Portsmouth Hospitals NHS
NHS Trust

**TRUST BOARD PART I – JUNE 2012**

**Agenda Item Number: 91/12**
**Enclosure Number: (4)**

| | |
|---|---|
| **Subject:** | Annual Paediatric Safeguarding Report |
| **Prepared by:**<br><br>**Sponsored by:**<br><br>**Presented by:** | Dr Sheila Peters, PHT Named Doctor for Safeguarding Children<br><br>Julie Dawes, Director of Nursing<br><br>Dr Sheila Peters, PHT Named Doctor for Safeguarding Children<br>Pamela Aspinell PHT Named Nurse for Safeguarding Children |
| **Purpose of paper**<br><br>*Why is this paper going to the Trust Board?* | Regular Reporting<br>For Information / Awareness |
| **Key points for Trust Board members**<br>*Briefly summarise in bullet point format the main points and key issues that the Trust Board members should focus on including conclusions and proposals* | • Need to continue to ensure strategic presence of Safeguarding Children at Trust Board level, alongside safeguarding adults and general safeguarding, as required by statute and commissioning.<br><br>• Challenge of staff turnover and high demands on Safeguarding Children team<br><br>• Need to maintain target levels of Safeguarding Children training across the Trust , including training to meet Children's trust 'Priority E' (early intervention)<br><br>• Preparations for move towards an integrated children's emergency service (Childrens Assessment Unit/ paediatric ED combined) for unscheduled care, will change skill mix and pathways for initial assessment – need to ensure that safeguarding procedures are integrated into this. |
| **Options and decisions required**<br>*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**:<br>*Clearly identify what will follow the Trust Board's discussion* | Bi-annual Safeguarding Children submissions to Trust Board will continue |
| **Consideration of legal issues (including Equality Impact Assessment)?** | |
| **Consideration of Public and Patient Involvement and Communications Implications?** | |

**SAFEGUARDING CHILDREN and YOUNG PEOPLE in**

**Portsmouth Hospitals NHS Trust (PHT)**


**Annual Report**
January 2011 – March 2012

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

## 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, (moved to Havant 2012 from Netley, Southampton) |
| Children's Trust Board | 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. May result in child being made subject to Child Protection Plan (CPP) |
| CQC | Care Quality Commission – inspects health care providers against a number of 'outcomes'. Outcome 7 - safeguarding children from abuse – requires us to ensure that children are safe in the care of PHT. |
| CDOP | Child Death Overview Panel – part of LSCB, statutory duty to review data around all child deaths (0 – 18) and report to LSCB |
| 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. |
| LSCB | Local 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 eg 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. |

## SUMMARY OF THE YEAR

This report is produced annually. The reporting period changed last year from January – December, to April – March – this report therefore covers the period from January 2011 – March 2012.

**Quarter 1 (April – June)**

- (January 2011) - Julian Wooster, Director of Portsmouth Children's Trust Board, singled out 'health' as being of note for their 'considerable contribution to safeguarding children in Portsmouth' (January 2011, LSCB Away Day).
- March 2011 – Children's Trust Board outlined its 6 priorities, of which Priority E, 'Excellent safeguarding and early intervention practice, processes and procedures' has particular impact on PHT training and practice – see main body of report
- PHT safeguarding children strategy updated April 2011
- Deloitte Internal Audit – Oct - Dec 2010, reported May 2011 – recommendations all completed (see main body of report)
- Joint OFSTED/CQC Integrated Inspection of Portsmouth City Council (PCC) Safeguarding and Looked After Children's Services May 2011. Action plan - PHT to provide PCC and NHS Portsmouth further assurance in respect of their statutory safeguarding children responsibilities through Section 11 Children Act 2004, contracts, audit, outcome focused objectives and performance indicators; and develop a more 'robust performance management and quality assurance approach'. See main body of report.

**Quarter 2 (July – September)**

- Joint OFSTED/CQC Integrated Inspection of Portsmouth City Council (PCC) Safeguarding and Looked After Children's Services reported July 2011, found 'a good contribution from health partners for the safeguarding inspection, and a good health rating for the city's overall effectiveness of services for looked-after children and young people.'

