Portsmouth Hospitals NHS
NHS Trust

TRUST BOARD PART I – OCTOBER 2011

Agenda Item Number: 184/11
Enclosure Number: (8)

Subject:	Safeguarding Children and Young People Annual Report 2010
Prepared by: **Sponsored by:** **Presented by:**	Dr Sheila Peters, PHT Named Doctor for Safeguarding Children Julie Dawes, Director of Nursing Dr Sheila Peters, PHT Named Doctor for Safeguarding Children
Purpose of paper *Why is this paper going to the Trust Board?* *(Delete as appropriate)*	Regular Reporting For Information / Awareness
Key points for Trust Board members *Briefly summarise in bullet point format the main points and key issues that the Trust Board members should focus on including conclusions and proposals*	• PHT's performance rated highly in several independent reviews/audits • Benchmarking showed strategic presence of safeguarding children at Trust Board level is weak compared to comparable Trusts. • Emergency Department safeguarding children procedures (acknowledged as crucial in Government recommendations) recently affected by PCT decision to withdraw health visitor liaison service. Revised procedures in place, impact assessment ongoing. • Maintaining PHT-wide training in safeguarding children is a constant endeavour.Post-2010 report note – recent Childrens Trust strategy 'priority E' - embedding early intervention requires significant training investment. • Funding secured for replacing the outdated PHT Safeguarding Children database, which will enable us to satisfy requirements for accountability.
Options and decisions required *Clearly identify options that are to be considered and any decisions required*	• Ensure safeguarding children agenda remains high priority at Trust Board level
Next steps / future actions: *Clearly identify what will follow the Trust Board's discussion*	Bi-annual Safeguarding Children submissions to Trust Board will continue, to ensure the Board is kept up to date with changing requirements around the safeguarding children agenda.
Consideration of legal issues (including Equality Impact Assessment)?	Ongoing evidence collection in preparation for CQC assessment (Outcome 7)
Consideration of Public and	Child safety day (open to public) planned for 4.11.2011.

Patient Involvement and Communications Implications?	

SAFEGUARDING CHILDREN and YOUNG PEOPLE in

Portsmouth Hospitals NHS Trust (PHT)

Annual Report
January – December 2010

Author: Dr Sheila Peters, PHT Named Doctor for Safeguarding Children
With thanks to the PHT Safeguarding Children Team for their support.

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SAFEGUARDING CHILDREN GLOSSARY

CAF	Common Assessment Framework – multiagency tool for assessing child's needs and context to plan intervention.
CAIU	Child Abuse Investigation Unit – specialist child protection police team, based in Nutley, Southampton
Children Trust	Established in 2004 - multi-agency representation at Director and Chief Executive level from all the major public service delivery partners in Portsmouth City. www.portsmouthchildrenstrust.org
CPC	Child Protection Conference – multiagency meeting convened where a child is felt to be at risk of significant harm
CDOP	Child Death Overview Panel – part of LSCB, statutory duty to review data around all child deaths (0 – 18) and report to LSCB
DP	Designated Paediatrician for Unexpected Child Deaths
IMR	Individual Management Review – initiated within PHT as soon as a decision is taken by the LSCB to proceed with a SCR (sooner if a case gives rise to concerns within the Trust)
JCPR	Joint Child Protection Record – list held by social care of children currently subject to child protection plan in their area. Accessed via ED reception staff.
PSCB	Portsmouth Safeguarding Children Board
MAPPA	Multi-Agency Public Protection Arrangements (MAPPA) – introduced in 2001 to ensure that a risk management plan is drawn up for the most serious sexual and violent offenders. Led by police, with co-operation from other agencies including social care, health, housing and education services
NSDU	National Safeguarding Delivery Unit – set up in 2009 to oversee safeguarding activity and training nationwide. Abolished June 2010.
PRAM	Pregnancy Risk Assessment Meeting – multiagency meeting held where there are concerns around the wellbeing of the unborn child e.g. neglect
SARC	Sexual assault referral centre – 'Treetops' – team of staff to help victims deal with the trauma of rape or serious sexual assault. Adult-orientated but will see over-13year-olds.
SCAYP	Safeguarding Children and Young People
SCR	Serious Case Review – LSCB required to order this when a child has died or sustained serious injury, and abuse or neglect are known or suspected to be a factor in the death,

	or where the case gives rise to concerns about inter-agency working to protect children
SIRI	Serious Incident Requiring Investigation (previously SUI) - an event on PHT premises which results in, or could have resulted in serious injury, unexpected death, permanent harm, significant public/media concern, or disruption to health care services. Also an SHA requirement when an infant dies unexpectedly at less than 28 days of age.
WNB	Was not Brought Policy: Children do not 'DNA' appointments; rather they 'are not brought' to appointments. Therefore, we would encourage all staff to use the nomenclature of WNB (Was Not Brought) rather than DNA (did not attend).

