CENTRAL MANCHESTER FOUNDATION TRUST (CMFT)

VULNERABLE BABY SERVICE

SUMMARY

Since December 2003 Central Manchester Foundation Trust (CMFT) has implemented a Vulnerable Baby Service (VBS) across Manchester city centre, as part of its Community Children's Safeguarding programme. The aim of this service is to reduce the risks of Sudden Unexplained Deaths in Infants (SUDI).

The VBS tackles SUDI using two approaches. It facilitates multiagency case planning meetings for any unborn baby or infant under 12 months of age, who is considered to be vulnerable, and reviews the plan with the lead professional, before measuring outcomes for the families. It also employs a Public Health approach to reduce risk behaviours for all babies born in Manchester.

Initially the service was implemented as a pilot, which was then developed into a mainstream service. As a result SUDIs have dropped significantly, and health staff and multi agency partners have developed closer and more productive partnerships. The social marketing campaign BeCotSafe, which arose from this pilot, has also won several regional and national awards.

KEY OUTCOMES

Service User Outcomes

- The numbers of baby deaths have reduced by 60% since the service first went into operation 7 years ago. SUDIs in Manchester have dropped significantly from 1.8 per 1000 live births to 0.52 in 2011. In approximately 70% cases of SUDI, unsafe sleeping was recorded as an issue.
- Between 2004 and 2011 1047 families have been referred to VBS (only 1 of those babies has been SUDI and moved out of area before meeting took place).
- Particular at risk groups such as teenage parents and mothers of premature and low birth weight babies have been very receptive to advice and support, reflected in the survival of their infants across the city. Very few deaths are now seen in high risk groups e.g. teenage parents and babies who are premature or low birth weight.
- An audit of outcomes for babies aged 18 months, who have been through case planning, showed improved attendance at appointments, an increased disclosure of domestic abuse and that 86% fathers continue to be involved.

Workforce Outcomes

- There has been an increase in staff engagement, in particular amongst midwives, as staff have become stakeholders in baby outcomes, specifically to reduce SUDI.
- Staff are very motivated by local data, and take satisfaction from the impact their work has had on these figures.
- Staff asked for Safe Sleeping Practice Guidance for Manchester residents, so that advice was consistent to the families. This was introduced in 2005 and a consistent approach across the workforce had a significant impact on the reduction of deaths.

GOOD PRACTICE CASE STUDY

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- Midwives now attend regular update sessions and training as part of their induction.
- Multi-agency partners and health professionals continue to be members of the VBS Steering Group which helps ensure engagement and two-way communication.
- Manchester staff work closely with the Foundation for the Study of Infant Death (FSID) and share learning and resources nationally. This allows them to feel connected and to gain information and support, as well as being able to feed up into a national network.
- Clinical staff have more time for clinical duties, as administrative staff organise the meetings, type and distribute minutes. This ensures the cost effective use of staff and ensures that queries are dealt with in a timely manner, an element of the service which is very well reviewed.

KEY AIMS

- To reduce infant mortality in Manchester
- To involve families in the design of their package of support
- To increase levels of support to vulnerable families
- To improve long term outcomes for children
- To reduce stress levels
- To facilitate joint working
- To improve job satisfaction
- To improve communication

KEY STAGES OF SET-UP

The VBS was set up under the preceptorship of the Designated Nurse for Safeguarding, who chairs a multi agency steering group for the service that was established in 2004. This had been crucial to maintaining management support across all partner agents. Ongoing evaluation and response to learning helps to identify gaps and themes as they emerge.

HOW IT WORKS

Service Coordination

There are four staff involved in running the service including:

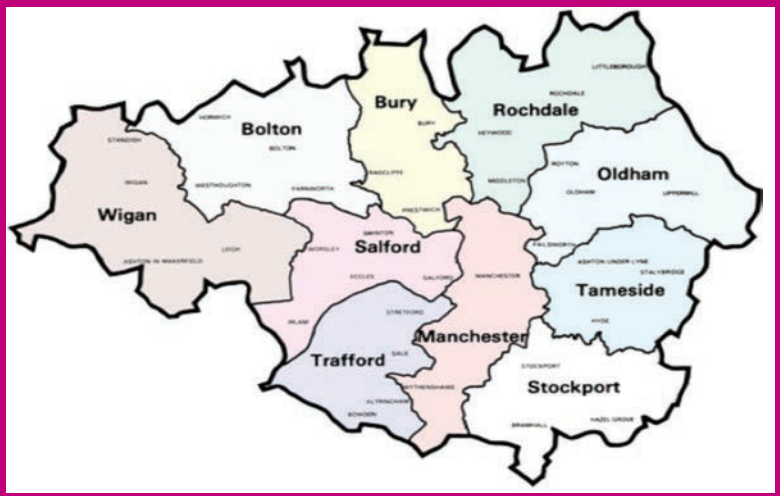
- Manager (with a Health Visiting background)
- Specialist Midwife
- Project Assistant/Administrator
- Administrator

These staff are all co- located at Rusholme and deal with queries, referrals, and training across the city, assessing local baby deaths, and responding to inform best outcomes.