**Quarter 3 (October – December)**

- PHT Serious Case Review Action plans well received by NHS Portsmouth Oct 2011
- Specialist Advisor in Safeguarding Children joined the team in November
- Safeguarding Children Practice Educator/Specialist Practitioner and Named Nurse Safeguarding Children organised a PHT Child Safety Day 4th November 2011, supported by SGC team. Display stands in PHT Atrium with multi-agency partners.
- 'Safer Babies' campaign re-launched
- Substance misuse guidelines revised

**Quarter 4 (January – March)**

- 4LSCB procedures revised and updated
- Detailed safeguarding schedule contracting negotiations with SHIP commissioners
- PHT 'diagnostic imaging in suspected Non Accidental Injury' guideline reviewed and updated
- New Safeguarding Children Database progressing well (live from July 12)

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**SAFEGUARDING CHILDREN and YOUNG PEOPLE IN PORTSMOUTH HOSPITALS NHS TRUST**
**ANNUAL REPORT 2011**

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

## (1) THE NATIONAL SAFEGUARDING CHILDREN LANDSCAPE

- The **Laming** 2009 recommendations were highlighted: *All agencies that have a statutory duty to cooperate (local authority children's services, district councils, police, primary care trusts (PCT), NHS trusts, Connexions, probation, Youth Offending Service, Cafcass, secure training centres and prisons) should clarify the chain of accountability and responsibilities for child protection from the front line through to their most senior level.*

- The **Every Child Matters** website was moved to the 'Children and young people' section of the DfE (Department of Education) site at the end of 2010.

- **Child health profiles** were launched in February 2011 - www.chimat.org.uk/profiles - these give background demographic information about the children in each area; and comparative analysis with other local authorities across the country. The national childrens' health service **mapping** programme was discontinued in June 2011

- The **Munro report** was released in May 2011. The full report can be accessed at http://www.education.gov.uk/munroreview/downloads/8875_DfE_Munro_Report_TAGGED.
  Key recommendations impacting on Health (likely to be implemented via LSCB/Childrens trust Board direction) are as follows:
  1) Revision by HMG of *Working Together to Safeguard Children* and *The Framework for the Assessment of Children in Need and their Families* and their associated policies, to include increased attention to timeliness, quality and effectiveness of assessments and interventions, and encourage local approaches to assessment forms and IT systems
  2) Inspection framework to examine the effectiveness of the contributions of all local services in the child's journey from needing to receiving help
  3) Use of nationally collected and locally published performance information to help benchmark performance, facilitate improvement and promote accountability.
  4) End OFSTED evaluation of SCRs (the OFSTED childrens' services annual rating process had already ended in December 2010)
  5) Focus on early recognition and intervention for children in need.

## 2) PROGRESS AGAINST GUIDANCE AND RECOMMENDATIONS

- **Joint OFSTED/CQC Integrated Inspection of Portsmouth City Council (PCC) Safeguarding and Looked After Children's Services May 2011 - Outcome 7 – safeguarding children from abuse**
    - Return submitted 'compliant/minor concerns' – ongoing work to evidence compliance
        - **Action plan –**
        - NHS Portsmouth Safeguarding Board to receive annual safeguarding children reports from PHT - DONE
        - NHS Portsmouth Safeguarding Board to receive PHT Section 11 audit returns – IN PROGRESS
        - Key Performance Indicators for PHT Safeguarding Children Team to be developed - DONE
        - PHT Clinical Supervision policies for all clinical staff whether dealing with adults or children to include the need for safeguarding children to be a standing item for discussion – INTRODUCED
        - Adult services to set up and embed systems to ensure that children's safeguarding is consistently addressed within adult services - INTRODUCED

- **'Section 11' (of Children Act 2004)**
    - Regular detailed LSCB audit – 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 by health professionals in Portsmouth.'

