SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

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EXECUTIVE SUMMARY

REPORT TO THE BOARD OF DIRECTORS – 15 NOVEMBER 2017

Subject	Annual Safeguarding Children Report 2016/17
Supporting TEG Member	Professor Hilary Chapman, Chief Nurse
Authors	Sharon Clarke & Sara Thomas, Named Professionals for Safeguarding Children
Status[1]	**N**

PURPOSE OF THE REPORT

- To inform the Trust Executive Group and Healthcare Governance Committee of the current arrangements for safeguarding children at Sheffield Teaching Hospitals NHS Foundation Trust (STHFT).
- To provide assurance that STHFT meets relevant standards for safeguarding children.
- To demonstrate key achievements in safeguarding children over the last 12 months (2016/17).
- To identify the key priorities for 2017/18 to improve the processes, policies and audits, training and assurance for safeguarding children.

KEY POINTS

- The Trust meets its statutory requirements to safeguard children.
- There has been a considerable increase in safeguarding activity across the Trust in 2016/17.
- The Trust is able to provide assurance to Sheffield Clinical Commissioning Group and the Sheffield Safeguarding Children Board by complying with all external audits and having a robust programme of internal audits.
- The Trust has fully co-operated with all investigations, including Serious Case Reviews and Learning Lessons Reviews. This has included the completion of action plans to improve systems, processes and individual practice.
- The Trust has improved its compliance with safeguarding children training requirements. Work is on-going to build on this achievement in 2017/18.
- Objectives for the coming year have been identified to enable the safeguarding children team to build on the progress made in 2016/17.

IMPLICATIONS[2]

AIM OF THE STHFT CORPORATE STRATEGY 2012-2017		TICK AS APPROPRIATE
1	Deliver the Best Clinical Outcomes	✓
2	Provide Patient Centred Services	✓
3	Employ Caring and Cared for Staff	✓
4	Spend Public Money Wisely	✓
5	Deliver Excellent Research, Education & Innovation	✓

RECOMMENDATIONS

The Trust Executive Group / Healthcare Governance Committee / Board of Directors are asked to debate the contents of this report and confirm that they are assured that the Trust has robust arrangements for safeguarding children.

APPROVAL PROCESS

Meeting	Date	Approved Y/N
Trust Executive Group	27.09.17	Y
Healthcare Governance Committee	23.10.17	Y
Board of Directors	15.11.17	

Sheffield Teaching Hospital NHS Foundation Trust

Safeguarding Children Report

April 2016 – March 2017

1.0 Introduction

Sheffield Teaching Hospitals NHS Foundation Trust (STHFT) is committed to ensuring that all patients receive high quality care that promotes their health and wellbeing, whilst ensuring that they are safe and protected from harm. The Trust has a number of organisational arrangements and processes in place to ensure that this can be achieved.

