This report relates to the recent integrated inspection of safeguarding and services for looked after children which took place in the above Authority recently.

It provides more detailed evidence and feedback on the findings from the Care Quality Commission’s (CQC) component of the inspection, and links these to the outcomes requirements as set out in the Essential Standards for Quality and Safety.

Thank you for your contribution to the inspection and for accommodating the requests for interviews and focus groups with your staff and those of partner agencies at relatively short notice.

The team provided feedback to your local Director of Children’s Services at the end of fieldwork and the joint inspection report to the authority is now published on the Ofsted website and can be accessed via this link: The joint inspection report.

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This report includes findings from the overall inspection report, and provides greater detail about what we found, mapped where relevant to the Essential Standards, in order that your organisation can consider and act upon the specific issues raised.

A copy of this report is being sent to your commissioning PCT, and CQC Regional Director. This report is also being copied to the Strategic Health Authority/Monitor as appropriate and CQC’s head of national Inspections, who has overall responsibility for this inspection programme.

The Inspection Process

This inspection was conducted alongside the Ofsted-led programme of children’s services inspections. These focus on safeguarding and the care of looked after children within a specific local authority. The two-week inspection process comprises a range of methods for gathering information – document reviews, interviews, focus groups (including where possible with children and young people) and visits – in order to develop a corroborated set of evidence which contributes to the overall framework for the integrated inspection.

CQC contributes to the inspection team and assesses the contribution of health services to safeguarding and the care of Looked after children relating to that authority. Our findings from the inspection contribute to the joint report published by Ofsted and also enrich the information we use to assess providers against the Essential Standards of Quality and Safety. This report sets out specifically the evidence we obtained in relation to these standards and extracts from the published report are included and identified.

CQC used a range of documentary evidence in advance of and during this inspection, and interviewed individuals and focus groups of selected staff and, where possible, children and young people, their parents and carers in order to provide a robust basis for the findings and recommendations.

This document sets out the findings in relation to the organisations listed above, but includes some areas which apply to one or more other NHS bodies where pertinent.

Context:

There are 115,910 children and young people aged 0-19 years living in Manchester according to the 2009 mid-year population estimate. This accounts for 24% of the city’s total population of 483,830. Manchester has been growing at over 1% a year since 2001, twice the average rate of growth in England and Wales. The number of children aged five to 14 years has decreased during this period, but there has been an increase of over 20% in the number of children aged under five. The 2007 Index of Multiple Deprivation ranked Manchester as the fourth most deprived local authority area in England. In 2009, 77% of pupils lived in one of the 20% most
deprived areas in England. In 2010, 37% of primary school pupils and 34% of secondary school pupils were eligible for free school meals, significantly more than nationally. In the 2001 census, 31% of children and young people aged 0 to 19 years were from minority ethnic groups compared with 26% for the total population. According to the January 2010 school census, 35% of primary school pupils and 30% of secondary school pupils spoke English as an additional language, well above other areas of the country. Over 170 languages are spoken across Manchester schools. (Ofsted Report 2010)

The Manchester Safeguarding Children Board (MSCB) has an independent chair and brings together the main organisations working with children and families in the city including the local authority, Greater Manchester Police, NHS partners, schools and the voluntary sector. It gives strategic oversight of safeguarding through quality assurance, partnership performance management and learning from serious case reviews. (Ofsted Report 2010)

NHS Manchester commissions all health services for Manchester, including general practitioners, pharmacists, orthoptists and dentists. There are three practice-based commissioning hubs based on the areas covered by the former Primary Care Trusts: North Manchester, Central Manchester and South Manchester. The main health care providers are Central Manchester Hospitals Foundation Trust (CMHFT), University Hospitals South Manchester Foundation Trust, Pennine Acute Trust and Manchester Mental Health and Social Care Trust. CMFT provides secondary paediatric services to its local population and is the tertiary (specialist) paediatric hospital. (Ofsted Report December 2010)

1. **General – leadership and management**

1.1 The council, MSCB, Children’s Trust and other lead agencies give safeguarding the highest priority and provide effective leadership. All partner agencies are increasingly effective at meeting their statutory responsibilities and services across the broad safeguarding agenda are improving. The partnership has well developed systems in place to evaluate value for money. The council and its partners are increasingly effective at working together to find solutions to meet the diverse needs of the people who live in the communities of Manchester.

1.2 The council and its partners give safeguarding the highest priority. There is very good cross party commitment to the safeguarding agenda and elected members who champion the needs of children and families. The MSCB provides effective leadership on safeguarding with a very significant impact on service improvement through the learning from serious case reviews. Agencies have good access to high quality training leading to a good level of awareness about safeguarding and child protection among partner agencies. MSCB and the Children’s Trust Board provide effective challenge.

1.3 Priorities are effectively actioned by the multi-agency Safeguarding Practice Improvement Group and partners are appropriately held to account for their work. Highly competent senior officers across the partnership provide clear
strategic direction, respond effectively to the changing demand for the services and prioritise the allocation of resources to support safeguarding. Multi agency district wide leadership teams provide good local leadership to promote joint working and better coordinated responses. Partnership working is a very good (Ofsted December 2010)

2.0 Outcome 1 Involving Users

2.1 The involvement of young people in influencing the strategic planning and delivery of services is good. The CMUHFT and the UHSMFT have active youth fora. The forum for UHSMFT has worked on care pathways specifically around developing adolescent clinics. The adult and paediatric consultants both attend the adolescent clinic to ensure a smooth transfer of care.

2.2 The teenage pregnancy midwife holds an ante natal drop in clinic at the Connexions Centre in response to requests from young people. This allows the young person to receive their ante natal care at the same time as their connexion appointment to sort out benefits and other issues and has shown to increase access to ante natal care.

2.3 The looked after child health team stated that all young people were given a choice as to where their annual health review took place.

2.4 Access to interpretation services is good. NHS providers have access to either telephone based interpreters or face to face workers. Manchester NHS Interpretation Services has a number of link workers who support the work of health visitors. An example was given of a nursery nurse who was unable to gain access to carry out a home visit and involved the Urdu and Punjabi Link Worker who was able to facilitate contact and the home visit successfully took place.