SAFEGUARDING CHILDREN and YOUNG PEOPLE IN PHT
ANNUAL REPORT 2010

'Safeguarding Children and Young People is Everybody's Responsibility'

(1) INTRODUCTION AND REVIEW OF THE YEAR

National:

- '**Working Together to Safeguard Children 2010'** released: Key changes affecting PHT:
    - shift of training to include people working with parents as well as those working with children
    - new section on importance of child in focus
    - increased focus on CAF and expectation that health care professionals will be competent to undertake CAF.
    - Clarified definitions around 'unexpected' deaths and CDOP
- Follow-up to the **Lord Laming's report to the Government March 2009**:
    - **NSDU** recommended and set up July 2009, abolished June 2010, Munro review commissioned.
    - Recommendation that 'all staff who work with children receive initial training and continuing professional development which enables them to understand normal child development and recognise potential signs of abuse or neglect' (*embedded in PHT level 3 training).*
    - National implementation of further recommendations awaited:
    - New statutory targets for safeguarding and child protection with new national indicators for safeguarding and child protection
    - National systems for checking if a child presenting to ED has recently presented at *any* ED
    - National training programme to improve the understanding and skills of the children's health workforce (including paediatricians, midwives, health visitors, GPs and school nurses) to further support them in dealing with safeguarding and child protection issues.
    - **Independent safeguarding authority** (ISA) (vetting and barring) disbanded
    - Standards for Better Health replaced by **Care Quality Commission (CQC).** In April 2010, the Trust's services were registered with the CQC. A new set of 'outcomes' against which health providers are monitored. Outcome 7 - Safeguarding people who use services from abuse.
    - **OFSTED** reported October 2010 child deaths from serious incidents down nearly 50 per cent over preceding year

Local:

- OFSTED Jan 2010 - PHT's IMR contribution rated 'outstanding'
- PHT completed SHA audit of Standard 7 of NSF for children –child protection and safeguarding – see section (2) below
- PHT CRB catch-up programme to check all staff with contact with children
- Risks during year and how addressed
- **Not reaching training figures** – Safeguarding Children Trainer recruited Dec 2010

- **Workload in excess of capacity** for safeguarding children & young people - Potential for appointment of further staff following the acceptance by the Trust of the SCAYP business case for development
- **Lack of a Safeguarding Children Supervision Policy**/guidelines for all PHT staff to follow – work in progress
- **Safeguarding Children Data base** (created in 2003 as a local solution to a temporary problem) is now not suitable or fit for purpose. Case submitted February 2010 as part of Business Planning for 2010-2011 - funding not available. Submission to SHA/ innovation for funding 16.08.10- unsuccessful. Remains on risk register
- **Safeguarding Children Strategy**-not current, being updated
- Unable to fully implement '**rapid response' process** required by Working Together 2006/10 – addressed by PHT Named Doctor for SGC taking on 'Designated Doctor for Unexpected Child Deaths' role April 2010.

Safeguarding Children Team:

The Portsmouth Hospitals NHS Trust Safeguarding Children and Young People's (SCAYP) Team consists of:

- Named Nurse 1 wte
- Named Midwife 1wte
- Named Doctor 2 PA/week (1 PA protected)
- Safeguarding Children Practice Educator 0.8.wte appointed Dec 2010, came into post Jan 2011
- Administrative Assistant 2.0 wte
- Network of facilitators across the Trust

The SCAYP Team have weekly operational meetings, and 3 monthly management meetings

(2) PROGRESS AGAINST GUIDANCE AND RECOMMENDATIONS (Including local child deaths and SIRIs)

2010 SHA audit of Standard 7 of NSF for children –child protection and safeguarding

Key findings:

- The safeguarding of children in all areas across the Trust is highly satisfactory and meets both core and developmental standards of SfBH now CQC.
- The mandatory training of staff across the inter-professional spectrum in safeguarding children meets the benchmarked criteria of policy recommendations and detailed records are maintained.
- The Named Nurse for SGC keeps meticulous records and is in constant dialogue with colleagues across the inter-professional spectrum
- HV in ED was commented on as 'best practice'– **note** this service is under review by commissioners and may be withdrawn.

