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**Previous Meetings**

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<th>ECC</th>
<th>Audit Committee</th>
<th>Quality &amp; Safety Committee</th>
<th>Finance &amp; Investment Committee</th>
<th>Management Board</th>
<th>IM&amp;T Strategy Committee</th>
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Safeguarding Children Annual report
2015 - 2016


AUTHOR: Linda Salt
Named Nurse

REPORT DATED: 31st October 2016

REPORT ISSUED TO: Safeguarding Committee
1. EXECUTIVE SUMMARY

1.1 The Wrightington, Wigan and Leigh NHS Foundation Trust Board (WWL) is provided with the Trusts Safeguarding Children Annual Report, which résumés the extent of safeguarding children activities taken place within the Trust and with external partners during 1st April 2015 – 31st March 2016 and outlines the areas of priority for 2016/17.

1.2 The Care Quality Commission (CQC) inspection of the Trust during December 2015 identified some areas of concerns in relation to the Trusts processes and procedures related to safeguarding children. The Trust had previously identified the same areas of concern and recovery plans were in place.

1.3 All hospital staffs have a statutory responsibility to safeguard and protect children and families who access WWL services. Safeguarding and promoting the welfare of children is defined as protecting children from maltreatment and preventing impairment of children's health or development (Working Together to Safeguard Children March 2015).

1.4 The report summarises the progress made on the Safeguarding Children Action Plans and work streams. It also outlines both child protection activity and staff training figures for 2015/2016.

1.5 WWL safeguarding children’s team experienced significant fluctuation of staffing throughout the period reported. There has been a new Head of Children Safeguarding and Named Nurse in post since September 2015, a new Named Doctor and some notable absences due to ill health.

1.6 Referrals to the safeguarding children’s team have fluctuated through the reported year. However, the number of child protection medical examinations carried out increased significantly in the second half of the year reported. There is anecdotal evidence that the introduction of the multi-agency ‘Injuries on non mobile children’ pathway has increased referrals for full child protection medical examinations.

1.7 Amendments have been made to improve the system of collection and collation of safeguarding children activity. This is to improve the identification of trends and inform future focus and work streams of the safeguarding children’s team.

1.8 Local serious case reviews and multi-agency reviews have highlighted the need to put children at the centre and to listen to what they say, to make every contact count by focussing on getting it right the first time and being alert to the risk of self-harm and suicide in children. Hence there has been work on capturing the ‘voice of the child’ throughout WWL.
1.9 Safeguarding children training, educational opportunities and competency level of WWL staff have been reviewed and now reflect the requirements of the Intercollegiate Document (2014).

1.10 Over the time frame of this report WWL had not received the full outcome of their recent inspection of services by CQC, therefore, the inspection results are not noted.

2. PURPOSE

2.1 The annual report is to provide assurance to WWL Trust Board and Wigan Clinical Commissioning Group (WCCG) that the Trust continues to fulfil its statutory responsibilities in relation to ‘make arrangements to safeguarding children’ as stated in section 11 of the Children Act (2004).

2.2 The purpose of the safeguarding children annual report is also to inform members of the WWL Trust Board of the Safeguarding Children activities within WWL during the year 1st April 2015 to 31st March 2016, and the identified priority areas for 2016/17.

3. INTRODUCTION

3.1 This report provides analysis of the current standard of safeguarding children throughout the Trust for the financial year 2015-2016. The management and care of safeguarding children and young people has continued to be regarded as high profile, both nationally and locally.

3.2 The implementation of national and local drivers for safeguarding is mainly directed through central government, NHS England via Wigan Clinical Commissioning Group (WCCG) and Wigan Safeguarding Children Board (WSCB). This in turn is steered through the Trust’s WWL Safeguarding Committee and Safeguarding Children Team.

3.3 Wrightington, Wigan and Leigh NHS Foundation Trusts (WWL) has put in place measures throughout the organisation to ensure that WWL is doing everything it can to prevent the abuse and neglect of the children and young people who access services. The Trust has established processes and systems to ensure there is a timely and proportionate response when allegations of abuse are identified. Work is continuing to further improve WWL safeguarding children systems.