3.0 Outcome 4 Care and welfare of people who use services

3.1 The provision of health visiting across Manchester is inadequate. The Healthy Child Programme for children 0-5 years is delivered through a skill mix that includes community staff nurses and community nursery nurses who are employed by Manchester Community Health Services.

3.2 The Healthy Child Programme is not being delivered in full. The Healthy Child Programme provides the opportunity to identify risk factors that make children more likely to experience poorer outcomes later in life. The health visiting teams are only carrying out targeted risk assessed ante natal visits; the first contact visits to new mothers are taking place anytime between 10 days and up to 28 days after the baby has been born in some teams that are particularly stretched in terms of capacity. Teams have put in place arrangements to offer support and make contact with new parents whilst they are waiting for their primary visit. The teams offer the 8 month development check through locally agreed initiatives; for some this is part of 18 month assessment clinic and for others this is through attendance at scheduled baby clinics. The 2 year development check is not being routinely delivered.
Provision of early intervention and support, including delivery of the “Baby Matters” (that includes baby massage, advice on weaning and dental health) varies across the city and provision is influenced by local need and staff capacity. Some teams are very concerned that the lack of capacity is adversely impacting on the ability to deliver core business.

3.3 The community staff nurses and community nursery nurses support families with behaviour management, weaning, sleeping problems, domestic abuse, working with families with special needs, immunisations, BCG clinics and following up non attendance as directed by the health visitor. Community staff nurses will also co-work some of the management of cases for looked after children and child protection and child in need cases, with close supervision.

3.4 The school nursing service in Manchester is good. School nurses have a crucial role to play in safeguarding as they have regular contact with children aged 5-19. The school nursing service offers the extended role as well as participating in the National Programme of child measurement and usual health checks including vision. However, vacancies are now starting to impact on the ability of school nurses to contribute to the “healthy schools” initiative and deliver public health teaching.

3.5 Provision of sex and relationship education and advice in Manchester is good. Services are provided by NHS Manchester community health services and Brook. There is access to contraceptive services 7 days a week across the city through a number of providers. ‘Fresh’ provide services to young people under 25, Brook provide services to young people under 18 and the Palatine service, which is an outreach service that works with the hard to reach young people, will carry out home visits. The service provides contraceptive and sexual health services (CASH) and operates the C Card initiative and has trained youth workers so that they can administer contraception. In addition to these services young people have access to contraceptive implants and oral contraception through trained pharmacists.

3.6 NHS Manchester and partners are using data around conception rates intelligently. The service recognises that a high percentage of their under 18 conceptions are with young people aged 16 plus. In an attempt to effectively target the young people they have identified courses at local colleges where the young people have a higher risk of unplanned conception and now provide additional resources onto these courses. In addition, there are contraception clinics on college campuses across Manchester.

3.7 Conception rates for under18s in Manchester are now starting to reduce. During the first two quarters of 2010 they have decreased from 73.0% to 71.6%. The most significant trend is the outcome of conceptions with the proportion of conceptions resulting in abortion has increased from 28% in 1998 to 49% in 2008 though the recent unvalidated figures are showing a substantial decrease.
3.8 The provision of services for young people seeking a termination of pregnancy is good. Young people can either self refer or ask a professional to refer to the central booking service. This has led to 80% of terminations now being carried out under 10 weeks of gestation. All contracts with providers stipulate that pre and post termination counselling and contraception must be offered to young women.

3.9 There is a teenage pregnancy midwifery service offered by both CMUHFT and UHSMFT that accepts referrals for any young woman under 18 and offers early assessment. Services provided for pregnant teenagers 3 specialist clinics to young parents across Central Manchester including parent education in a clinic held once a month on a Saturday afternoon in response to a post natal questionnaire. In addition, there are 2 community clinics at children centres to facilitate early engagement in early years support as well as offering contraceptive advice, prescribing and screening.

3.10 There is an improving picture on the health of looked after children and young people. Local data shows that 73% of looked after children and young people have up to date immunisations; this improvement is as a result of the newly introduced immunisation care pathway and the work done with foster carers who can now consent for vaccinations. HPV vaccination for young female looked after children is 81% which is above national average. There is a good increase in the number of looked after children placed in Manchester who have contact with a dentist, however, this is less so for those children and young people placed out of area. Recent work to ensure looked after children and young people are registered with a dentist has been successful for both in area and out of area placements. Registrations with a dentist are now at an overall 90%, with 96% for those looked after children in Manchester and 84% for those placed out of area.

3.11 The arrangements for initial health assessments and annual health reviews for looked after children and young people are adequate. Initial Health Assessments for looked after children and young people are carried out by paediatricians. Review health assessments are carried out by health visitors for the under 5 children and school nurses or specialist looked after child nurses for over 5s. The team have carried out audits on the past three months returns on the quality of completed initial and review health assessments and identified issues that are being addressed through training and feedback.

3.12 Each looked after child or young person has a key link health worker who has received training in completing annual health reviews and who takes responsibility for ensuring that these are completed in a timely way. It is part of their role as link health worker to ensure that they attend the looked after child reviews or as a minimum ensure there is a health contribution to the looked after child review. This responsibility is monitored through safeguarding supervision provided by the named nurses.

3.13 The arrangements for carrying out either an initial health assessment or health review for looked after children who are placed outside of Manchester
are adequate. When a child or young person is placed out of county, the
looked after child health team contact their counterparts in the receiving area
to agree the process for the child or young person’s initial health assessment
and annual health reviews. There is an agreement to fund the assessments
in areas where there is a charge.

3.14 There have been issues around the timeliness of social workers responding
to requests for updated information in a timely way for the annual health
reviews; this has recently improved from a response rate of 11% to 30%
though substantial progress still needs to be made.

3.15 The provision of advice around substance misuse and sex and relationships
to looked after young people is adequate. Looked after young people are
encouraged to access universal services for substance misuse and sex and
relationship education and advice. More in-depth conversations take place
during the young person’s annual health review. Where the young person
requires additional support then this is available from the specialist looked
after children nursing team.

