strategy meeting then an incident form is completed. This has enabled the safeguarding team to identify recent trends showing an increase in health visitors not being invited to strategy meetings and to address this with the partnership.

5.2.21 In the sexual health service there is good oversight of frontline practice. Referrals to children's social care are tracked through a database and outcomes are followed up. This supports practitioners to have access to the decisions and plans made by children's social care as a result of the referral made, which in turn promotes effective joint up working within the service and between agencies. This good practice is checked through the use of audits. These have included an audit of the assessments of young people under 13 years old who attend the service and an audit of the assessment of 16 and 17 year old clients. Audit findings are fed back to the team in the protected learning sessions to facilitate shared learning, challenge, lessons learned and peer reflection to support continuous improvement of practice.

5.2.22 In one of the GPs we visited (Ashcroft) we noted strong operational governance of safeguarding practice. There are clear management systems and processes in place with appropriate flagging, updating and reviewing of vulnerable children, including those who are in need and those supported at early help. Recognition of the risks posed by, and vulnerabilities of, adults within the household is supported by appropriate linking of information between parent and children's records and this is good practice.

5.2.23 We also noted some areas of operational records governance that require strengthening. We have commented earlier about the use of paper records hampering effective safeguarding practice and this was particularly evident in the CAMHS. The disjointed and often haphazard way that documents are ordered in files makes safeguarding information difficult to isolate and retrieve. There is no system for monitoring or tracking actions and limited accountability. For instance, there was some delay in entering key notes from an important contact in one of the cases. Generally, the nature of the files in the CAMHS indicated a poor understanding of record keeping governance. [Recommendation 6.1](#).

5.2.24 Record keeping and monitoring is variable in the adult substance misuse service. The safeguarding matrix in each client's file intended to be used to record and track safeguarding activity was inconsistently used with some key information missing from records. This does not support good operational oversight of the case or of the records. [Recommendation 8.2](#).

5.2.25 We noted frequent engagement with young people across Manchester to help design or improve services. For example, on behalf of the MSCB, the Royal Manchester Children's Hospital's Youth Forum were asked to identify what their safeguarding priorities were and what safeguarding meant to them. The forum set out their five key priorities as Bullying, CSE, Neglect, Early identification, help and support and vulnerability through disability or as a young carer. The trust report that this has contributed to wider consultation led by the MSCB to inform future work.

5.2.26 The 'Voice Box' youth participation group is a forum where young service users help to develop services available to them in formats that best meet their needs. For example, the forum was instrumental in developing 'I Matter', a proactive safeguarding resource for Manchester schools designed to be delivered through the PHSE programme in schools. Its aims are to enhance young people's knowledge and skills to identify and manage risks and keep themselves and others safe. This is a good example of co-production with young people.

5.3 Training and supervision

5.3.1 Midwives at Wythenshawe Hospital do not currently benefit from regular one-to-one supervision that is recorded to support their continuous professional development and reflective practice. Whilst midwives have regular *ad hoc* access to the named midwife or safeguarding midwives this is too dependent on individual midwives raising issues rather than a routine offer to all members of the midwifery team. There are plans to introduce quarterly one-to-one safeguarding supervision from September 2017, with six-monthly supervision for hospital based midwives although at the time of our review this was not yet in place. [Recommendation 3.15](#).

5.3.2 The level three safeguarding training offer at Wythenshawe maternity does not meet requirements; this has been an issue highlighted in previous CQC inspection reports. The compliance rates of 75% for nursing and midwifery staff falls below the trust target of 85%. Additional training dates have been offered to increase the coverage but this has not yet had an impact. [Recommendation 3.16](#).

5.3.3 High priority has been given to strengthening safeguarding children practice in North Manchester General Hospital maternity. The trust reports that 83% of the maternity workforce is now trained at the appropriate level against a trust target of 90%. Two midwifery practice educators have been appointed and this has provided additional support to the professional development of midwives. However, our assessment of the quality of safeguarding practice we have seen indicates that further targeted workforce development is required. This will ensure midwives are sufficiently confident and skilled in undertaking complex safeguarding work, such as writing reports for child protection conference. It will also help to fully embed newer approaches to assessing risk in practice, such as domestic abuse checks, using the 'Signs of Safety' approach and using chronologies. [Recommendation 2.9](#).