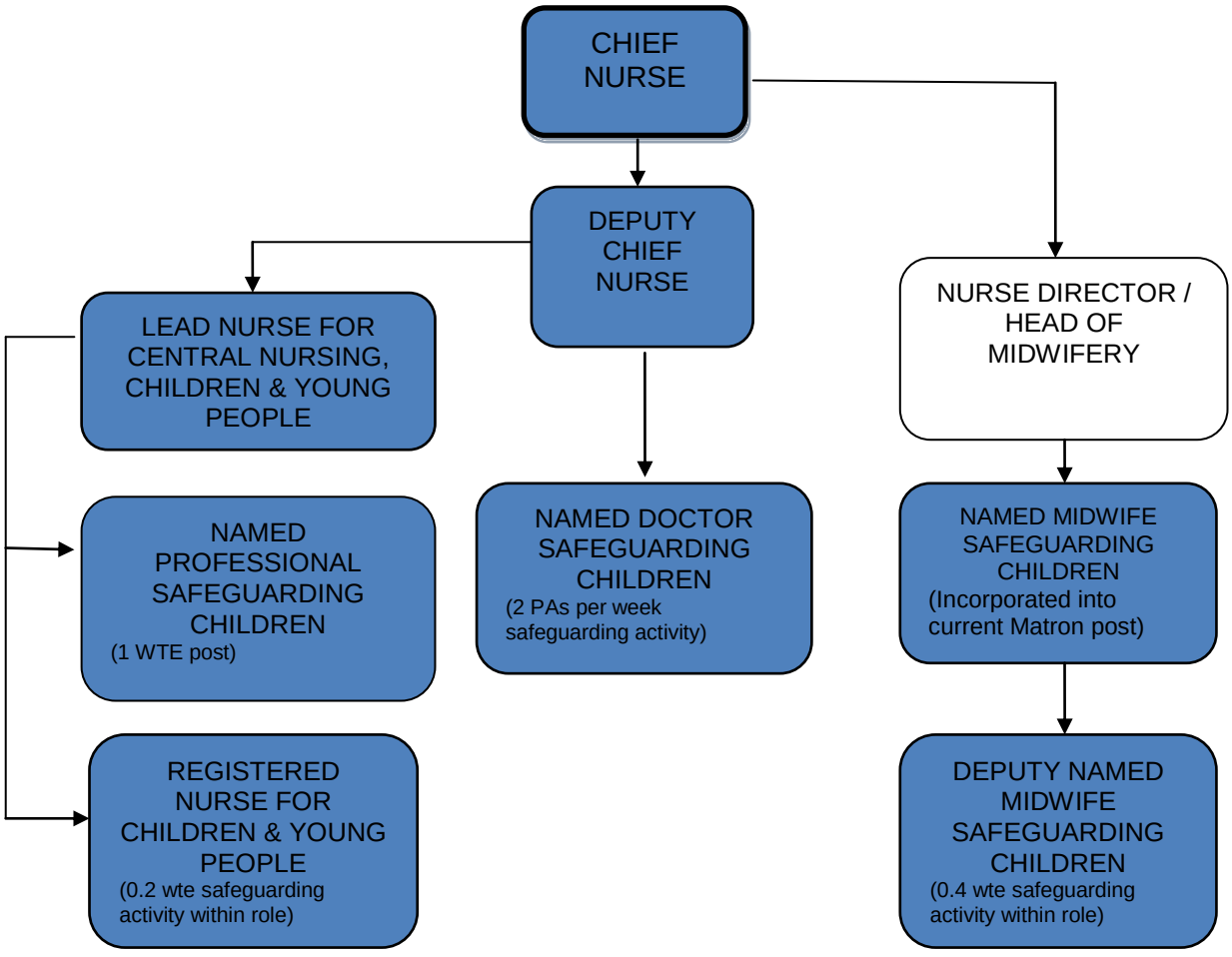
The purpose of this report is to provide assurance and evidence to STHFT Healthcare Governance Committee that the Trust is meeting its statutory requirements for safeguarding children. The annual report will reflect the structures, processes and activities related to safeguarding children relevant within STHFT from April 2016 to March 2017. This will include;

- A summary of safeguarding children arrangements within STHFT.
- A report on the team's progress against 2016/17 objectives.
- A report on the governance and accountability arrangements, including compliance with inspection, audits, and key performance indicators.
- Highlighting service developments and specific issues that the Safeguarding Children Team has encountered.
- Identification of objectives for 2017/18.

2.0 Safeguarding Children Team

The Safeguarding Children Team is led by the Chief Nurse who is the Executive Board member responsible for safeguarding children, ensuring there is a clear line of accountability to the Board of Directors. The statutory requirement of providing named professionals responsible for safeguarding children has been achieved. The team includes the Lead Nurse for Central Nursing/Children and Young People, Named Professional (formerly Named Nurse role), Named Doctor, and Named Midwife for Safeguarding Children. Due to the retirement of the previous Lead Nurse for Children and Young People, new appointments have been made and the team has continued to work well throughout the transitions of post holders.

Safeguarding Children Structure / Team



There continues to be a significant overlap between safeguarding children and safeguarding adult policy at both a local and national level. As such, there is a close working relationship with the Trust's Safeguarding Adults Team. To improve this

relationship further, both teams have agreed to develop a joint safeguarding strategy and work plan, developing clear aims and objectives, whilst ensuring the efficient use of skills and resources.