BACKGROUND

In 2002 Manchester had the highest Infant Mortality Rate of any other core city in the country. The Designated Nurse for Safeguarding recognised that there may be learning from the local high levels of SUDI and commissioned a multi agency working party to explore this. The development of a targeted approach was recommended with a project manager to drive this work forward. The VBS has been available in Manchester since 2004. Since the implementation of their report into practice, the pilot has developed into a mainstream service.

The VBS operates out of an office at Rusholme Health Centre, reaching hospital and community based staff across the whole of Manchester City Centre.



GOOD PRACTICE CASE STUDY

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Approach

The VBS tackles SUDI using two approaches:

- The service facilitates multiagency case planning meetings for any unborn baby or infant under 12 months of age living in Manchester who is considered to be vulnerable as defined by the referral criteria. The VBS reviews the plan with the lead professional and measures outcomes for the families.

  Any practitioner can refer into the service if the family meets the criteria. In each case the assessment of need and liaison with partners continues and is carried out by the VBS staff. In consultation with the key worker and family the meeting is arranged so that is it in a venue and at a time that suits the parents. Any multi- agency partners who are or may be involved are invited and the meeting is chaired and minuted by VBS. It is intended to be a relaxed but structured meeting to identify and discuss the family needs and mobilise resources to meet those needs by an identified date.

- A public health approach is also employed to reduce risk behaviors for all babies born in Manchester. It was recognised early in the development of the service that targeting vulnerable families was effective but there needed to be a general population approach to reducing risk also. A Safe Sleeping Practice Guidance document was created, which is delivered by face-to-face training to all midwives across Manchester, and multi-agency partners have also adopted the recommendations e.g. Housing, in particular temporary accommodations. In 2008 a social marketing campaign was developed and the learning is used in training, and has been implemented with parents.

Principals

- Intervene early to help keep infants safe and reduce risks of harm
- Provide a framework for effective multi-agency working
- Respect equality, diversity and social inclusion
- Promote effective information sharing to inform decision making
- Consider the holistic needs of the family and the infant within it
- Identify needs and coordinate a package of support to the family to improve outcomes for the child/infant

Referral Criteria

Analysis of infant deaths in Manchester shows that there were environmental factors which could have influenced the outcome for these babies. Therefore these referral criteria include:-

- Alcohol/Substance misuse
- Violent criminal history against child or partner
- A previous child not living with parent
- Late booking for ante natal care
- Homelessness with mental health issues/ domestic abuse/probation
- Hearing impaired parents

RESOURCES

A business case for the original pilot was supported by the Thematic Partnership for Safeguarding and the cost investment in 2006 was 90k. Evaluation resulted in mainstreaming of the service within the Trust.

MULTI-AGENCY PARTNERS

GOOD PRACTICE CASE STUDY

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KEY CHALLENGES

- Bids for funding was an annual challenge during the first 2 years of the pilot However now that is mainstreamed less time is spent composing bids, which allows more time to be spent on improving outcomes for the population.
- It was a challenge to ensure that staff were committed to the service and understood its aims, but marketing the service specifically to staff, and delivering training to win hearts and minds enabled this to happen.
- It is difficult to ensure that messages get to those hard to reach and more vulnerable groups i.e. where babies are premature, exposed to nicotine, victims of violence/abuse, from mobile families, or have parents who are teenagers, alcohol users or drug users. To address this challenge a proposal was put to Manchester Public Health Commissioners to raise money to develop a social marketing campaign. A local advertising agency was employed which designed and managed the campaign and money was also invested in an external evaluation of the campaign.

KEY LEARNING

- Safe Sleep Practice Guidance is invaluable and should be shared with all multi-agency partners. This needs to be "owned" by heath staff, especially midwives who are the first point of contact for parents when a baby is born. The hearts and minds of midwives and their commitment to the simple message is crucial, as practice by parents is difficult to modify even after 10 days.
- There are always new ways of approaching challenges but you have to keep trying until you find one that works!
- Know your demographic, analyse the local SUDI, speak to front line staff
- Evaluate, keep looking for gaps or themes and address them
- Understand that staff change, training and updates are a way of life
- Target specialist staff groups
- The safety of the baby should be the priority
- There is no quick fix, but there is always more that can be done

SUSTAINABILITY

The service is sustained through effective communication at all levels of the multi-agency partnership, with regular updates offered to partners to keep them engaged.

NEXT STEPS

The learning will continue to be shared with colleagues in neighbouring Trusts and nationally. The model will be rolled out locally to target other vulnerable groups of children, not just babies. A service is being set up to target children aged 0- 4.5, who are at risk of neglect.

SUPPORTING MATERIAL

The following resources are available as an appendix to this case study:

- Evidence of VBS success
- Presentation on VBS

FURTHER LINKS

The VBS works closely with the Foundation for the Study of Infant Deaths (FSID) which is the UK's leading baby charity working to prevent sudden deaths and promote health. FSID funds research, supports bereaved families and promotes safe baby care advice. Further information can be found at www.fsid.org.uk

CONTACT FOR FURTHER INFORMATION

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