5.3.4 Supervision of specialist midwives is undertaken at North Manchester General Hospital maternity. However, a regular, targeted supervision model is not yet in place to support the development of practice. The trust plans for all specialist midwives to receive one-to-one supervision with the named midwife and for other midwives to be offered group supervision based on discussions with team managers every quarter. This approach has yet to be implemented. [Recommendation 2.10](#).

5.3.5 Learning from serious case reviews is evident through observable changes in midwifery practice in some areas in North Manchester General Hospital. For example, the focus on the baby's father or mother's partner is now stronger in the booking record. The development of an electronic version of the serious concerns form has enabled better and more timely communication with other relevant professionals when a specific concern is highlighted. Screening for alcohol use and maternal mood is now routinely undertaken. Additional training on domestic abuse has been delivered and the team is also about to roll out a new programme of work to help reduce risk of babies being shaken. Midwives have also received additional training in relation to FGM and reporting responsibilities and this is positive.

5.3.6 The need for good staff engagement and managing the impact of workforce turnover is well understood by the midwifery safeguarding team at St Mary's Hospital and the level of support provided is exceptional. Priority is given to communicating regular updates to staff, including changes in safeguarding policy and practice. Take-up of training is good and the trust's safeguarding training figures against the relevant guidance (all three levels) is reported as over 90%. This compares well with many other NHS Trusts in England. Coaching is effectively built into the development of midwives who benefit from additional support in writing their first child protection reports or first attendances at conferences. Safeguarding midwives also personally support midwives at conference where cases are complex.

5.3.7 Monthly group supervision is provided by the safeguarding midwifery team to specialist midwives, link midwives and the IDVA (one-and-a-half hours each month), This helps update frontline teams on any changes to safeguarding practice and encourages case discussion and reflection on complex safeguarding work. Different speakers from other agencies are invited to provide 30 minute inputs to ensure midwives are well informed about wider partner developments.

5.3.8 Community midwives at St Mary's have good contact with the safeguarding midwives enabling advice and support to be provided as and when it is needed. One-to-one supervision is provided to midwives on request. Formal group supervision is provided to community midwives every two months and it is expected they will attend, as a minimum, at least twice a year, along with attendance at the monthly community midwifery forum. This strong supervision offer enables midwives to provide a safe and effective service to vulnerable women and their babies.

5.3.9 Health visitors and school health nurses are required to access one-to-one and group supervision facilitated by a specialist nurse from the safeguarding team on a quarterly basis. The format includes three one-to-one sessions and one group session each year on a quarterly basis. All (100%) of the health visiting and school health nursing team are shown as accessing safeguarding supervision and practitioners report that they value the support and challenge. The supervision records use 'Signs of Safety' model and are routinely filed in the family's records, resulting in records that are more robust and complete.

5.3.10 There is good compliance with safeguarding children training across the health visiting and school health nursing workforce. In the first quarter of this year, 93% of staff were up to date with level three safeguarding training. Staff can access a range of training and topics such as FGM and domestic abuse which ensures they are fully equipped to identify and respond to concerns in their client group.

5.3.11 The safeguarding team at Wythenshawe Hospital recognise that safeguarding training levels are below the expected 85%. The ED and paediatric medical team is an area of particularly low compliance at 69% and 62% respectively although we are advised that staff who are not yet trained are booked onto level three training. In addition, the trust cannot be assured all staff requiring level three safeguarding training have accessed the recommended 12 to 16 hours over a three-year period, as the database is unable to record external training over and above the seven hours provided by the trust. [Recommendation 3.16](#).