The teams continue to work closely together on several safeguarding themes and projects. In 2016/17 this work included;

- Collaboration in training development and delivery.
- Development of systems, processes and policy for the management and recording of female genital mutilation (FGM).
- Collaboration to ensure STHFT representation as a key partner in the Multi-Agency Risk Assessment Conferences (MARAC) for high risk victims of domestic abuse.
- Delivery of PREVENT training, as part of the national counter-terrorism strategy.

As part of the newly developed joint adult and children safeguarding work plan for 2017/18, the Safeguarding Children Team will be working closely with colleagues from safeguarding adults to ensure the Trust has in place robust arrangements for the identification and management of victims of modern slavery as a new emerging theme within safeguarding.

3.0 Safeguarding Children Objectives

Section 3 will review the objectives set for and reported within the 2016/17 annual report and discuss the progress made against these.

Objectives	Achievements
Objective 1 Improve safeguarding children training compliance (all staff)	• Level 1 Safeguarding Children Training – 97% (Increase of 2%) • Level 2 Safeguarding Children Training – 85% (Increase of 8%) • Level 3 Safeguarding Children Training - 85% (Increase of 1%)

	Although still not at the required compliance level of 90%, there has been a gradual improvement of compliance against all three levels of training. To facilitate further improvements, the team are exploring a range of measures including, increased accessibility of training, use of pre-recorded training materials and the ability for staff to complete self-declarations of training compliance where relevant evidence for this exists. It is anticipated that these measures will continue to build upon the progress achieved in 2016/17
Objective 2 Named Doctor to review safeguarding children training for trainee medical staff and improve compliance with all levels of training	Compliance for Medical and Dental Staff This includes a range of medical and dental staff, determined by the Electronic Staff Record and safeguarding children mandatory training requirements. • Level 1 Safeguarding Children Training – 77% (Decrease of 4%) • Level 2 Safeguarding Children Training – 65% (Increase of 11%) • Level 3 Safeguarding Children Training - 65% (Increase of 1%) Safeguarding children training compliance remains an issue for medical and dental staff across the Trust, with lower compliance for this staff group being a significant barrier to the Trust meeting its 90% compliance target. A review of the Royal College of Paediatric Child Health (RCPCH, 2014) Roles and Competencies for Health Care Staff is currently in progress. Upon publication, this will provide an opportunity to review STHFT Training Needs Analysis (TNA) ensuring that staff are assigned the appropriate

	level of training. The Named Doctor for Safeguarding Children is continuing to address training compliance with senior colleagues.
Objective 3 Develop a safeguarding children form for use in Lorenzo which will be used as part of the individual electronic patient record	This action has been completed with the new Safeguarding Children Lorenzo form launched on 03/04/17. At the time of writing a total of 181 Child Safeguarding Lorenzo forms have been completed. Use of the form has resulted in significant improvements in the documentation, information sharing and the reporting of safeguarding children concerns identified within the Trust. From April 2017 the Trust has been able to comply with guidance in Working Together to Safeguard Children (HM Government 2015) and SSCB Safeguarding Procedures Manual (SSCB, 2017) which require all referrals to Children's Young People and Family Services where children have been identified as at risk of significant harm to be followed up in writing. Initially launched in the Trust's Emergency Department, work is on-going to ensure that this is embedded across the Trust to all areas using Lorenzo. In areas not yet using Lorenzo forms, alternative processes are in place to capture these data using the newly launched Multi-agency Confirmation of Referral Form. With support from the Information Technology Department, this form is in the process of being developed into an electronic intranet-based form to make the system more efficient for non-Lorenzo users.

	Development of the Lorenzo Safeguarding Form has been considered a significant achievement for the team and requests have been made by other organisations to utilise or replicate this process due to the significant benefits of having accessible electronic safeguarding records.
Objective 4 Continue to work with multi-agency partners in updating Female Genital Mutilation (FGM) policies, procedures and training.	This objective has been achieved. The Named Professional for Safeguarding Children has continued to work with multi-agency partners to support the development of a city-wide policy and pathway for the identification and management of FGM. A Trust policy was also ratified in August 2016 which reflects both national and local guidance.