4. ROLES AND RESPONSIBILITIES

The director of Nursing has executive responsibility for safeguarding children. The Safeguarding Children’s Team consists of:

*Band 8a – 1.0 x WTE*  Named Nurse and Head of Safeguarding Children
There is a consultant Paediatrician whose role also includes Named Doctor at 2x PA.

5. **OVERVIEW**

5.1 WWL provides safeguarding services to ensure children and young people remain safe in its care, have their needs met and are supported to develop to their full potential.

5.2 The Care Quality Commission, Wigan Clinical Commissioning Group and local Safeguarding Children Board requires Health Organisations to take reasonable steps to ensure that commissioned services are compliant with essential healthcare standards regarding arrangements to safeguard and promote the welfare of children under section 11 of the children act (2004).

5.3 WWL provides safeguarding arrangements for children and young people by;

- Working with partners to protect children and participate in reviews as set out in Working Together to Safeguard Children (HM Government 2015);
- Agreed systems, standards and protocols in place in regard to sharing information about a child and their family, both within the organisation and with external agencies.
- Ensuring that WWL policies and procedures are current and compatible with local and national guidance.
- Delivering up to date safeguarding training in line with national standards and including all local learning from reviews.
- Offering safeguarding support and supervision to staff across the Trust.
- Compliance with legislation and government guidance, for example;
  - Safeguarding children and young people: roles and competences for health care staff Intercollegiate Document 3rd edition (2014),
  - NICE Guidance Domestic Abuse. Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively. Public health guidance 50 (2014),
  - NICE Domestic violence and abuse Quality Standard (2016),

5.4 The Safeguarding Children’s Team provides specialist support, advice, training and supervision to all staff within the Trust and works closely with partner agencies on behalf of the Trust to keep children safe.
6. ACTIVITY

6.1 Referrals to the children safeguarding team (including maternity cases) are generally received via fax and telephone. The method of collection and collation of referrals has been revised to standardise the data. There is currently no recognised database to do this in a systematic way. During the time frame of this report changes have been introduced to the gathering and reporting of activity data. Future data can be reported in a dashboard/table format.

6.2 Over the time frame October 2015 to 31st March 2016 WWL safeguarding team saw an increase in paediatric referrals to the safeguarding children’s team and a subsequent increase in activity. This increase has coincided with the formation of a new team resulting in a period of greater stability.

6.3 Paediatric referral are received for all children aged 0-18 years where safeguarding issues have been identified. The referrals are generated from any department across the Trust, however, most of the concerns identified and raised are by the A&E and Paediatric departments. The matters recognised as causing safeguarding concerns for children are widespread in nature and also include issues which some parents are living with, such as mental illness, addictions and domestic abuse, which does have an impact upon children.

6.4 **Paediatric referrals April 1st 2015 – March 31st 2016**
6.5 The WWL Named Midwife has received referrals and maternity alerts which have fluctuated in number throughout the year, as the service becomes embedded. Nevertheless, the most reported issues for safeguarding in WWL maternity services is consistently, parental mental health, domestic abuse and substance misuse, the combination of these issues has been identified in national serious case reviews as the ‘toxic trio’ because it is likely to cause significant harm for child growing up with such issues.

6.6 Maternity referrals April 1st 2015 – March 31st 2016

6.7 The Named Midwife worked with community services to complete the local serious case review ‘Child E’ action plans in partnership with WSCB. This work has included extensive review of ‘routine enquiry for domestic abuse’ to all maternity service users.

6.8 There were 101 child protection medical examinations completed throughout April 2015 to September 2015 and 146 during October 2015 to March 2016. Anecdotal evidence suggests that the introduction of the multi-agency ‘Injuries on non mobile children’ pathway has increased referrals for full child protection medical examinations for the Trust.
6.10 The majority of referrals for child protection examinations are received from Wigan social care, some of which have been via the ‘Injuries on non-mobile child’ pathway, other health staff have referred directly via the pathway to WWL paediatricians.