3.16 As from September 2010, the council’s children’s services have introduced a
new pathway for the completion of Strength and Difficulties Questionnaire
(SDQ). The social worker will send out the SDQ to the carer who will then
return it to the local authority’s data collection team who will score it and send
the score through to the social worker and the health looked after child team.
Any scores above the agreed thresholds will result in a further SDQ
questionnaire being sent to the school and young person to complete with a
referral to the specialist CAMHS team for looked after children if necessary.
This is very new and the looked after child health team have not seen any
completed SDQs and there is no evidence of impact on the health and
wellbeing of looked after children.

3.17 The health information given to young people when they leave care is
adequate. The current provision is a letter that includes details of the young
person’s medical history, any immunisations that they have had and details of
any outstanding immunisations that are still required. There is work taking
place on compiling a history of the young person called “My Life so Far” which
will be a more comprehensive life history, however, this work is not yet
complete.

3.18 The CMUHFT provide child and adolescent mental health services (CAMHS).
The range of provision by CAMHS is very good. Referrals to core CAMHS
are through any health professional and are discussed at weekly referral
meetings. The service operates within the trust’s maximum 11 weeks from
referral to treatment and there is no waiting list. There are good links with the
drug and alcohol team that support young people with arrangements for
referral between services.

3.19 The CAMHS service provides a comprehensive range of interventions at tiers
2, 3 and four with additional specialist services that include Emerge (a service
for young people aged 16 and 17), the CT LAC service (Looked after
children’s services in Manchester), youth offending specialist support service and special projects around emotional wellbeing in schools and the Children and Parents Service (CAPS). They also provide a care pathway for ADHD through a virtual team and Social Communication Assessment and Interventions through a dedicated team.

3.20 The specialist CAMHS service for looked after children is well regarded by all partners. It has an establishment of 5.6WTE across disciplines including social work, psychology and psychiatry. Referrals are received jointly from health and the child or young person’s social worker and discussed at monthly multi disciplinary meetings where the most appropriate treatment pathway is agreed on and arranged. The service sees all referred looked after children and young people regardless of whether the placement is viewed as stable and offer an assessment service to Manchester looked after children placed out of area. They will offer appointments to those children and young people who are placed within one hour’s travelling distance of the clinic. The specialist CAMHS service for looked after children also offers consultations to foster carers.

3.21 The CMUHFT CAMHS offers Multi Dimensional Treatment Foster Care. It is one of two national sites training specialist foster carers to help with behaviour either in the family home or in foster care and prevent placement breakdown. Four children have gone through the programme and a further two are part way through. The programme lasts between 6 and 12 months. Outcomes are measured by looking at a set of behaviours and early indications are positive.

3.22 The Learning Disabilities Service is a clinical psychology led service for children and young people who have severe learning disability and offers assessment and interventions with good links with the learning disability children’s nursing team.

3.23 The Manchester Mental Health & Social Care Trust provides mental health services to adults. Within the trust there is a tertiary ten bedded mother and baby unit called the Anderson Ward which looks after pregnant mothers from the second trimester onwards and will accommodate mums with their babies up to the age of 12 months. Any baby on the ward for over 3 months becomes looked after under Section 85. This unit provides a caring, supporting and safe environment for new mothers and mothers to be who require in-patient treatment for their mental illness.

3.24 Provision of accident and emergency services for children and young people is good. The A&E department at the children’s hospital, which is part of CMUHFT is open 24 hours a day, 7 days a week and will treat children and young people up to 16 years. The unit sees approximately 120 children a day. There are 6 cubicles and 2 consulting rooms that are also used as clinic rooms. In addition, there are 3 resuscitation bays and a clinical decision unit that will assess children for up to 12 hours and a medical assessment unit that will facilitate stays up to 24 hours.
3.25 The paediatric A&E at UHSMFT is open 24 hours a day, 7 days a week and will treat children and young people to the age of 16. The department is fully staffed by suitably qualified, paediatric nursing staff and medical staff. The unit treats approximately 50 children and young people a day. The trust has recently opened a paediatric medical assessment unit that GP’s can refer into should they consider a child needs a period of assessment or observation and this is relieving some of the pressures on the paediatric A&E.

4.0 **Outcome 6 Co-operating with others**

4.1 There is good partnership working at the Old Moat Children’s Centre with co-location of health visiting, midwifery and council staff. Health visitors interviewed stated that the co-location had positively influenced relationships across teams resulting in earlier and targeted interventions for families and avoided duplication of effort. The Old Moat Children’s Centre has a multi agency leadership team that is signed up to a shared business plan and priorities that are based around the five Every Child Matters outcomes. This helps to ensure a common message is given to families who use the Children’s Centre. An example was given around healthy eating and how this message is consistently delivered ante and post natal, promotion of breast feeding, in the parenting groups and in early years educational provision.

4.2 Health visitors and school nurses in Manchester are involved in the Common Assessment Framework (CAF) and will refer families to the early intervention teams where CAF is likely to be required. In one school there is a CAF co-ordinator and this was felt to effectively facilitate the CAF process. School nurses are part of a school’s panel meeting used to discuss non attendance and behaviour issues and will often initiate CAFs to support families who are struggling. Staff in the focus group provided good examples of where CAF had been used to co-ordinate packages of care to complex families and had avoided escalation to child protection. Health visitors carry out joint visits with colleagues from children’s services and feel that their contribution to child in need and child protection cases is highly valued. The named safeguarding nurse supports health visitors and school nurses in attending case conferences and in writing reports. It is clear that the contribution of the health visitors and school nurses to the child in need and child protection work is viewed as an organisational priority.

4.3 Partnership working to support young women during and after pregnancy is good. The Connexions service pregnancy personal advisers and the Palatine service work closely and of particular benefit is the support given post pregnancy with contraceptive advice and prescribing. The family nurse partnership works closely with pregnant young women who have a high level of need to support them during their pregnancy and up until the baby is two. A recent quote about the service was “They have guided me through and helped me make my daughter be the best she can” this young woman was supported through periods of homelessness and is now back in education and is wanting to go on to college. There is a multi agency pathway to care, support and advise young women who are looked after and become pregnant. This pathway was developed following the identification of gaps in
services to support this group of vulnerable young women and it is hoped that final sign off by all partners will happen by the end of this year.