4.0 Safeguarding Children Activity

Section 4 will demonstrate the work undertaken by the Safeguarding Children Team to ensure that the Trust continues to fulfil its statutory requirements and those outlined in the Safeguarding Annual Assurance Assessment Tool which is submitted to the NHS Sheffield Clinical Commissioning Group (SCCG). Much of the work undertaken by the team ensures that the Trust continues to meet these required standards whilst maintaining safe and effective delivery of day-to-day safeguarding services. This includes the provision of training, supervision and advice to staff and multi-agency colleagues.

The following sections will provide an annual review of activity and achievements related to specific themes, including key achievements and challenges.

4.1 Safeguarding Children Activity and Referrals

As reported in previous annual reports, collating data about safeguarding children activity across the Trust has been difficult due to the lack of a Trust-wide tool. Although a system has been in place for several years using Datix reports, compliance with this has been below the expected standard resulting in unreliable figures which may have potentially failed to reflect the true extent of safeguarding activity across the Trust. It is anticipated that in 2017/18 the introduction of the safeguarding children Lorenzo form will mark a significant transition in the Trust's ability to report more accurately on safeguarding children activity. Furthermore, processes introduced in April 2017 whereby all referrals to Children Young People and Family Services are sent via the Safeguarding Children Team will result in improved information sharing and reporting of concerns, demonstrating the Trust's response and commitment to supporting children, young people and families and making the necessary referrals when children are identified as at risk of abuse and neglect.

Chart 1 – Safeguarding Children Activity Figures (Excluding Maternity Service)