6.11 Child protection medical exams (referral sources)
7. Reviews

7.1 Serious Case Reviews (SCR) are convened by a LSCB for every case where abuse or neglect is known or suspected and either: a child dies; or a child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child. WWL safeguarding children’s team have participated in two new serious case reviews and two new local area reviews during the period reported. Some of the earlier local SCR’s have taken a protracted length of time to come to completion and have required significant input during the time frame of this report.

Summary of reviews:

7.2 Child C and Child D SCR’s have been completed and signed off by Wigan Clinical Commissioning Group and Wigan Children Safeguarding Board (WSCB).

7.3 Child E SCR has been published and a revised multi-agency action plan produced by WSCB, actioned by WWL.

7.4 There have been two new serious case reviews commissioned in this time period with WWL involvement. Child F and Child G are part of the same review has commenced. The case of another young person who sadly died was agreed to be a subject to SCR following consideration at the national SCR panel. However, this case has not yet commenced.

7.5 Local area reviews;
There have been 2 local area reviews during the period of this report. WWL have participated fully and will working through the multi-agency action plans, which are monitored by WSCB Learning and Improvement committee.

7.6 Child death reviews:
WWL staff facilitate and assist with the sudden death in childhood (SUDC) and the Child Death Overview Panel (CDOP) process. CDOP is a review of all child deaths up to the age of 18 which requires WWL to participate under ‘duty to co-operate’ reporting to the local Greater Manchester CDOP panel. The safeguarding children team will be picking up this work in the near future.

8. Wider activity

The Domestic Violence, Crime and Victims Act 2004 is statutory guidance which places a duty on Community Safety Partnerships to make arrangements for Domestic Homicide Reviews. Health bodies are required to participate in these as requested.

8.1 Domestic Abuse arrangements across the trust have been reviewed and revised during this time period and benchmarked against the NICE DV Guidance 2014. An action plan of work has been produced which involves training, policy writing, awareness raising and further inter-agency working. The volume of work with regard to addressing the Domestic abuse agenda has proved to be challenging. The Trust was found to have only partial
engagement with the local MARAC/ISAPP process; this has been included in the Trust wide action plan.

8.2 The Senior Nurse for safeguarding children has revised the Child Sexual Exploitation (CSE) in line with national guidance and awareness-raising. The scale of CSE has continued to grow from the well-publicised cases in Rotherham, Rochdale and Oxford with additional reports for Wigan from Greater Manchester Police.

8.3 Work has commenced principally by Named Dr and Named Nurse to strengthen joint working with Wigan children’s social care to ensure difficult cases are managed appropriately. Regular meetings have been planned bi-monthly throughout 2016 to promote a greater understanding of the safeguarding children’s agenda from the acute trust and social care perspective.

8.4 The safeguarding children’s team have endeavoured to support staff in key departments with the safeguarding children agenda e.g. Accident and Emergency, Paediatrics and Maternity in the form of clinical walk rounds. However, this has proved to be challenging to facilitate in a routine manner due to capacity within the team.

8.5 A Safeguarding Bulletin has been introduced, jointly with the WWL Vulnerable Adults team. This is a way to share lessons learned and topical information to frontline staff in a timely manner and share learning from local and national case reviews. For example, the safeguarding bulletin included information from local serious case reviews for Child C, Child D Child E respectively in editions from October, November and December 2015.

8.6 Safeguarding Supervision has been facilitated mainly by the Named Midwife and Senior Nurse. Peer group supervision has been offered routinely, particularly for staff working in teams who carry a greater safeguarding risk. Group supervision has been offered and is increasing in popularity. Paediatric peer group supervision continued to be well attended and is facilitated by the Named Doctor for safeguarding children. Supervision sessions in the future need to be captured and reported in a dashboard format, once collection and collation of data has been made possible.

8.7 Early help was introduced to staff at the Trust, as part of the Wigan continuum of need and assessment. Social care have an expectation that all cases of concern will be subject to an Early Help assessment prior to any escalation. This new process is likely to have an impact on the workload of clinical staff particularly within maternity services and other staff working in community settings. The safeguarding children team have provided information sharing, training and support for the introduction of Early Help.