5.3.12 Staff in the ED and paediatric ward at Wythenshawe have an established supervision model. Quarterly group supervision is offered by the safeguarding specialist nurses to staff in direct contact with children and young people and all paediatric nurses have annual one-to-one supervision. It is not clear from data, though, whether all staff take-up this offer of supervision and increased assurance is needed. [Recommendation 3.17.](#)

5.3.13 Safeguarding training compliance is above MFT targets for ED staff at Royal Manchester Children's Hospital and Manchester Royal Infirmary. Positively, ED managers have identified the need for a high level of competency in safeguarding for all staff and have ensured that a number of staff at band four are trained to level three. This ensures that practitioners are supported with early identification and understanding of safeguarding concerns. A bespoke level two training package has been developed for reception staff who are the first point of contact for families and this is good practice.

5.3.14 Royal Manchester Children's Hospital have not introduced a formal safeguarding supervision model for the ED or children's ward staff. Advice and guidance are reported to be available but there is no scheduled protected time to allow practitioners the opportunity for reflection and learning in a supportive structured environment. [Recommendation 3.18.](#)

5.3.15 This is also the case for the ED and children's ward at North Manchester General Hospital where no formal supervision is offered to staff over and above advice and guidance as and when required. [Recommendation 2.11.](#)

5.3.16 Managers at North Manchester General Hospital are working towards achieving level three safeguarding training targets of 80%. A proactive approach by the consultant paediatrician in the ED has led to the development of a bespoke level three training package. This forms part of a rolling programme delivered by the safeguarding team and consultant paediatrician when clinical commitments allow. Safeguarding training data shared on-site by ED and the paediatric ward showed that staff training ratios ranged from 83 to 100% with a trajectory of 100% anticipated by mid-August. This is a significant achievement. Despite this, the trust are not assured that relevant staff have undertaken the required amount of hours training (12 to 16 hours) at level three over a three year period. Similar to Wythenshawe, the training database is unable to record external training over and above the six hours provided by the trust. [Recommendation 2.12.](#)

5.3.17 Safeguarding supervision takes place in CAMHS only as part of management or clinical supervision. Although the team risk registers provide the means to monitor children and young people with complex needs the team leaders are not clear as to the number of live safeguarding cases being held by the team. Entries made in records by staff about safeguarding issues arising in supervision are not monitored and so actions may not be followed up properly. This was evident in one of the cases we were tracking across services where a verbal referral for a young person and a sibling in relation to sexual assault were not properly followed-up in writing and no action taken to ascertain whether other agencies were taking action. This case would have benefited from effective challenge and advice through supervision. [Recommendation 3.18.](#)

5.3.18 CAMHS service leads were unable to provide definitive numbers of practitioners that have been trained to level three as the database used to record this does not disaggregate this well. This makes it more challenging for service managers to quickly identify the training needs of the practitioners in their individual services. We have subsequently reviewed training data which indicates that level three training is below the trust target for staff who are new to role but we have been assured that this is on trajectory to meet targets once the new staff are integrated. [Recommendation 3.19.](#)

5.3.19 Looked after children nurses are mostly trained to level four safeguarding children in line with the relevant guidance. Additional training is provided in relation to FGM, domestic abuse and so called honour based violence. Safeguarding supervision for looked after children nurses takes place on a one-to-one basis each month provided by the trust's safeguarding team. Peer support is also available as is individual case support as and when it is required.

5.3.20 Safeguarding supervision takes place in the adult mental health service. Although not a separate scheduled safeguarding session, cases of concern are highlighted at every management supervision session and there is a process to ensure that managers have a clear picture of safeguarding cases managed by each team member and can monitor the progress of actions arising. This ensures key activity is not overlooked.

5.3.21 Safeguarding cases in the adult substance misuse service are formally reviewed every six weeks. There are also 'flash' meetings held daily where practitioners can share cases that are causing them concern, although these meetings are very short and allow only limited time to discuss complex safeguarding cases in depth. Although there are opportunities for staff to receive safeguarding supervision, the effectiveness of this is limited as we noted a variable quality in the safeguarding work that was overseen in this way. [Recommendation 8.3.](#)

5.3.22 There is good supervision and development offer in the sexual health service. Good progress has been made to expand the capacity and capabilities of the whole workforce with a whole team approach and inclusion in the monthly half day protected learning sessions. This approach supports consistency in safeguarding practice within the service. Sexual health outreach practitioners have regular one-to-one safeguarding supervision with a specialist nurse from the 'Protect' team. This supports sensitive challenge and reflection of safeguarding practice that aids their development and helps to secure improved outcomes. The remaining frontline staff have access to safeguarding supervision in groups as part of monthly protected learning.