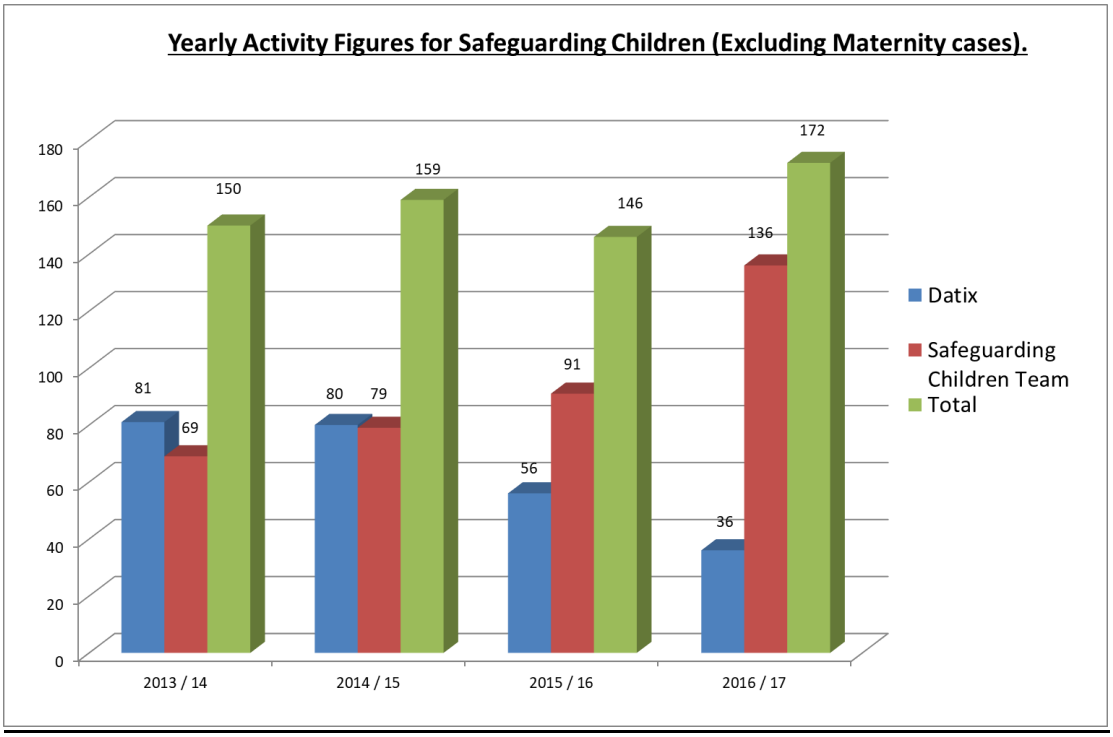


Chart 1 demonstrates the gradual increase in contacts made to the Safeguarding Children Team for advice and support over the last four years. Whilst demonstrating the year on year increase in number of contacts made to the team, the data do not accurately reflect the team's on-going support and involvement in many of the cases. A significant number of the cases discussed with the team are complex and require substantial input over several days or weeks, internal and external communications, meetings and on-going referrals. For 2017/18 the team has introduced a contact log to improve data collection and enable a more accurate representation of input by the Safeguarding Children Team. In 2016/17 a total of 36 safeguarding children cases were recorded on Datix which is a significant decrease from previous years. Due to low compliance with reporting safeguarding cases on Datix, this requirement has been removed from the safeguarding children process in April 2017, as figures will now be collated from the Lorenzo form and submission of the Multi-Agency Confirmation of Referral Form.

Chart 2 – Activity Figures by Outcome (excluding maternity cases)

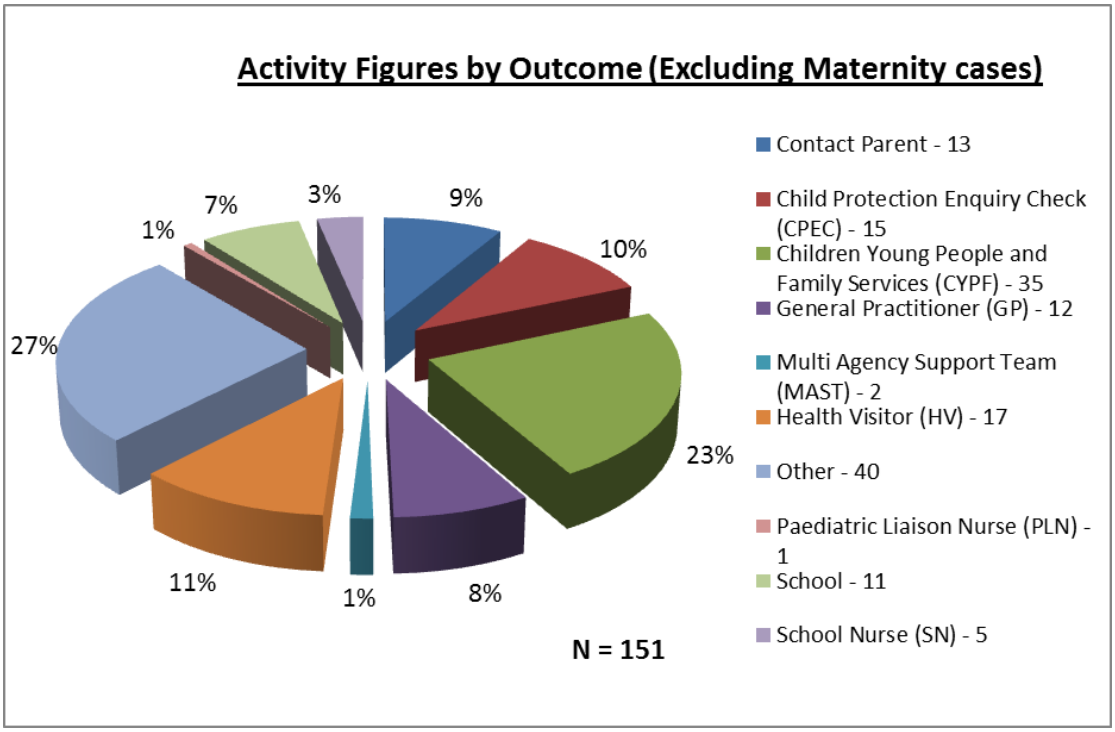


Chart 2 demonstrates the range of services accessed following advice calls that the Safeguarding Children Team received in 2016/17. Although this only reflects a small proportion of the safeguarding activity undertaken by the Trust as a whole, it does demonstrate that staff are fulfilling their responsibilities to recognise children at potential risk of harm and sharing information with other professionals where risks have been identified. It is however important to highlight that the requirement to share information with multi-agency colleagues can be challenging and time consuming, due to the number of processes and professionals that can be involved in a safeguarding children case.