Recommendations:

- Consider wireless broadband access to schools (especially in Trusts with no education facility – not applicable to PHT)
- Commendation given to Basingstoke's 'managed learning environment' training software package.

Benchmarking return to Hampshire County Council, July 2010 - presented to Paediatric Standards and Quality Committee (PSQC).

- Capacity, Capability and Systems' - compared with comparable Trusts in SHA. Looked at Workforce/ Training/ Internal Reporting Structure
- Workforce - key Named Doctor, Named Nurse and Named Midwife posts are adequately staffed, but WTE supporting the Named Doctor role, was very low compared to comparators.
- Training - PHT was broadly directly comparable to all peer groups for the percentage of staff who were eligible and did/did not have up to date training recorded
- Internal Reporting Structure: PHT was weak with regards to Safeguarding Children discussions occurring at Executive Team/Board level.

Section 11 Compliance LSCB – final report February 2010

- **'**Health returns are robust, detailed and a real celebration of the excellent work that has been undertaken in regard to safeguarding children by health professionals in Portsmouth.'

IMR and SIRI

A) IMR case 'AE' SCR subcommittee Feb 2010.

Recommendations:

- WNB policy; implemented April 2010
- Day surgery discharge communications to school nurse/HV - Random audit of 50 notes annually by Day Surgery Unit (0-16) and outcome of audit reported back to Governance

B) IMR case 'FK' action plan 1.7.2010 (case 2008):

- Requirement for Safeguarding Children Supervision Policy, being formalised
- Midwifery record cards – introduced in 2010, use to be audited

C) SUI May 2010 'NB'

- Adolescent with chronic illness, well known to unit, absconded from ward during the night
- 'Missing child' procedures not followed
- Young person's code of conduct developed in response.

D) SIRI Nov 2010 'AM'

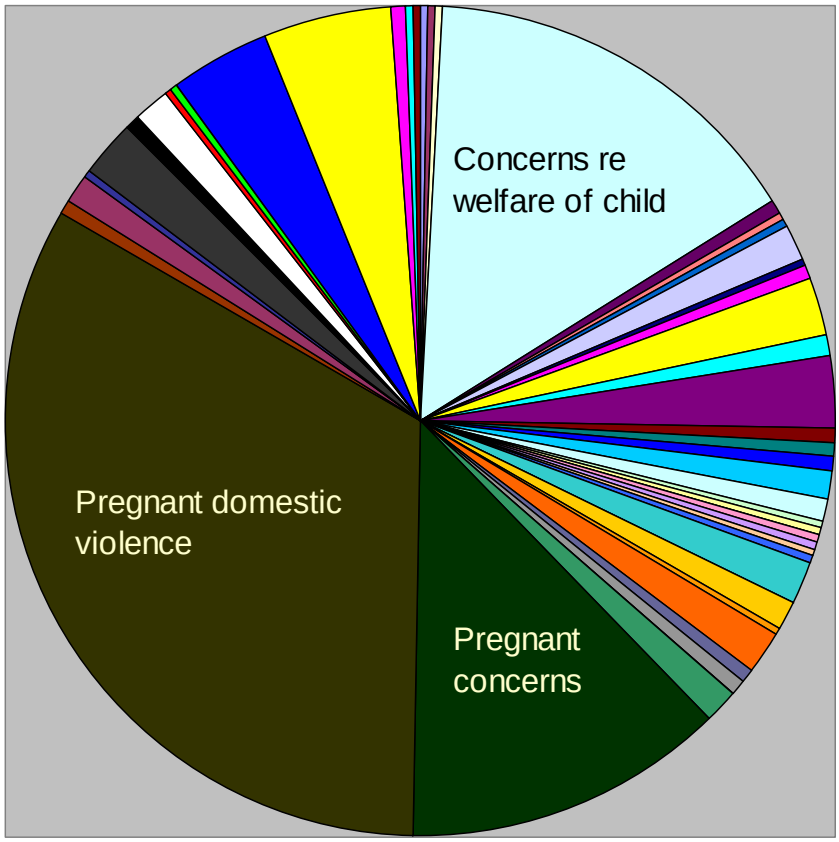
- Unexpected death at home of infant aged less than 28 days
- Complex cardiac anomaly identified at post mortem
- Seen twice in PHT during life, no suggestion that defect could have been identified clinically post-natally
- Anomaly scan missed as family out of the country and had scan done in their home country– SIRI recommendation that anomaly scan should be arranged in PHT regardless.