4.4 There is good awareness and training around the link between domestic violence and the impact on the child. All midwifery staff, school nurses and health visitors across the three providers received notifications of when the police had been called to an incident of domestic violence and triaged the notification according to protocol. Staff in both A&E departments and the urgent care centre were clear about the need to refer to the council’s child and family services if they treated an adult who had presented with injury following domestic violence or other risk taking behaviours. The staff were clear about the processes to follow regarding notifications of domestic abuse from the police and also about any disclosures of domestic abuse from clients. They were able to talk confidently about recourse to Multi Agency Risk Assessment Conference (MARAC) and referrals they had made to children and family services. The named nurse for UHSMFT was able to confirm that there had been a significant increase in referrals to the local authority around risk related activity by adults. This trust had developed a process that when a referral has been made by A&E staff to the local authority because of risk related activity by adults, a short summary report was sent to the child’s health visitor or school nurse so that they are aware of the intervention. This has been well received by the community nursing staff.

4.5 The child and adolescent mental health service for 16 and 17 year olds during transition is adequate. The Emerge team are commissioned from CMUHFT. Emerge is a multi disciplinary community based team that offers support for 16 and 17 year old young people. There is an open referral to the service that offers initial assessment and ongoing intervention where appropriate. They team see all referrals within four weeks and offer community based appointments and support CAF. The team support transition into adult mental health services. The planned in patient facilities for 16 and 17 year olds is commissioned from the Greater Manchester West Mental Health NHS Trust on the McGuinness Unit. The adult crises team will pick up emergency referrals and liaise with the Emerge Team or the Early Intervention team, depending on need. Transition planning takes place a minimum six months before a young person is 18. There is, however, no directly commissioned service for adults with Attention Deficit Disorder or young adults on the autistic spectrum to transition into at aged 18.

4.6 There is a newly established CAMHS Youth Offending Specialist Team consists of 3WTE specialist nurses that are linked into the youth offending teams across Manchester. The team are new and early feedback from the young people they have been involved with and the youth offending teams are positive.

4.7 The emotional health in schools project works in 9 high schools across Manchester and provides a mental health service to young people aged 11-16. The service provides training and consultation to education staff and assessments and interventions to young people and their parents and carers. The service can refer into core CAMHS and other more specialised teams.
such as learning disability services. The scheme has evaluated very positively with young people and carers and is helping to address emotional health issues at an earlier stage and to stop escalation.

4.8 There is a good Children and Parents Service (CAPS). CAPS is a multi agency service between CAMHS, Early Years and Play and Family Action. It is jointly commissioned and operates on an Early Intervention Model with children between 0 to 12 years. Evaluation of the project has demonstrated significant improvements in child behaviour, parental depression/stress, increased school attendance and attainment.

4.9 Families with babies and children with disabilities are especially vulnerable and often require additional proactive support to prevent family breakdown. The arrangements to support families with babies and children with disabilities across Manchester are adequate. Early years support services provide support to parents with babies and young children with disabilities alongside the pre school special needs team and allied health professionals. There are sensory teams that offer regular appointments and track progress throughout a child’s education and do act as key worker to families. Allied health professionals and the community paediatricians offer clinics and support into special schools. There is, however, some concern around the impact of recent staff vacancies within the learning disability nursing team and occupational therapy. The focus group advised of a recent trend in Manchester with a number of children presenting at primary school and nursery school with unidentified need and this was thought to be a possible consequence of the lack of capacity within health visiting to deliver the 2 year check as part of the Healthy Child programme.

4.10 There is a local authority led transition planning team for disability that works with families and young people to arrange smooth transfer of care from children’s services into adult services. The team aim to implement a pathway starting at 14 years taking a co-ordinated approach to person centred planning. There are a number of projects involved in identifying and supporting young people with disabilities to enter into employment. One project is “Getting a Life” and some young people have gained employment after working with the project.

4.11 The “Aiming High” short term breaks provide a range of respite for families to avoid family breakdown. Further work has been carried out under “Aiming High” in training professionals in disability. It has also trained parents to deliver training to professions around increasing knowledge and understanding the pressures of being a parent with a child who has disability

4.12 Speech and language therapists are working with colleagues and families to produce communication passports for children and young people who have communication problems. Families hold the passports and use them to inform professionals how to effectively communicate with their child.

4.13 There is multi agency guidance on safeguarding and promoting the welfare of disabled children and young people that is currently in draft. This was
identified as a gap in the 2006 Joint Area Review (JAR). There have been incidents of confusion with safeguarding referrals being passed between the children's disabled team and the district teams and whilst there is now clear guidance on roles and responsibilities, these have yet to be communicated across the city and embedded in practice.

4.14 The Healthy Child Programme starts in midwifery. Midwives in both the CMUHFT and UHSMFT use the standard booking tool as well as a mental health screening tool when booking pregnant women. The booking forms and screening tools have prompts to address emotional health and wellbeing issues, including domestic violence. If the midwife identifies any concerns then these are escalated according to the organisation’s protocol. The midwifery services are also starting to include Pre CAF assessments as part of their booking service. All the midwives spoken to were able to describe the referral process to the council’s children and families service.

4.15 There is good support for women who are pregnant and have additional needs. NHS Manchester has commissioned a team of specialist midwives who work citywide and are employed by the CMUHFT. These specialist roles include a perinatal mental health specialist that works closely with the specialist midwifery team in Manchester. The post supports all pregnant women who have a mental health problem and also offers pre conception advice. The post has been successful in pro actively supporting women during their pregnancy and has minimised the need for any crisis intervention. There is a specialist midwife for refugees and asylum seekers who is well regarded by the communities to which she delivers services. She receives many referrals through hospital and community midwives, word of mouth and through charities that work with the communities to help prevent women booking maternity care late in their pregnancy or turning up in labour without any antenatal care.

4.16 The vulnerable baby service is effective and well regarded. The service was developed as a consequence of work looking at the high infant mortality rate in 2002. This work identified common factors that were prevalent in the deaths and the service is aimed at identifying and mitigating risk. The service is led by a multi agency steering group and takes referrals where there are chaotic lifestyles around drug use, previous infant death, criminal activity, etc. The service receives approximately 150 referrals a year and will proceed to around 80 specialist case planning meetings. The data from the service shows fewer referrals to child protection, however, those that did take place were robust and well evidenced and intervention was timely and well planned.