4.2 Jessop Wing Specialist Vulnerability Midwifery Team

The Jessop Wing Vulnerability Team consists of 9.2 wte (whole time equivalent) specialist midwives and 0.64 wte clinical support worker who support pregnant women and their families where specific vulnerabilities are identified during pregnancy. There is currently 1 wte vacancy that is being advertised nationally. The team are supported by administrative staff (3.2 wte) whose role is to coordinate the care pathway and manage all communications systems and referrals into the team.

The Vulnerabilities Specialist Midwifery Team's role and purpose is to improve the accessibility and appropriateness of care to vulnerable pregnant women, partners and their babies. This is achieved by identifying and focusing on key aspects of care that are meaningful to each mother and co-ordinating the care provided between statutory and non-statutory agencies. The team provide enhanced care to women who are identified as having vulnerability issues including safeguarding (child and adult), women with substance misuse issues, domestic abuse, significant mental health problems, learning disabilities, homelessness, women who have been identified as seeking asylum or having been trafficked.

Women are referred into the team internally by midwifery, obstetric, neonatal and gynaecology staff. Referrals are also received from outside agencies such as social care, who are already working with women who become pregnant. Occasionally women who have accessed the service before self-refer. Care is provided in the family home, hospital, GP clinics and opportunistically in other agency settings such as drug treatment services or via charitable projects.

The team support all staff in managing complex cases and providing up-to-date information via training events, 1:1 support and provide professional advice on an ad hoc basis. 1:1 supervision sessions are also provided as required for staff who are dealing with complex cases.

The team continually strives to change and improve the service. In response to increasing demand for the service in 2016/17 a process for triaging referrals by the Community Team Leader is planned for 2017/18. It is anticipated that this will provide all Community Midwives with senior 1:1 support, facilitating learning, reflection and appropriate decision making regarding on-going referrals. It will also ensure that the Vulnerabilities Team will be able to target their resources on the most complex cases.

Key achievements 2016 – 2017

- Service evaluation of care provided to women who disclosed domestic abuse.
- High level of attendance at Child Protection Conference, achieving 100% in quarter four of 2016/17.
- Child J Serious Case Review Independent Management Review completed, with resulting action plan on target.
- Introduction of Mini Appraisal for midwives who rotate through all areas of maternity services includes a competency assessment for Safeguarding Adults and Children.

Jessop Wing Specialist Vulnerability Midwifery Team Activity

Charts 3 and 4 below demonstrate the number of completed pregnancies in which the Jessop Wing Specialist Vulnerability Midwifery Team has been involved and the reasons for the referrals. The team was actively involved in complex cases where there were significant vulnerabilities requiring a high level of multi-agency involvement. In 'active' cases the team undertook a coordinating role, liaising with health and social care professionals as required to achieve the best outcomes for pregnant women and their families. Where this threshold was not met the team provided advice to the named community midwife who continued to be the lead professional in the woman's care, recorded as 'advice' cases. 'Not activated' cases identify those where a referral was made to the team, however following assessment

there was no identified need for the Jessop Wing Specialist Vulnerability Midwifery Team's involvement.