- **Children's Trust Board Priority E**
    - Scoping exercise carried out to identify staff groups requiring CAF training (predominantly midwifery, paediatric specialist nurses and dieticians, and key paediatric nursing staff)
    - Programme of CAF training in hand

- **Commissioning/contracting**

    - Arrangements for safeguarding children are specified in the commissioning process
    - Schedule C of the 'Standard NHS contract' requires 'clear leadership and accountability at Board level for safeguarding children. The Medical Director provides clear leadership to medical staff in the arena of safeguarding children.'
    - Safeguarding committee minutes and annual report are submitted to commissioners

- **Recommendations from Deloitte Internal Audit – Oct - Dec 2010, reported May 2011 (all completed):**

    - Business continuity plan for Safeguarding children to be written into the Safeguarding children strategy
    - Competency assessment after Safeguarding children training
    - Enhanced online Safeguarding children training to include levels 2 and 3
    - Ensure all clinical staff in W&C CSC and Paediatric ED have had CRB checks, and plan programme to complete CRB checking of all clinical staff with contact with children

- **Recommendations from SCR 'Child C' (SUDI October 2010) – completed**

    - Improvements in maternity record-keeping (including introduction of 'digipen')
    - Audit of maternity records including domestic violence awareness, safe sleeping advice.
    - Paediatric Emergency department – regular audit of completion of safeguarding checks
    - Childrens Assessment Unit – audit of safeguarding checks revealed poor performance. (in only 12/51 (23.5%) was the safeguarding checklist completed). Action - Checklist revised, new documentation introduced April 2012, re-audit planned.
    - Paediatric department – monthly audit (20 sets of clinical records) includes completion of safeguarding checks and notification of Health visitor when any child discharged – reporting back to PHT Safeguarding Children Committee. Health Visitor liaison difficult to achieve due to complexity of HV contact network, but PHT continue to work with PCTs on this.

**3) PHT SAFEGUARDING CHILDREN - STRATEGIC FRAMEWORK**

- **PHT Safeguarding Children Committee** – meets quarterly, draws together representatives from all CSCs where children and young people are cared for, along with the safeguarding team, HR and the Head of Nursing for W&C CSC. Committee reports into PSQC.

  Key points from 2011 not covered elsewhere in report:

  - CRB checks – (1) HR completed programme of ensuring all staff with contact with children have undergone CRB check. (2) LSCB recommended 3 yearly repeat checks for all staff with contact with children – significant resource implication and not statutory requirement therefore PHT not implementing. (3) Estates staff (Carillion) not CRB checked – legal advice sought, blanket checks not lawful – Paediatric Unit staff to maintain awareness that estates staff not CRB checked so must book in at reception and be supervised.

  - Policies - 'was not brought' policy updated, supervision policy ratified by PSQC April 2011

- **Emergency Department Safeguarding Children group** – meets quarterly, PHT teams joined by representatives from health visiting and social care. Reviews ED safeguarding children policies, interface with Childrens' Social Care and Primary Care, and procedures and training.

  Key points from 2011:

  - Portsmouth Children's Social Care planning to stop feeding into the Hampshire child protection database – assurance that no change will be made until new arrangements in place for PHT checking child protection status of children attending ED.

  - Health visitor liaison service in ED withdrawn by both Hampshire and Portsmouth in 2011. On ED risk register until alternative pathways for 'Cause for concern' forms had been developed.

  - Management of 'alleged sexual abuse' pathway updated

- **Governance:** Quarterly Governance reports submitted to Trust Governance and Quality Committee and Risk Register maintained.