4.17 There is good liaison between midwifery staff and the council’s children and families service regarding families where there is concern around an unborn child. Following a recent audit of pre birth assessments by the named midwife at CMUHFT, a referral pathway has been developed that recommends the council’s children and families service carries out the initial and pre birth assessment at 20 weeks. This has had a significant increase in those babies that arrive early having a child protection plan in place.
4.18 Specialist midwifery services in South Manchester include 2 Sure Start Midwives who will assist community midwives with the more complex families and provide parenting support, ante natal clinics and a programme called “Making your life better” within the Sure Start Children’s Centres. They follow up any non attendance by women who are of concern to services. One of the specialist midwives also has a remit around working with homeless families and will continue to visit young vulnerable women who are moved out of the area into emergency accommodation. This helps to ensure continuity and co-ordination of care and preparation for the birth.

4.19 The involvement of the looked after children health in the training of foster carers is good, the nursing staff provide input into the training of the pre registration of foster carers as well as the ongoing training as part of the NVQ process. The team also provide briefings to social workers and team managers. This input ensures that foster carers and social workers are aware of the role of the looked after child health team and the services that they can offer. Each looked after child nurse has a named responsibility for all local authority residential children homes and five of the independent homes and support the establishment with various health initiatives such as healthy eating.

4.20 There are adequate arrangements in place to safeguard children and young people attending the accident and emergency units within the children’s hospital at CMUHFT and the urgent care centre run by NHS Manchester.

4.21 There are routine checks made on children and young people who attend the walk in centre around repeat attendance though these are not necessarily recorded. Staff will only check to see if a child or young person has a child protection plan if there are concerns. All attendances of children and young people up to 16 at the centre are notified to the relevant health visitor or school nurse and general practitioner.

4.22 When children attend the paediatric A&E at the children’s hospital, the IT system automatically records repeat attendance and this is checked by the triage nurse and treating clinicians. A note is made on the casualty card to indicate that this has been checked. The staff do not check each child’s attendance to see if they are on a child protection plan; instead they assess each child’s presentation and if there are concerns then they will check with the council’s children and families service. The trust’s policy on safeguarding supports this approach. Notifications of all attendances are sent to the child’s GP and to the child health team within community services who then send this out to either the health visitor or school nurse. If a clinician treats a child for an injury or incident that is around home safety, then the card is kept in a file and the following day a telephone call is made to the child’s health visitor or school nurse to advise them of the attendance. This process does not form part of any written policy or guidance. If a young person has been treated in the children’s hospital clinical decision unit or the medical assessment unit then as well as providing the normal notification letters to the child health and general practitioner, arrangements are also made for a nurse from the community children’s nursing service to carry out a home visit.
Because young people sometimes attend the neighbouring adult A&E unit, the trust's safeguarding team check any relevant attendance to ensure that appropriate follow-up action and any referrals have taken place.

4.23 The arrangements in the paediatric A&E at South Manchester University Hospital NHS Foundation Trust to safeguard children are good. When children and young people attend the paediatric A&E and book in with the receptionists, the system generates a casualty attendance card that also shows the number of repeat attendances. These attendances are considered as part of the triage and the medical staff use the sticker with the 5 prompts advised by NICE. Notifications of attendance of children and young people are automatically generated and sent to the health visitor or school nurse and the GP. If it is the child’s third attendance within 12 months, then a more in-depth letter is sent to the health visitor or school nurse and GP to highlight them of the repeated attendance. The A&E staff do not have IT access to whether a child has a child protection plan in place, however, the unit has a low threshold when to refer to the local authority and if there are concerns, then staff will telephone the council’s children and families service to check if a plan is in place and agree a way forward. Any referrals to local authority are copied to the named nurse.

4.24 There are good arrangements to care for young people under 16 who present at either the paediatric or adult A&Es across the city with self harm or substance misuse who require admission. However, the arrangements for young people aged 16 or 17 are confusing and lead to unacceptable waits or frequent moves before a suitable bed can be found.

4.25 The drug and alcohol support services to young people in Manchester are adequate. The Eclipse service provides advice and treatment on drug and alcohol misuse as well as training and support to partner agencies. The service supports the “Think Family” approach and works towards developing resilience with young people who are living with parents or carers where there is adult substance misuse. The service offers open referral and does not operate a waiting list for access. There is a good partnership arrangement with CAMHS and other partners including Connexions. There were good examples of joint working between Eclipse and adult substance misuse services around transition and developing individual pathways of support.

4.26 The designated nurse for NHS Manchester is actively involved in promoting learning through serious case reviews. She identified that a number of children involved in critical incident reviews had received dental treatment under a general anaesthetic. NHS Manchester is now leading work to devise a pathway for all children who are referred to the hospital dental service for extractions to be followed up with a view to identifying neglect. To complement this work, one pilot piece of work under the “Manchester Smiles” project has involved staff from the oral health improvement advice team visiting a local school and talking to the children and any interested parents about dental health, followed up with a visit from a local dentist who carried out dental checks and applied fluoride to the children’s teeth. As part of the dental check, if the dentist identified the need for further treatment, then she
made a referral and notified the school nurse. There is a clear escalation path to the safeguarding team if the child does not attend for treatment. The oral health improvement advice team are also involved in the training of foster carers for LAC.

4.27 Staff working in adult mental health care had good awareness of the potential impact on children who were in contact with adults who have mental health. The focus group were able to talk confidently about the training they had received around their role in safeguarding and confirmed that there was a risk assessment tool in use across the Manchester Mental Health & Social Care Trust following the recommendations from a serious case review.

5.0 Outcome 7 Safeguarding

5.1 There is good representation from all four provider NHS trusts and NHS Manchester on the MSCB with clear escalation routes through organisations’ governance structures. There is strong evidence of learning from serious case reviews.

5.2 Designated professionals are a vital source of professional advice on safeguarding children matters to the health economy. The designated safeguarding nurse for NHS Manchester is one WTE and is line managed by the Medical Director and Consultant in Public Health. The designated nurse has a full time deputy who has full deputising responsibility. The designated doctor is employed for 3PA and is directly line managed for these sessions by the medical director. The designated doctor function is to primarily support serious case reviews and attend the MSCB. Both designated positions have appropriate access to safeguarding supervision and are represented on the MSCB. There is, however, some concern at the lack of capacity within the designated doctor role to deliver one-to-one safeguarding supervision to the named doctors in the provider trusts.