CDOP report 2009 – 2010 – summary of learning points relevant to PHT

- An audit tool should be used for substance misuse in pregnancy in order to access treatment/interventions
- Robust inter-agency assessments should be in place where there is evidence of significant alcohol consumption; a multi-agency discussion should occur if there is evidence of rejection of professional support and there are concerns about vulnerability
- There should be robust procedures in place for when a child 'Was not Brought' to health appointments.
- All drivers and escorts commissioned by agencies to transfer children should be competent in First Aid, to ensure if a child becomes unwell on route, basic first aid can be given, whilst awaiting an ambulance to arrive.

(3) CLINICAL ACTIVITY

The Safeguarding Children office were notified of 771 cases in 2010. See 'interagency working ' for workload arising from referrals. Breakdown of notifications by nature shown in pie chart below.



- Burn <1
- Burn 1-4
- Burn 5-16
- Concerns re welfare of child
- Death of a child <1 year
- Death of a child 1-4 years
- Death of a child 5-16 years
- Deliberate Self Harm
- Deliberate Self Harm < 16 Substance Misuse
- Deliberate Self Harm<16 Alcohol
- Deliberate Self Harm<16 Overdose
- Deliberate Self Harm<16 Self Harm
- Domestic Violence - Female
- Domestic Violence - Male
- Fall
- Fictitious Illness 1 - 4 years
- Head Injury <1
- Head Injury 1-4 years
- Head Injury 5-16 years
- In need of Soc Servs help
- Neglect < 1 year
- Neglect 1 - 4 years
- Neglect 5 - 16 years
- Other
- Paternal Deliberate Self Harm/Overdose/Alcohol
- Physical Abuse < 1 year
- Physical Abuse 1 - 4 years
- Physical Abuse 5 - 16 years
- Pregnant - Adoption
- Pregnant <16
- Pregnant Alcohol
- Pregnant Alcohol and DV
- Pregnant Alcohol and Overdose
- Pregnant Concealed
- Pregnant Concerns
- Pregnant Domestic Violence
- Pregnant Homeless
- Pregnant Learning Disability
- Pregnant Learning Disability and DV
- Pregnant Mental Health
- Pregnant Mental Health and DV
- Pregnant Neglect
- Pregnant Overdose
- Pregnant Previous Child Death
- Pregnant Previous Children on CPR
- Pregnant Substance Misuse
- Pregnant Substance Misuse and DV
- Sexual Abuse 1 - 4 years
- Substance Misuse <16

Specific pathways:

- 'Bruising in pre-ambulant infants' protocol launched (district-wide). Impact of protocol on workload (e.g. radiology – skeletal surveys) to be evaluated.

- 'WNB' policy launched – children not brought to appointment in PHT. Applicable across all areas of PHT where children are seen.

- Assessment of alleged child sexual abuse **-** service limited by 'in hours' nature of community-run child protection clinic with staff trained in assessment. Over-13s can be seen in SARC ('Treetops') Under 13s out of hours - unmet need.

(4) STRATEGIC FRAMEWORK

Context - reporting to Governance and Risk management

- Safeguarding Children Committee – meets quarterly, draws together representatives from all CSCs where children are cared for, along with HR and the Head of Children's Nursing. Committee reports to Clinical Governance via the PSQC

- Emergency Department (ED) Safeguarding Children group – meets quarterly, PHT teams joined by representatives from health visiting and social care. Reviews ED safeguarding children policies, interface with social care and primary care, and procedures and training.

- Quarterly Governance reports submitted and Safeguarding Children Risk Register maintained

- Regular contact with the PCT Named Nurses and Nurse Consultant

- Completion of Trust returns for CQC compliance, SHA safeguarding governance review, LSCB

(5) INTERAGENCY WORKING

Context - interagency working both with individual cases and in terms of representation on Portsmouth Safeguarding Children Board (PSCB) and other local safeguarding groups

- District Safeguarding Children Group disbanded April 2010 as members felt it was duplicating activity undertaken in other forum.

- Named Nurse attends quarterly meetings of PSCB.