- **Accountability**: Completion of Trust returns for CQC compliance, SHA safeguarding governance review, LSCB audits

## 4) PHT SAFEGUARDING CHILDREN - CLINICAL ACTIVITY

**Safeguarding Children team:**

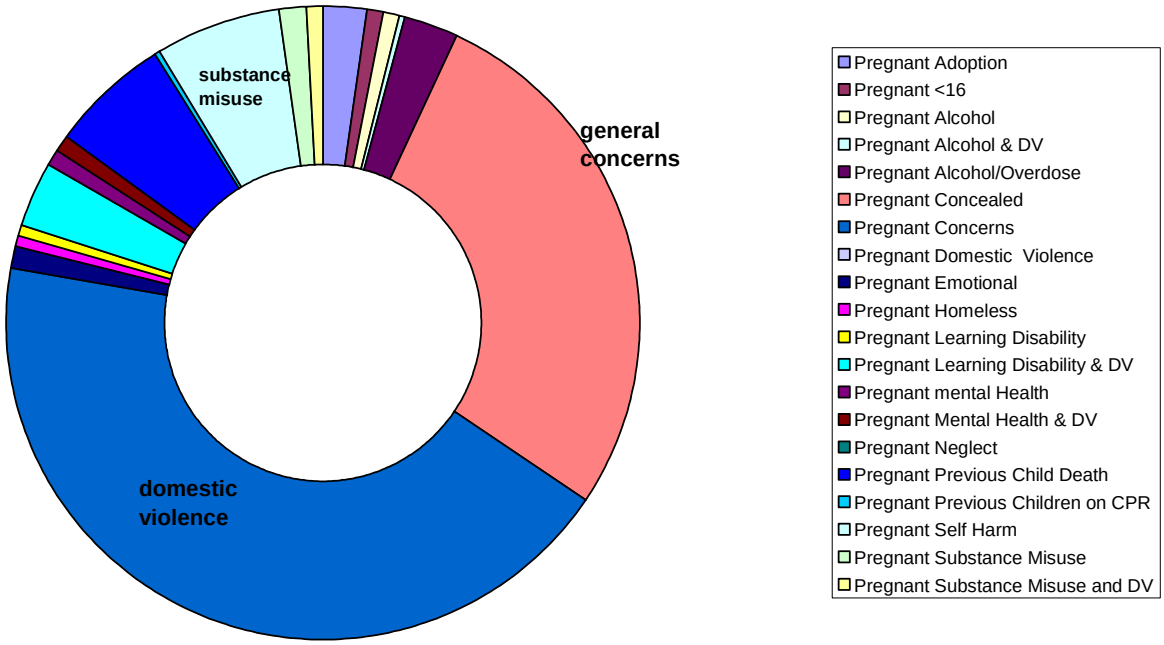
The Portsmouth Hospitals Trust Safeguarding Children and Young People's (SCAYP) team was enhanced during 2011 by the arrival of a Specialist Practice Educator/Practitioner, and a Specialist Practitioner . The team now consists of:

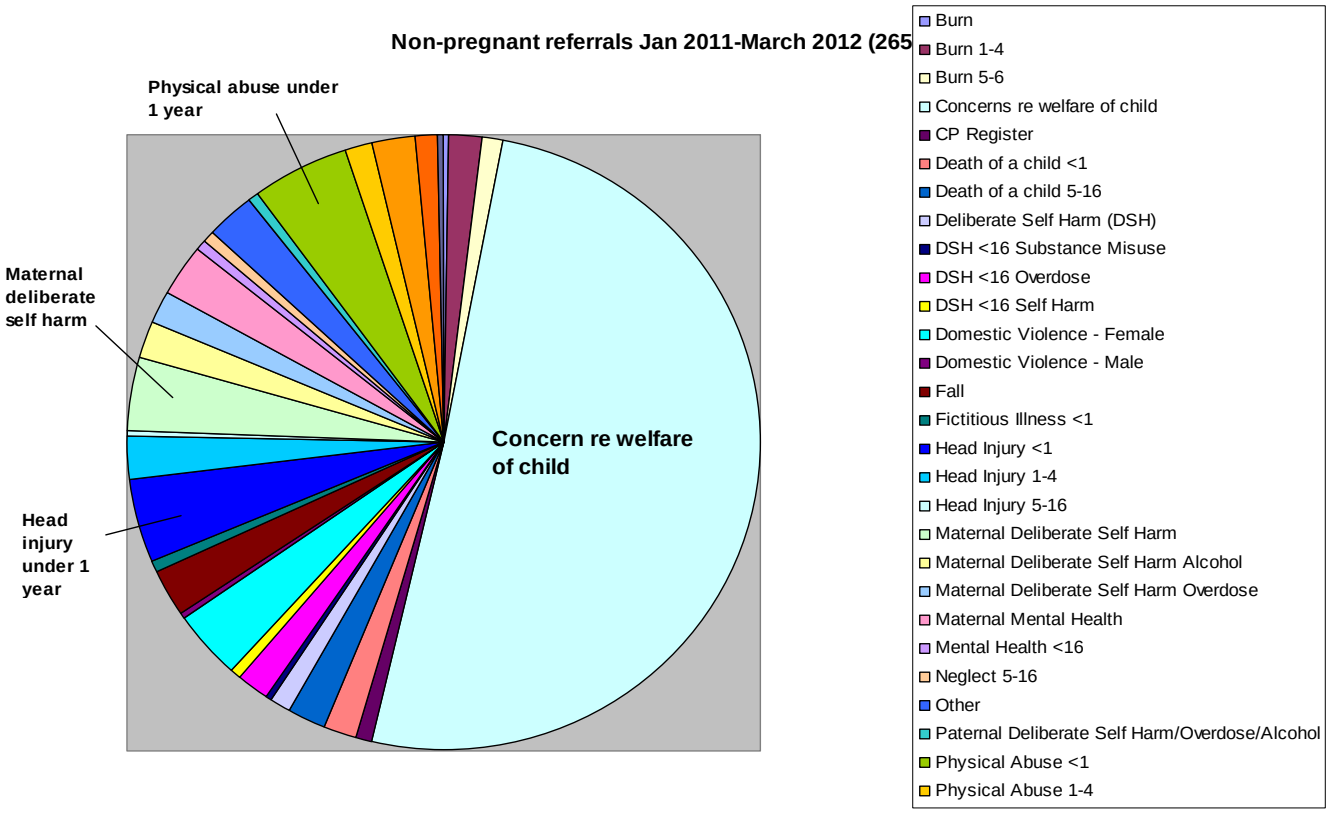
- Named Nurse 1 wte
- Named Midwife 1wte
- Specialist Practitioner 0.9 wte
- Named doctor 2 PA/week (1 PA protected)
- Safeguarding Practice Educator/Practitioner 0.53.wte
- Administrative Staff 2.0 wte
- Network of facilitators across the Trust - re-activated Dec 2011, meet bi-monthly

In addition, Maternity established the role of 'public health lead' and 3 midwives were appointed to lead on domestic violence, mental health, and substance abuse, respectively.

The office received 902 referrals over the period of the report

**Pregnant referrals Jan 2011 - March 2012 (635)**




Non-pregnant referrals Jan 2011-March 2012 (265
Physical abuse under 1 year
Maternal deliberate self harm
Head injury under 1 year
Concern re welfare of child
Burn
Burn 1-4
Burn 5-6
Concerns re welfare of child
CP Register
Death of a child <1
Death of a child 5-16
Deliberate Self Harm (DSH)
DSH <16 Substance Misuse
DSH <16 Overdose
DSH <16 Self Harm
Domestic Violence - Female
Domestic Violence - Male
Fall
Fictitious Illness <1
Head Injury <1
Head Injury 1-4
Head Injury 5-16
Maternal Deliberate Self Harm
Maternal Deliberate Self Harm Alcohol
Maternal Deliberate Self Harm Overdose
Maternal Mental Health
Mental Health <16
Neglect 5-16
Other
Paternal Deliberate Self Harm/Overdose/Alcohol
Physical Abuse <1
Physical Abuse 1-4