8.8 Safeguarding Children Policy and range of SOP’s updated to reflect changes due to Working Together 2015.
8.9 Child Protection - Information Sharing (CP-IS) is now live in a number of NHS trusts and local authorities around England with information being successfully shared between them. Alerts are triggered to local authorities informing them that children under their care has accessed an unscheduled care facility. WWL participate the national CP-IS information sharing. There has been a review of current scope and system of use for WWL staff. The safeguarding children’s team continue to work with Health and Social Care Information Centre (HSCIC) and support CP-IS.

8.10 New safeguarding children intranet site created to provide sign posting, contact details, safeguarding news and materials for safeguarding updates and is available to all staff.

9. Safeguarding Children Training

9.1 There has been a review and benchmarking exercise of the quality of the safeguarding children training packages and level of safeguarding children competency requirements of all WWL staff in post against the standard Intercollegiate Document safeguarding children competency (2014).

9.2 Training packages accessed by trust staff were found to be in need of updating and accessed at incorrect intervals.

9.3 The level of training competency allocated to all staff dependent upon job role and place of work was not consistent with the standard.

9.4 Revised packages are currently under construction including new WWL eLearning packages.

9.5 The safeguarding children’s team continue to work closely with WWL Training and Development team to realign all staff in post who have been re-aligned to the correct level of training competency needs onto the MOODLE system.

9.6 A See Training Needs Analysis (interim) was produced December 2015.

9.7 A Risk assessment completed regarding compliance level of safeguarding children training.

10. NATIONAL CONTEXT

10.1 The national drivers for WWL safeguarding children’s team to propel work forward are as follows;
19.2 Safeguarding children national NHS Accountability and Assurance Framework (NHS Commissioning Service Board 2013) Updated (June 2015 following consultation in early 2015) The purpose of this document is to set out clearly the safeguarding roles, duties and responsibilities of all organisations commissioning NHS health and social care. It sets out how the health system operates, how it will be held to account both locally and nationally. The document does make clear the arrangements and processes to be undertaken to provide assurance to the NHS England Board with regard to the effectiveness of safeguarding arrangements across the system, including the key role of Designated and Named Professionals for Safeguarding Children.

10.3 Independent Inquiry into Child Sexual Abuse (Goddard Inquiry)
In March 2015 the Goddard Inquiry was established to investigate the extent to which institutions have failed to protect children from sexual abuse. This is an Independent Inquiry commissioned following several of high profile cases, where systematic failures have been identified in the enabling the perpetration of sexual abuse. For example, in relation to the Saville scandal, (Lampard Report 2015) hospital staff were implicated in the facilitation of abuse, often by an omission of actions. The Independent Inquiry into Child Sexual Abuse will investigate whether public bodies and other institutions have taken their duty of care seriously enough to protect children from sexual abuse in England and Wales. The review has already suggested that Health providers ensure that any documentation of sexual abuse, no matter how historical, is preserved for the duration of the inquiry.

10.4 Together with the national drivers, local initiatives exist which include; WCCG Commissioning and Validation Document, Wigan LSCB Section 11 (Children act 20014) audit, recommendations from local Serious Case Reviews and Local Area Reviews, internal reviews of incidents relating to children. The WWL safeguarding children team have a work plan to standardise activity in order to address these programmes of work.

11. REPORTING AND MONITORING

11.1 WWL safeguarding children’s work plans and arrangements are reviewed and monitored through the WWL Safeguarding Committee which reports to WWL Quality and Safety Committee to inform the board. This is the opportunity for the safeguarding children’s team to provide an update on service developments, any existing or potential areas of risk in relation to safeguarding children and young people.

11.2 Wigan Local Safeguarding Children’s Board (WSCB) require WWL to complete section 11 audit on a regular basis.

11.3 WWL are monitored regarding safeguarding contractual obligations by Wigan Clinical Commissioners (WCCG) via the completion of a validation document annually, this was completed in October 2015. Safeguarding is
also a standing agenda item on the joint Quality Safety and Safeguarding Group (QSSG) bi monthly meeting.

11.4 Within WWL safeguarding children cases are considered at Paediatric Peer review on a weekly basis. The Peer Review provides a forum for learning and challenge within the safeguarding children arena.