- PHT represented on Hampshire Multi-Agency Safeguarding Forum (MASF) and Portsmouth Safeguarding Health Forum.

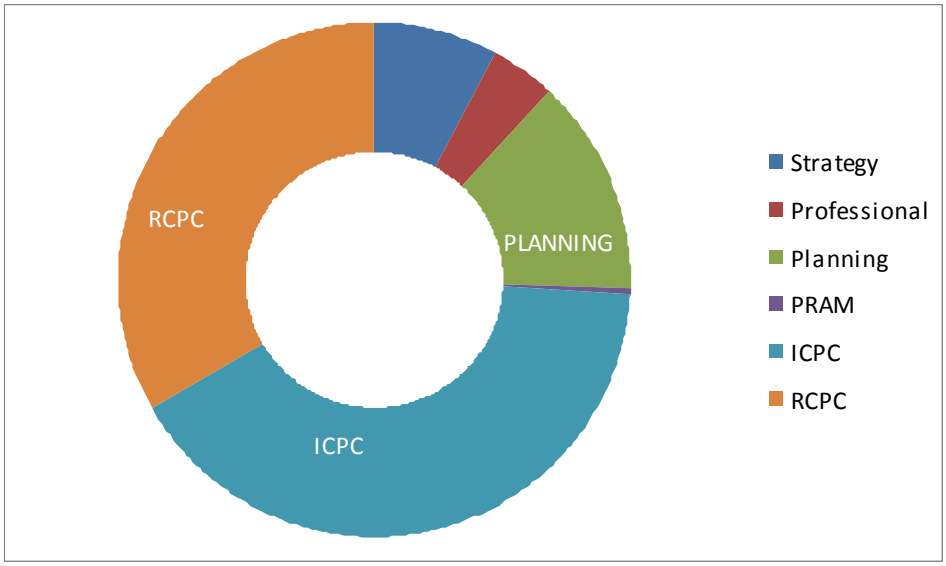
- Named Doctor working with local agencies in developing local policies in implementation of Chapter 7 of Working Together 2010 – child death review process.

- CDOP/Rapid response. 4 'phase 2 'meetings in response to unexpected child death.

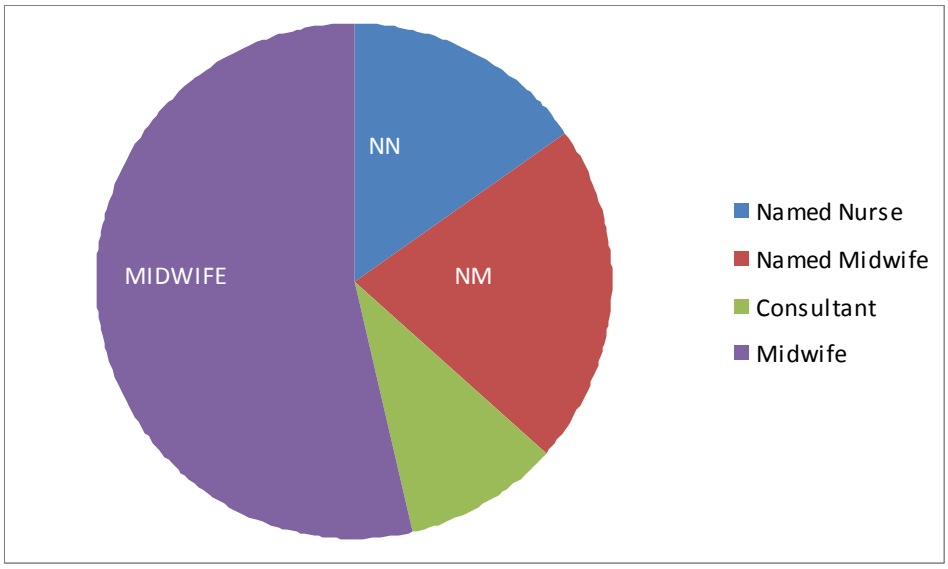
- Supporting local MAPPA work.

- Invited to 500 interagency conferences/strategy meetings (2/3 paeds, 1/3 maternity), attended half of them.

Type of meeting:


RCPC
PLANNING
ICPC
Strategy
Professional
Planning
PRAM
ICPC
RCPC

Attended by:


NN
NM
MIDWIFE
Named Nurse
Named Midwife
Consultant
Midwife

(6) TRAINING

Context - Standard 5 of the National Service Framework for Children, Young People and Maternity Services (2003; 2004) requires us to ensure all staff are suitably trained and aware of action to take if they have concerns about a child's welfare, and these processes must be in place by 2014.