5.3.23 We previously reported on the primary care link nurse programme as developed by the MHCC Designated Safeguarding team with the support of the named GP (see 'Leadership and Management' above). This is a robust support mechanism for GPs with twice yearly visits by the link safeguarding nurse to each GP practice and it is highly regarded by GPs across Manchester.

Recommendations

1. Manchester University NHS Foundation Trust and Pennine Acute Hospitals NHS Trust should:

- 1.1 Work together to ensure the ante-natal referral pathway from maternity departments to health visitors is consistent, effective and timely.
- 1.2 Develop the capability of the electronic patient record systems used in the EDs at each hospital site to support practitioners' analysis of safeguarding risk and to ensure staff are alerted to children who might be subject of local authority intervention.
- 1.3 Ensure GP discharge letters about a child or young person's attendance at ED has enough information to enable GPs to consider any further support that can be offered to a child.

2. Pennine Acute Hospitals NHS Trust should:

- 2.1 Develop the pathways and the arrangements for communication between the ED at North Manchester General Hospital and the maternity unit to ensure that pregnant women who present in ED are appropriately assessed and their immediate care benefits from midwifery oversight.
- 2.2 Ensure that all children who attend the ED at North Manchester General Hospital benefit from an effective safeguarding assessment to identify any additional needs or risks.
- 2.3 Ensure that adults who attend the ED practitioners at the ED at North Manchester General Hospital and who exhibit behaviour that might have an adverse impact on children are subject of an effective safeguarding assessment that is properly recorded on the patients' files.
- 2.4 Ensure that young people aged 16 and over who attend in mental health distress are assessed in a way that enables practitioners to consider social history and safeguarding vulnerabilities linked to age.
- 2.5 Develop the use of the 'Special Circumstances' form and the use of chronologies in the maternity unit at North Manchester General Hospital to enable midwives to build a picture of evolving risk over time.
- 2.6 Ensure documents relating to child protection processes, such as reports for conference made by midwives and also conference minutes, are properly retained on maternity records.

- 2.7 Plan the layout of the ED at North Manchester General Hospital to enable better observation of children in the waiting area.
- 2.8 Ensure there is adequate cover in the trust's safeguarding team to provide support to front line staff in the ED at North Manchester General Hospital.
- 2.9 Develop the confidence and skill of midwives at North Manchester General Hospital in complex safeguarding work to enable effective use of tools to assess and communicate safeguarding risks.
- 2.10 Expedite plans to introduce group supervision, as a minimum, for midwives together with one-to-one safeguarding supervision for specialist midwives.
- 2.11 Develop and implement a safeguarding supervision model for staff in the ED and children's wards at North Manchester General Hospital.
- 2.12 Ensure that the number of eligible clinical staff at North Manchester General Hospital who receive safeguarding training at level three of the relevant guidance and for the requisite amount of hours complies with trust targets.

3. Manchester University NHS Foundation Trust should:

- 3.1 Ensure the safeguarding assessments, as indicated by screening questions on the booking-in documentation for children at Wythenshawe hospital, are completed in every case in order to identify additional needs and risks.
- 3.2 Develop the templates used for booking-in children and young people and the Royal Manchester Children's Hospital ED so that they provide practitioners with the prompts to explore safeguarding concerns effectively.
- 3.3 Develop templates for use when booking-in adult patients in Manchester Royal Infirmary ED so that staff are prompted to explore the impact on children of adults who present with risky behaviours.
- 3.4 Develop formal arrangements for providing oversight of children's attendances at Wythenshawe Hospital and Royal Manchester Children's Hospital to ensure that timely, relevant information is passed on to community children's health teams.
- 3.5 Ensure records from 'team around the child' and child in need processes are faithfully uploaded to the client's records.
- 3.6 Ensure clinical and nursing records in children's wards are reconciled into a single record with accessible information for all staff who care for the patient during the episode of care.