12. Future Developments
WWL safeguarding children’s team have work streams planned for April 2016 to March 31st 2017, these include;

✓ An external audit of the safeguarding children’s service by Mersey Internal Audit Agency (MIAA).
✓ WWL are awaiting a safeguarding children specific Inspection by CQC, the format of which is now Multi-agency. Under Section 20 of the Children Act 2004, CQC along with Ofsted, HMI Constabulary, and HMI Probation inspections must provide an in-depth view of how all agencies work together to help and protect children at risk of significant harm. The agencies involved in the process are; police, probation, health and children’s social care. Services reviewed under these inspections include all health providers and commissioners, police forces, probation services and children’s social care. Following the inspection recommendations for improvement are made to the relevant sectors and a multi-agency action plan developed to support improvement. The inspection can take place at any time in the near future for WWL.
✓ Raise awareness throughout WWL regarding Child Sexual Exploitation, Child Radicalisation and Child Trafficking.
✓ Increased frequency of face to face mandatory safeguarding children’s training level 2 and level 3, to assist with full compliance.
✓ Participation in WSCB multi-agency meeting, sub groups and case file audits as part of partnership working.
✓ Sub groups for WSCB does extend the workload, for example, task and finish groups and training, particularly for target areas. There is a duty to cooperate with WSCB.
✓ Further the domestic abuse agenda across the trust, encouraging staff to attend the Trust wide Domestic abuse committee, completion of the DV NICE trust wide action plan and further roll out of the Domestic Abuse training and participation of local DV campaigns.
✓ The MARAC/ISAPP process continues to be difficult for WWL to fully engage due to capacity within the safeguarding team. The local ISAPP considers the high risk referrals regarding domestic abuse and medium risk where a crime has been committed.

✓ Support the introduction of a hospital based IDVA and evaluate the service.

✓ Safeguarding Supervision has continued to be facilitated by the Named Midwife and Senior Nurse. An emphasis on Peer group supervision to be offered routinely for those staff groups who carry the greatest risks for child protection.

✓ Review of existing SOP’s and policies in line with government agenda.
✓ Continued attendance at WWL and Multi-Agency meetings
✓ Audits as per Safeguarding Children Team Audit Calendar.
✓ Completion of actions from Multi Agency Reviews.

✓ Flagging of high risk and vulnerable children on a compatible IT system for children at risk of CSE

13. CONCLUSION

13.1 Activity has continued at a gathering pace within the team. This is set to continue as the new WWL safeguarding children training and Domestic Abuse training is rolled out; alongside the increased demand of support for both patients and staff around Domestic Abuse.

13.2 There has also been a surge of safeguarding children risks identified within the local population by Greater Manchester Police, Wigan Safeguarding Children’s Board and Central Government. As an example, organisations have been asked to be more watchful to identify; Child Sexual Exploitation, Child Radicalisation, Female Genital Mutilation and Child Trafficking. WWL staff will be made aware of the diversity of risks to children and skilled up to identify such risks. This will be achieved mainly through training and supervision.

13.3 Although safeguarding is ‘everybody’s business’, essentially every NHS organisation and the staff working within it have a professional duty to ensure that the principles and responsibilities of safeguarding children are consistently and diligently applied. Safeguarding children is complicated work. The work is constantly under review and further development in an effort to improve outcomes for children. WWL remain committed to effectively safeguarding children.
13.4 Partnership working is fundamental to safeguarding and WWL safeguarding team aim to continue to work collaboratively with WWL colleagues and local partner agencies to strengthen safeguarding arrangements within this Trust.

Safeguarding Children Team is confident that they have instilled and continue to support robust safeguarding children systems, policies and structures, along a strong assurance framework.

14. REFERENCES

CHILDREN ACT 1989

CHILDREN ACT 2004

DOMESTIC VIOLENCE, CRIME AND VICTIMS ACT 2004

INDEPENDENT INQUIRY INTO CHILD SEXUAL ABUSE (GODDARD INQUIRY)

NICE GUIDANCE Domestic Abuse. Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively. Public health guidance 50 (2014)

NICE Domestic violence and abuse Quality Standard (2016)


Safeguarding children and young people: roles and competences for health care staff, intercollegiate document (updated 2014).