- Training programmes in PHT are based around the guidance in the 'Intercollegiate Document April 2006 - Safeguarding Children and Young People: Roles and Competences for Health Care Staff'. All staff must be trained to level 1; level 2 training is for staff with regular contact with children; level 3 for staff working predominantly with children. This guidance has been added to with the release of 'Working Together 2010' which includes almost all clinical staff as needing level 2 training, as they have contact with adults who are parents.

- Training modalities include 'MOODLE' e-learning package, training DVD, eMOT, face-to-face 3 training and departmental bespoke level 2 sessions. All junior staff in paediatrics and ED receive a safeguarding session at induction; the annual 'SPEARS' day for surgeons includes a safeguarding session; bespoke departmental level 2 sessions are arranged on request (anaesthetics, gastroenterology, rheumatology, dermatology). The database of numbers trained is maintained by Learning and Development. Training modalities will be enhanced in 2011 by the arrival of a Specialist Safeguarding Children Practice Educator

Level of Training	**Number Trained 2009**	**Number Trained 2010**
1 (update required every 3 years)	4230	1726
2 (annual refresher update required)	93	194
3 (annual refresher update required)	336	103

The named professionals are all trained to level 4.

Figures for percentage of staff up-to-date with Safeguarding Children Training all levels:

Essential Skills Training - Safeguarding Children Compliance 2010

Training	Division	% of staff in date
Safeguarding Children	Cancer CSC	78%
	Clinical Support CSC	79%
	Corporate Functions	80%
	Elderly Services CSC	81%
	Emergency Care CSC	75%
	Facilities Management Division	94%
	Head & Neck CSC	83%
	Internal Medicine CSC	78%
	Internal Surgery CSC	77%
	Muscular Skeletal CSC	83%
	Renal CSC	87%
	Theatres CSC	80%
	Women's & Children's CSC	90%
	Charitable Funded Division	50%
	Corporate Division	100%
	Recharged Staff Division	33%
	Research & Development Division	75%
	Trading Division	97%
Overall Trust		81%

(7) AUDIT

Context - audit of safeguarding children practice

- External Audit – Oct - Dec 2010, DELOITTE. Draft report (November 2010) found 'limited assurance' in some areas but this was challenged by the Safeguarding Children Team on various grounds and was subsequently uplifted to 'substantial assurance'.

- Recurring - random audit of 50 notes annually by Day Surgery Unit (0-16) and outcome of audit reported back to Governance.

- Audit against NICE guidance ('when to suspect maltreatment in children') undertaken, in hand December 2010 – report by May 2011.

- ED re-audit of use of Safeguarding Children processes – all cause for concern forms were seen by HV's and fed back; ongoing education required in completing safeguarding children trigger checklist; some concern around robustness of JCPR checks.

(8) SUMMARY AND THE YEAR AHEAD

Objectives/progress against recommendations:

- Need to strengthen strategic presence of Safeguarding Children at Trust Board level (benchmarking showed weak compared to comparable Trusts).
- Need to protect existing good practice (ED procedures highlighted in Government recommendations, but existing health visitor liaison service may be under threat).
- Need to keep abreast of training changes and opportunities (managed learning packages, national training programmes).
- Collecting, storing and retrieving data around safeguarding children activity is crucial in satisfying requirements for accountability. The PHT Safeguarding Children Database is the 'engine' of safeguarding children activity; it is becoming outdated and needs replacing.
- Formalise Safeguarding Children Policy
- Parents receiving a copy of clinic letters – not universal practice for a variety of reasons, not solely safeguarding children: remains on the agenda.

Key documents:

Children Act 2004 - www.everychildmatters.gov.uk/
Training competencies- www.rcm.org.uk/info/docs/safeguarding_children
CQC- http://healthdirectory.cqc.org.uk/_db/_documents/CFU_RHU.pdf
Local multiagency procedures**;** www.4lscb.org.uk
Working Together 2010: https://www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-00305-2010
Intercollegiate training competencies (Sept 2010) : http://www.rcpch.ac.uk/sites/default/files/asset_library/Health%20Services/Safeguarding%20Children%20and%20Young%20people%202010.pdf
Local intranet site: http://pht/Departments/safeguarding-children/default.aspx