5.3 The role of named GP is currently undertaken by a newly developed group of 5 GPs with a special interest who come together as a safeguarding reference group. The reference group is in the early stage of its development and a representative will be attending the December meeting of the MSCB. The GPs involved in the reference group have a good spread of special interest and links with the LMC. The job description for the named GP for the MSCB is currently being revised to reflect this structure.

5.4 Manchester NHS is currently working well in supporting general practice towards meeting their responsibilities under Working Together through the promotion of specially adapted training course, the re-launch of the GP toolkit, identifying safeguarding leads within the GP practices and the implementation of the “Manchester Standard” which contains specific requirements from practitioners around quality working practices. NHS Manchester has provided targeted training over the summer and has identified those practices where training is still required. The GP Safeguarding Referencing Group is now helping to develop an approach to those practices and GPs that have not
attended safeguarding training. Historically it was acknowledged that there had been a problem with GPs attending case conferences and strategy meetings, however, work with the local authority’s Safeguarding Improvement Unit had identified that attendance had been compromised by the invitations not being sent. This issue has now been resolved and work is ongoing to ensure that a contribution is sent from primary care. The PCT has developed a special training package tailored to the need and interest of dentists around the safeguarding agenda and this has been made available to dentists and practice staff.

5.5 The Child Death Overview Panel (CDOP) is not yet working to its full capability mainly due to complexity of the arrangements within the region. The Chair of the CDOP has put together a paper to stimulate discussion across Greater Manchester and the North West as to how to improve the effectiveness of the CDOP. There have been issues around data quality though these are now starting to improve following the sponsoring of an administrator post in a local acute trust. There have been some early findings around sudden infant deaths that have late booking with midwives, maternal obesity, safe sleeping and housing as contributing factors, however, more detail is required. The most recent CDOP Annual Report does not refer to evaluating the support offered to bereaved parents and/or carers following child death, however, there is a public health registrar who is currently working on a project on bereavement services across Greater Manchester and this is expected to report in spring 2011.

5.6 The looked after child health team consists of two designated looked after children nurses that job share one WTE role, the designated doctor for looked after children who works 2PA per week and a named doctor who works 2PA per week. In addition, there is a specialist looked after child nurse for 16-18 year olds, 3 specialist nurses who cover looked after children out of mainstream education and one WTE specialist nurse who works with the unaccompanied asylum seekers who are looked after. There is admin support, however, this is insufficient for the team to be able to maximise the improved and increased data flows that is now available to the team from the local authority.

5.7 It is a requirement of Working Together that all NHS organisations should identify a named doctor and a named nurse, and a named midwife if the organisation provides maternity services. The named professionals have a key role in promoting good professional practice, provide advice and expertise for fellow professionals and support the organisation in its clinical governance role.

5.8 There is a good establishment of safeguarding provision within the community provider of NHS Manchester. There named doctor provision is 4PA shared between 3 doctors, the named nurse and 6WTE named nurses each aligned to a district across the City. The named nurse group offer a 24 hour, 7 day week on call service to provide advice and support to the health staff working in Manchester on safeguarding issues and report increase in contact with acute providers and those professionals working in out of hours and urgent
5.9 The capacity of the named safeguarding team within the Manchester Mental Health and Social Care Trust does not sufficiently support the implementation of the responsibilities as outlined in “Working Together.” The current establishment is 0.8WTE named nurse (4 days); 1PA named doctor, plus named doctor responsibility within job description for Consultant Psychiatrist for babies up to one year on the Mother and Baby Unit. The trust has some resource in safeguarding link nurses, however, this role is not formalised and not subject to any performance management or resource. The named nurse is heavily involved in providing safeguard training across the trust and supporting the safeguarding agenda at team meetings. The strategic responsibilities of the named nurse role are carried out by the Associate Director of Governance. At the time of the integrated inspection the trust had last received a safeguarding annual report in December 2008; though there was a draft report due to be presented to the trust board in December 2010. The named doctor takes the lead in writing the individual management reports for any serious case reviews and also presents reports and reviews of actions to trust board and sub committees. He is involved in the training of junior doctors as part of their induction training and in delivering the training to senior medical staff as part of their mandatory updates. He also gives support and advice on safeguarding to doctors across the trust.

5.10 The capacity of the safeguarding team to deliver the duties of named nurse and named doctor as outlined in “Working Together” within the CMUHFT is adequate. The lead nurse for safeguarding across the trust for children and adults is the named nurse. The named nurse has weekly meetings with the Director of Clinical Effectiveness and has informal access to the Medical Director. The line management for both the named doctor and named nurse is appropriate. The named nurse has access to good supervision, though it is reported that there is insufficient capacity within the designated doctor to provide formal safeguarding supervision to the named doctor. The named nurse is supported in her role by 1WTE Acting Band 7 child protection nurse, 1WTE Band 6 child protection nurse, 1WTE Grade 5 admin and 1WTE band 3 admin (2 posts) one post is funded by the MSCB for work around the child death overview panel. There are 7PAs (1.2WTE) shared between two consultant paediatricians, one of which has the named safeguarding role. The management accountability and reporting is not contained within the job description of the named doctor. The safeguarding team is supported by a formal network of link nurses. Link nurses are a minimum Band 6 and receive 2 days training; the link nurses are expected to attend safeguarding link nurse meetings that are held every two months and attendance is monitored. Although the link nurse role is part of the individual’s job description, the duties do not form part of the annual objectives and performance in the role is not included as part of the yearly appraisal. The Director of Clinical Effectiveness deputises for the Medical Director on the MSCB.