- 3.7 Implement a system to enable staff to carry out an effective environmental risk assessment of all wards where a child in mental health crisis might be admitted.
- 3.8 Develop the skill of staff within the ED in Royal Manchester Children's Hospital to be professionally curious about situations where a young person is at risk due to their own risk-taking behaviours or the behaviour of others and can articulate concerns effectively in subsequent referrals to children's social care.
- 3.9 Ensure that referrals made by CAMHS staff to children's social care consistently and effectively set out risk and that referral outcomes are followed-up to ensure staff are aware of the most up-to-date information.
- 3.10 Improve the understanding of CSE among CAMHS staff to enable them to effectively consider risk.
- 3.11 Work with the looked after children strategic group to take steps to address the systemic barriers to completing initial health assessments for looked after children within a timeframe that enables the health recommendations to be available for the first review at 20 days.
- 3.12 In the absence of an electronic patient record system, implement a process that assures the integrity of information stored within the paper records of the looked after children service.
- 3.13 Expedite plans to improve the quality and relevance of health histories provided to young people leaving care.
- 3.14 Continue with plans to increase the specialist safeguarding capacity of the maternity service at Wythenshawe to reflect increased levels of complexity in casework where substance misuse may feature.
- 3.15 Expedite plans to introduce formal one-to-one safeguarding supervision for midwives at Wythenshawe Hospital.
- 3.16 Ensure that the number of eligible clinical staff at Wythenshawe Hospital who receive safeguarding training at level three of the relevant guidance and for the requisite amount of hours complies with trust targets.
- 3.17 Develop, implement and monitor a safeguarding supervision model for staff in direct contact with children and young people and all paediatric nurses.
- 3.18 Develop, implement and monitor a safeguarding supervision model for staff in the ED and children's wards at Royal Manchester Children's Hospital and for staff working in the CAMHS.
- 3.19 Ensure that the number of eligible staff in the CAMHS who receive safeguarding training at level three of the relevant guidance and for the requisite amount of hours complies with trust targets.

4. Greater Manchester Mental Health NHS Foundation Trust should:

- 4.1 Ensure there is clear understanding among staff of the impact of mental ill-health and the needs of babies of clients who are placed with mothers in the mother and baby unit at Laureate House.

5. Manchester Health and Care Commissioning should:

- 5.1 Work with GPs to ensure there is a consistent approach to coding records and linking records of family members where children are subject of child protection plans.
- 5.2 Ensure that GPs are provided with the most up-to-date information about every case that is discussed at the MARAC.
- 5.3 Work with the local authority and with GPs to ensure GPs receive feedback about referrals and are fully informed of the outcomes of child protection conferences and child in need processes.

6. Manchester Health and Care Commissioning, Manchester University NHS Foundation Trust, Pennine Acute Hospitals NHS Trust and Greater Manchester Mental Health NHS Foundation Trust should:

- 6.1 Work together to identify where the use of paper records is a barrier to effective safeguarding practice and information governance across the health landscape. Include this as a feature in the strategic plans to develop services through the transformation plan.

7. Manchester Health and Care Commissioning and Manchester University NHS Foundation Trust should:

- 7.1 Ensure that thresholds for referral into early help and into CAMHS are better understood by GPs.
- 7.2 Work with GPs on a practice by practice basis to establish regular face-to-face information sharing meetings with community health practitioners about vulnerable families to enable more focussed planning.
- 7.3 Work with the Manchester Safeguarding Children Board and agency partners to develop and strengthen the role of the health practitioner in the MASH so that health information and its interpretation supports decision making at the safeguarding front door.

8. Change Grow Live should:

- 8.1 Ensure practitioners seek information and faithfully complete records about children associated with clients so that practitioners can 'Think Family' effectively.
- 8.2 Ensure the safeguarding matrix in records of adult clients is consistently used by managers in the adult substance misuse service to monitor safeguarding practice.
- 8.3 Improve the effectiveness of safeguarding supervision in the adult substance misuse service to ensure that the quality of safeguarding practice is consistent.

Next steps

An action plan addressing the recommendations above is required from NHS Manchester 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.