Chart 3 - Vulnerability Specialist Midwifery Team; Completed Pregnancies 2016/17

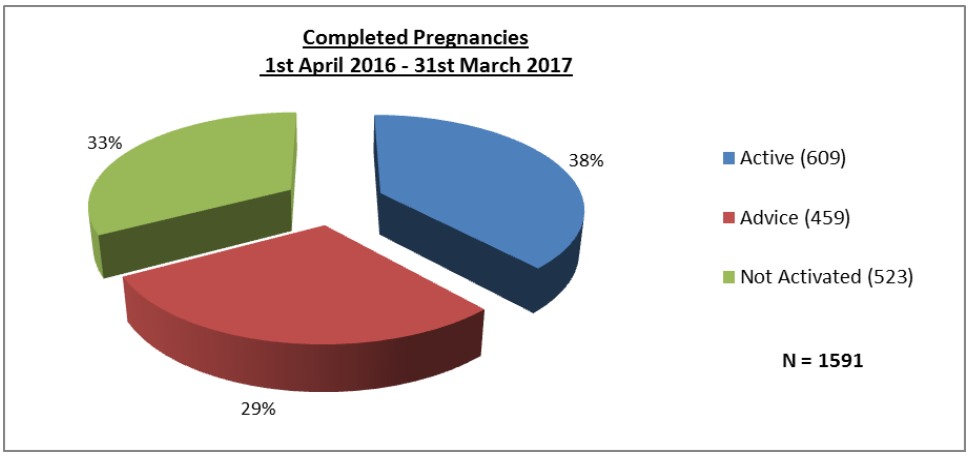
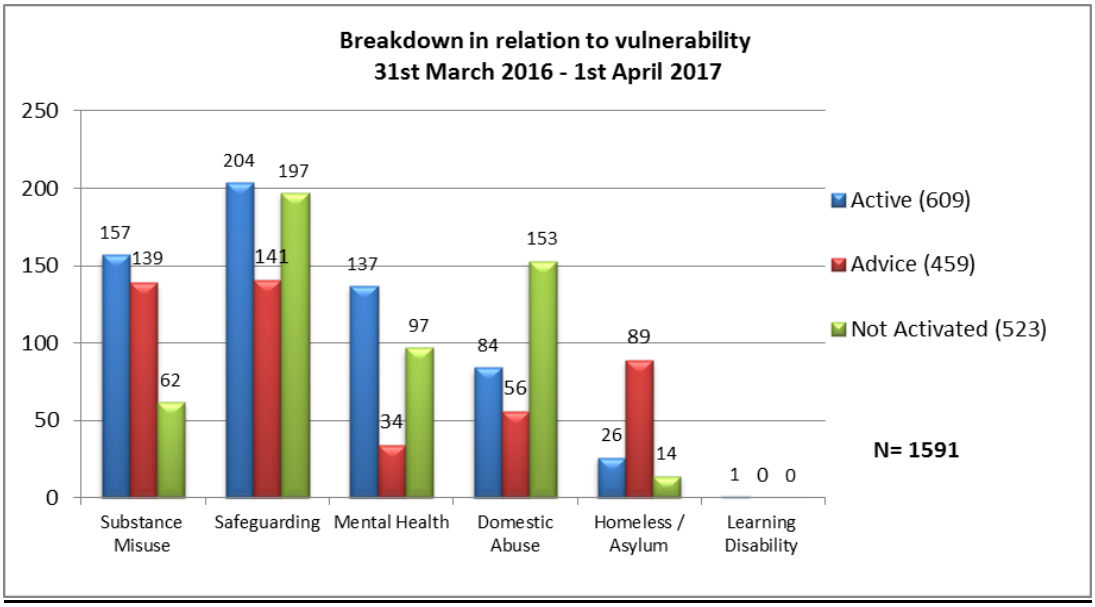


Chart 4 - Vulnerability Specialist Midwifery Team; Breakdown of completed Pregnancies 2016/17



4.3 Paediatric Liaison Nurse (PLN) Referrals

The PLN service is provided by the Sheffield Children's Hospital NHSFT with staff based within the Emergency Department, Charles Clifford Dental Hospital and the Jessop Wing. The Safeguarding Children Team has continued to have a close working relationship with the PLN nurses, and this is reflected by the PLN team's integration and involvement in many of STHFT safeguarding children pathways and processes. The PLN service manager is also a member of STHFT's Safeguarding Leads Meeting. This ensures clear communication and facilitates an understanding of individual roles, responsibilities and accountability in the safeguarding process.