5.11 The safeguarding team for the UHSMFT consists of one WTE named nurse, one named doctor with 2PA per week, one WTE named midwife, one WTE
safeguarding children’s nurse at Band 7, Band 7 specialist mental health midwife and one WTE Band 6 (two posts) support midwifery posts, one WTE Teenage Pregnancy Specialist Midwife and administrative support (currently vacant). The line management arrangements for both the named nurse and named doctor are appropriate. The named nurse has open access to the Chief Nurse if required. The named nurse is involved in the strategic function of the trust and provides support, supervision, training and networking though she is also involved in more operational practice when escalating safeguarding concerns with the local authority. The named doctor advises on safeguarding training for medical staff as well as support and advice. The named nurse receives her supervision from her line manager and the named doctor does not currently receive one to one supervision though has plenty of support through the professional named support group that exists across the city for all named and designated professionals. The trust is represented on the MCSB by the Head of Nursing and Midwifery and in her absence by the Chief Nurse. The trust has maintained an attendance of 100% at MCSB.

5.12 The number of child protection medicals provided are dramatically increasing year on year. The community paediatricians employed by the NHS Manchester community services carry out the child protection medicals at a health centre for all children over 18 months. Any infant under 18 month receives their child protection medical at the hospital. Any requests for out of hours medicals are carried out at either the hospital or scheduled in for the next working day. The community paediatricians are now struggling to cope with the increased demand in service.

5.13 The Sexual Abuse Resource Centre (SARC) is a highly regarded facility that operates across the Manchester region. The facility is hosted by the CMUHFT. It has one dedicated suite with appropriate equipment for children and young people. Examinations are carried out by a dual trained paediatrician or a suitably trained paediatrician and a forensic examiner. The centre examines approximately 400 children and young people a year. The centre has worked closely with the safeguarding team and now formally share information on referrals on young people aged under 18 so that the school nurse or health visitor can be involved if necessary.

6.0 Outcome 11 Safety, availability and suitability of equipment

6.1 The provision of equipment for disabled children and young people is adequate. The focus group reported confusion around referrals for equipment for disabled children and young people with long waits of up to 2 years for some specialist equipment and home adaptations. Adaptations purchased for use by children and young people for use in an education setting remained the property of the school and whilst some did allow a child or young person to transfer to a school and take the equipment with them this was not mandatory. Long waits and confusion around referrals can impact on a child or young person’s ability to access day to day living activities and on their quality of life.
7.0 **Outcome 13 Staffing numbers**

7.1 Staffing levels within both paediatric A&E units visited were reported to be good; shift patterns had been adapted to reflect need.

7.2 Vacancies within health visiting were of concern. There is currently a vacancy rate of 13.4%; however, in real terms with sickness and absence the vacancy in the field is 22%. Health visitors are managing cases of approximately 605 per health visitor which is high and impacts on their ability to deliver a comprehensive and timely service. The community provider has recently carried out service re-design and has recategorised 6 new posts as case planning posts at Band 7 to support the CAF process. The impact of these posts is not yet apparent.

7.3 The school nursing service operates through a skill mix of Band 7 team leaders, band 6 specialist school advisors, Band 5 school nurses, Band 4 assistant practitioners and Band 3 school nurse support. They work in 6 localities across the three areas. Each high school has a band 6 nurse allocated and all primary schools have a band 5 nurse allocated, however, due to vacancies some nurses are covering more than one school, which is against national guidance.

8.0 **Outcome 14 Staffing support**

8.1 The provision of training and supervision for safeguarding children within NHS Manchester is outstanding. Compliance for community services is 95.8% and for commissioning 94.44%. Individual supervision is provided at a minimum of quarterly for health visitors and school nurses and in groups for allied health professionals. The new supervision template forms include prompts around potential safeguarding issues for children in families where there is domestic violence, substance misuse or mental health, as well as around sexual exploitation. The template includes key dates for any reviews for looked after children or young people. There is good evidence of safeguarding supervision on the files reviewed as part of the inspection.

8.2 The MMHSCT continue to make good progress in highlighting the need for staff working in adult mental health to consider the child safeguarding agenda. The trust holds an Annual Improving Practice Day that includes presentations from across statutory and third sector organisations themed around children safeguarding and learning from serious case reviews. This has helped to embed increased awareness around the role of children safeguarding in adult mental health services. The content of the day is equivalent to Level 3 safeguarding training as outlined in the intercollegiate guidance on safeguarding training. Compliance figures on safeguarding training were inadequate. Safeguarding training at Level 1 is monitored by trust board and current performance indicator is shown as 62%. There is no monitoring of training and level 2 and 3 by trust. A discrepancy became
apparent during the inspection whereby the trust had incorrectly categorised its Level 1 training as much of the content was in fact Level 2 and Level 3.

8.3 During focus group discussion, staff from MMHSCT appeared unclear about the mandatory requirement for safeguarding training at Level 2 and Level 3 depending on their role. However, staff interviewed were clear about access to supervision both as part of their scheduled clinical supervision and who to access specific advice and supervision from on any complex cases that they were holding.

8.4 The level of compliance in safeguarding training within CMUHFT is inadequate. Mandatory Level 1 and Level 2 safeguarding training is currently at 50% and for level 3 there is concern within the children’s directorate that this is approximately 30%. The trust has recognised the deficit and has plans to ensure compliance by the end of the financial year, with additional training scheduled up until March 2011. Attendance at mandatory training is linked to the award of pay increments. Multi agency Level 3 training provided by the MSCB is accessible through the named nurse for any individual who has completed the trust’s level 3. There is monthly 3 hour training at Level 3 around basic recognition and response to safeguarding which is multi disciplinary. Medical staff have level 2 training supported by additional e-learning. The on line teaching package looks at different topics and safeguarding is included both as part of the overall learning and also as a specific subject. Arrangements for supervision were from either the named nurse or included in the clinical supervision from midwifery supervisors who had all received the appropriate training.

8.5 Safeguarding Training within the UHSMFT is good. Current statistics show that 86.1% of staff are trained at Level 1, 76.9% of staff at Level 2 and 100% at Level 3. Levels 1 is delivered face to face at induction, Level 2 is e-learning and Level 3 is multi disciplinary training. Doctors routinely undertake Level 2 and this is supplemented by training sessions from the named doctor twice a year to cover doctors on rotation. Safeguarding supervision is provided a minimum of quarterly to those staff that work on child protection or child in need cases, though this is not formally measured or reported. The trust are aware of this and a paper to address the issue is working its way through their governance structure.