## 5) CHILD DEATHS, IMRs, SIRIs AND SCRs.

**PHT Child deaths Jan 2011 – March 2012**

| | Number | Comment |
|---|---|---|
| Deaths within PHT (Neonatal Intensive care Unit) | 13 | 2 lethal congenital abnormalities<br>2 transfers in from home/elsewhere, succumbed<br>Extreme prematurity – 5 26 weeks or less, 3 26 -27 weeks (1 unexpected – see SIRI below)<br>1 Severe hypoxic brain injury<br>Also 2 deaths before admission – extreme prematurity, congenital abnormality |
| Deaths within PHT (outside (Neonatal Intensive care Unit) | 1<br>1 | Expected - complex congenital anomaly<br>Unexpected – overwhelming infection |
| Expected deaths of children under PHT care but dying elsewhere e.g. home/hospice | 5 | |
| Children brought in to PHT following unexpected death at home | 8 | 5 unexpected infant deaths, of which 1 went to SCR; 2 deaths by suicide (one suspected unintentional) in over-16's; 1 unexpected death in a child with complex disability |

- Unexpected deaths in children age under 16 brought in to/occurring within PHT are subject to Rapid Response.
- Unexpected deaths in young people age 16 – 18 are notified to CDOP as required, but are managed by the Emergency Department team (adults).
- The PHT team received a specific thank you from a police officer for our handling of a rapid response in February 2011

**CDOP** - The CDOP report 2010 - 2011 is not yet available for review

**Note:** Any unexpected death occurring in an infant aged under 28 days initiates a SIRI and is reported to the SHA.

**SIRI baby ES** (June 2011)

- Unexpected death at age 5 days
- Unrecognised maternal alcohol abuse
- IMR and case review (not SCR) - recommendations awaited

**SIRI Baby B** (August 2011)

- Neonatal Intensive Care Unit – 23 week twin, in utero transfer from Poole, prognosis uncertain but death sudden and may have been contributed to by routine care procedure. Referred to coroner, PHT SIRI process followed, not full 'rapid response' in view of extreme prematurity and infant had never been home. Coronial investigation ongoing.

**SCR Child D** (SUDI December 2011)

- Unexpected death at home of infant aged 22 days. Overlaying thought to be a contributory factor to death. Known to Childrens Services, Portsmouth; subject to a Child Protection Plan due to historical concern over physical abuse and neglect of mother's other three children
- SCR commenced 20.1.2012, PSCB to submit to OFSTED by 20.7.2012
- PHT IMR completed March 2012

## (6 INTERAGENCY WORKING

*Context - interagency working both with individual cases and in terms of representation on the Local Safeguarding Childrens Board (LSCB) and other local safeguarding groups*

- The PHT Named Nurse attends quarterly meetings of the LSCBs (Hampshire and Portsmouth)
- PHT is represented on Hampshire Multi-Agency Safeguarding Forum (MASF) and Portsmouth Safeguarding Health Forum.
- CDOP/Rapid response. 8 'phase 2 ' meetings in response to unexpected child death. Named Doctor continues to work with local agencies in embedding local policies in implementation of Chapter 7 of Working Together 2006 – child death review process – although the PHT component of this work has yet to be commissioned.
- Supporting local MAPPA work
- Invited to 484 interagency conferences/strategy meetings (63% Paediatrics, 37% Maternity) - attended 42%, apologies sent (and explanation – usually no contact with child concerned) for 58%.
- Annual LSCB audit of compliance with section 11 of the Children Act 2004
- Working with local authorities as they revise arrangements for accessing the Child Protection register ( a key part of our risk assessment in recognising maltreatment in children).
- Specific thanks from multi-agency partners for management of some cases – ED Jan 2012 'The staff's communication, helpfulness and their promptness in dealing with baby was most appreciated. It made a very difficult situation much easier. Thanks very much'.

## (7) 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. 'Working Together' 2010 also sets out guidance for training.*

- 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.

- Level 1 universal coverage enhanced with leaflet designed by SGC team and distributed with payslips in January 2011. More detailed booklet planned for 2012.

- In August 2011 the Trust-wide figure for staff trained in safeguarding children reached a new high of 89% - this reached 91% by year end.

- Learning and Development started a scoping exercise with all CSCs to clarify numbers of staff requiring level 2 & 3 Safeguarding Children Training. This work is scheduled for completion during 2012.