9.0 **Outcome 16 Audit and monitoring**

9.1 NHS Manchester has good board assurance around safeguarding. They receive 2 formal reports a year from the named and designate leads. In addition, there is a bi monthly governance committee that includes an update from the Safeguarding Children Governance Group. To supplement this, the Chief Executive chairs a PCT Safeguarding Group where issues around safeguarding are discussed. There is good evidence of issues that impact the whole Manchester care economy around learning from serious case reviews that are discussed at the Children Trust Partnership, MSCB and at trust board with the information then used to drive improvement through
commissioning and performance, examples include the use of intelligent CQUINs on CAF and risk assessments.

9.2 The designate nurse and doctor for Manchester NHS have good input into commissioning and ensure that the safeguarding policy is included in all contracts with providers, including a requirement to demonstrate assurance through audit. The PCT has an integrated governance group that meet monthly and have produced a performance assurance framework that is responsible for developing the Commissioning for Quality and Innovation and Payment Framework CQUIN’s and other quality indicators.

9.3 The safeguarding governance group covers both the provider and commissioning arms of the NHS Manchester. For all other issues, assurance is provided through the Provider Committee which is the sub committee of the PCT Board. The Provider Committee receive regular performance reports on key performance indicators including those aligned to health visiting and delivery of the “Healthy Child” programme.

9.4 The NHS Manchester has an excellent audit programme that explores the organisation’s safeguarding practice and learning from serious case reviews and other serious incidents. One recent audit was about record keeping within the health visiting and school nursing service that had identified a need for more robust written care planning. The safeguarding team have now devised a training course and this is being rolled out to all staff. There is another training course on health involvement in child protection and child in need, including how to prepare for attending the meetings and how to prepare a quality report. A further audit on referrals to local authority by health visitors and school nurses showed that the majority were appropriate. The escalation pathway used where there are concerns about the response of the LA works well and now the named nurses meet with district management leads to discuss cases of concern and overall practice.

9.5 The board assurance around safeguarding children within MMHSC is adequate. The Director of Nursing is the executive lead for safeguarding and is supported in this role by the Associate Director of Governance. The trust chief executive meets regularly with her health and local authority colleagues at two weekly meetings “Securing our Shared Future.” The Assistant Director of Governance represents the trust on the MSCB, involvement with the Children Trust Partnership is through the executive board of the MSCB. Issues around safeguarding, serious case reviews, outcomes of audits and national reports are discussed at the trust’s children safeguarding committee. This committee meets bi monthly and reports in to the Quality Board which is a formal sub committee of the trust board. Performance reporting around actions following serious case reviews is adequate. The trust executive leads were able to recount progress and status of actions to address the recommendations around risk assessments and information sharing.

9.6 The CMUHFT Board assurance around safeguarding of children is adequate. The Medical Director is the Executive Lead for safeguarding. Division clinical governance committees have a standing agenda item on safeguarding and
these feed into the work of the Vulnerable Children’s Group that is chaired by the Director of Nursing for Children. This group reports to the Trust Safeguarding Effectiveness Committee which is chaired by the Medical Director and is formal sub group of the trust board. The trust has a non executive who has a special interest in child safeguarding and who reviews all serious untoward incidents that have safeguarding implications and meets quarterly with the named nurse.

9.7 The CMUHFT has a good audit cycle on safeguarding issues and provided many instances of where findings from audit had changed operational practice. The trust has recently completed an audit into children and young people who do not attend for scheduled appointments and compliance with the Did Not Attend (DNA) policy. The findings of the audit has been to agree a change to the policy that will reflect improved outcomes for children who DNA. In future the consultant of the clinical will review all the DNAs and establish the reason for non attendance before deciding on the next steps. The revised policy is due for roll out in January 2011.

9.8 The board assurance for safeguarding within USMHFT is good. It has recently been revised to create a clear reporting structure. Safeguarding is monitored by the Safeguarding Children Governance Group that reports to the Risk Management Committee which is a formal sub group of the Trust Board and is chaired by the Chief Executive. The executive lead for safeguarding is the Chief Nurse.

9.9 The audit programme for safeguarding in the USMHFT is good. The trust has a 3 year audit cycle on safeguarding practice. There is evidence of impact on practice following audit. Of particular note is a piece of work around identifying who can legally consent for a looked after child undergoing planned surgical procedures. A Working Party was convened by the designate looked after child nurse and a flow chart has now been produced that has been appended to the consent procedure. There is evidence of learning from serious case reviews and actions taken include including a prompt on the casualty attendance card in adult A&E to check for any dependents in any adult who attends following assault, domestic violence, substance misuse or mental health crises. The trust also has a policy around children and young people who do not attend appointments and compliance with this policy will form part of this year’s audit cycle.

10. **Recommendations**

**Immediately**

*Accelerate plans to finalise and disseminate the multi-agency guidance on safeguarding for children with disabilities. (Ofsted 2010)*

*Ensure there are effective arrangements for safeguarding supervision in the Manchester Mental Health and Social Care Trust, South Manchester University*
Hospitals NHS Foundation Trust and for named doctors across the city. (Ofsted 2010)

Ensure the child death overview panel meets all its statutory duties and that all areas of its service operation are reported annually (Ofsted 2010).

Within 3 months

Ensure that school nurse provision is adequate to support young people who are out of school or home educated, and that health visitor capacity is sufficient to deliver the Healthy Child Programme. (Ofsted 2010)

Ensure there is sufficient acute inpatient provision for young people who have attended A&E for self harm, substance misuse or mental health issues"(Ofsted 2010)

Conduct a thorough analysis of the health profile of the looked after population to prioritise and target resources, and improve communication between children’s social care and the health service to ensure annual health assessments are completed in a timely way. (Ofsted 2010)

Improve the quality of health assessments for all looked after children and ensure care leavers are informed about their health histories and that records are comprehensive. (Ofsted 2010)

Improve data collection and intelligence gathering on looked after teenage conceptions in order to prioritise and target resources, and accelerate plans to introduce a care pathway of support for looked after children who become pregnant. (Ofsted 2010)

11. Next steps

An action plan is required from the commissioning PCT within 20 working days of receipt of this report. Please submit the action plan to your SHA copied to CQC through childrens-services-inspection@cqc.org.uk and it will be followed up through the regional team.