- Training modalities include 'ESR' e-learning package for level 1,2 and 3; training DVD; eMOT; and face-to-face level 2 and 3 training, both multi-professional and departmental (anaesthetics, Emergency department, ophthalmology, dermatology). All junior staff in paediatrics and ED receive a safeguarding session at induction; the annual 'SPEARS' day for surgeons includes a safeguarding session. The database of numbers trained is maintained by Learning and Development. Training modalities were enhanced in 2011 by the arrival of a specialist safeguarding practice educator

- Successful level 3 update delivered to 80 Consultants, Registrars, Senior Managers and Team Leaders across 2 occasions, strong feedback

| Level | Number trained 2009 | Number trained 2010 | Number trained 2011 |
|---|---|---|---|
| 1 (update required every 3 years) | 4230 | 1726 | 3209 |
| 2 (annual refresher update required) | 93 | 194 | 352 |
| 3 (annual refresher update required) | 336 | 103 | 562 |

The named professionals for Safeguarding Children are trained to level 4.

- Figures for percentage of staff up-to-date in SGC training are as follows:

## Essential Skills Training - Safeguarding Children Compliance 2011 (2010 figures in brackets)

| Training | Division | % of staff in date |
|---|---|---|
| **Safeguarding Children** | Cancer CSC | 92% (78%) |
| | CHAT | 90% (50%) |
| | Clinical Support CSC | 94% (79%) |
| | Emergency Care CSC | 91% (75%) |
| | Head & Neck CSC | 88% (83%) |
| | Internal Medicine CSC | 86% (78%) |
| | Elderly Services CSC | 92% (81%) |
| | Musculo Skeletal CSC | 92% (83%) |
| | Renal CSC | 94% (87%) |
| | Surgery CSC | 89% (77%) |
| | Women's & Children's CSC | 93% (90%) |
| | Corporate Functions | 90% (100%) |
| **Overall Trust** | | 91% (81%) |

**(8) AUDIT**

*Context - audit of safeguarding practice*

- Random audit of 50 sets of patient records annually by Day Surgery Unit (0-16) outcome of audit reported back to Governance
- ED - regular re-audit of use of Safeguarding Children processes. June 2011 - Good safeguarding procedures are in place within the ED, but documentation of full completion of ED child safeguarding checks was below the expected standards, especially between 0000 – 0800. Action - Awareness campaigns continue, re-audit planned.
- Audit against NICE guidance ('when to suspect maltreatment in children') completed Sept 2011, recommended increased focus on NICE guidance in training. Re-audit planned.
- SNAP audit of training effectiveness - on-going
- February 2011 – Inter-professional learning project students carried out audit of safeguarding knowledge across PHT – 9 departments, 117 staff. Suggestions made to better reach all staff with the 'safeguarding message'.
- Childrens' unit monthly audit of 20 sets of clinical records includes safeguarding check completion, child health record book completion, health visitor liaison

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## (9) SUMMARY AND THE YEAR AHEAD

Objectives/progress against recommendations:

- Continue to ensure strategic presence of Safeguarding Children at Trust Board level, alongside safeguarding adults and general safeguarding, as required by statute and commissioning.
- protect existing good practice and develop clinical supervision in safeguarding children
- meet the challenge of staff turnover and high demands on Safeguarding Children team
- maintain target levels of Safeguarding Children training across the Trust
- ensure that safeguarding procedures are integrated into preparations for move towards an integrated children's emergency service (Childrens Assessment Unit/ paediatric ED combined) for unscheduled care, which will change skill mix and pathways for initial assessment
- Prepare for safeguarding children peer review by Portsmouth City Council Oct 2012

**Resources:**

**Training competencies** - www.rcm.org.uk/info/docs/safeguarding_children
**Intercollegiate training competencies (Sept 2010) :**
http://www.rcpch.ac.uk/sites/default/files/asset_library/Health%20Services/Safeguarding%20Children%20and%20Young%20people%202010.pdf
**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
**Local intranet site:** http://pht/Departments/safeguarding-children/default.aspx