The largest number of referrals from STHFT staff to the PLN services are generated from the Emergency Department (ED). In 2016/17 a total of 1630 referrals were made to the PLN, with the majority of referrals relating to safeguarding or additional vulnerabilities within the family. This is an increase of 16% on last year's figures. A further 31 referrals were made to the PLN by staff following the ED Community Youth Team Pathway. This pathway specifically focuses on providing support for young people in relation to substance misuse, anti-social behaviour or gang-related activity. In 2016/17 the PLN nurses from the ED also provided input into the development of the Lorenzo Safeguarding Form and have been instrumental in supporting its use in practice.

Following the appointment of a new Paediatric Liaison Nurse at Charles Clifford Dental Hospital (CCDH), work has been progressing at engaging and supporting CCDH staff to make appropriate referrals. This has seen a steady increase in referrals to the service in the past year with a total of 362 referrals being made. The PLN has also made significant progress in 2016/17 in facilitating information sharing with other community health and social care professionals working with children. This has been instrumental in improving children's access to dental services at CCDH and ensuring that vulnerable children receive appropriate dental care.

Following the appointment of a new Paediatric Liaison Nurse within the Jessop Wing in 2016, work has primarily focused on supporting staff to identify and share more information about the most vulnerable neonates who are inpatients in the Neonatal Unit. There has also been work to improve the PLN's working relationship with the Jessop Wing Specialist Vulnerability Midwifery Team, further enhancing communication and information when working with vulnerable families.

4.4 Sheffield Safeguarding Children Board (SSCB)

The Chief Nurse represents STHFT on the Executive Board of SSCB. There are identified leads for each of the SSCB subgroups and a system of deputies has ensured that STHFT is well represented at all meetings. Following discussion and feedback in 2016/17, two SSCB sub-groups (the Learning, Policy, Practice & Improvement Group and the Training and Improvement Group) have been merged. This has slightly reduced the number of meetings the Safeguarding Children Team are required to attend. However under the new system, where new work streams are identified, a task-and-finish group will be appointed. This will require continued support and engagement from STHFT staff, to meet our responsibilities as a key partner on the SSCB.

Key Achievements in 2016-17

- The Named Professional has continued to be involved in working with the SSCB on the Sheffield city-wide Neglect Strategy. The Neglect Strategy continues to be a key objective in the current SSCB business plan, and its implementation aims to improve professionals' skills in identifying and working with families where neglect is an issue. The strategy was launched in 2016. STHFT have updated the safeguarding children intranet site with supportive literature and the strategy has been discussed in all level 2 and 3 safeguarding children training. Additional training focusing on neglect is planned for 2017/18.

- STHFT have continued to work collaboratively with Sheffield Safeguarding Children Board (SSCB) in developing processes and procedures for the identification and management of Female Genital Mutilation (FGM). One of the Named Professionals has been a key member of the city-wide FGM task-and-finish group. Work from the group has included the development of a city-wide FGM strategy, referral pathway and training to raise awareness of FGM amongst agencies and communities affected by FGM. A new STHFT policy on FGM has been developed and ratified for use within the Trust. The policy clearly sets out the role and responsibilities for staff in meeting national data collection standards and the mandatory reporting of FGM for all cases involving children under 18 years of age. Work is on-going within midwifery services to enhance their skills in obtaining accurate histories from women

who are victims of FGM or who could be at risk of FGM. This includes some additional enhanced questions regarding FGM that will be discussed at the ante-natal booking appointment. These new processes will be introduced in maternity services in summer 2017.

The Named Professional has attended a two day conference to discuss the 'Expert Consultation on Implementation of World Health Organization (WHO) guidelines on FGM in Europe' (March 2017). The objectives for the consultation were to present the recently launched WHO guidelines on the management of health complications from FGM to member states of the European region and to discuss plans for developing and implementing training materials for health care providers. Training staff on recognition and care for women who are victims of FGM or who are at risk of FGM is now embedded within all levels of mandatory safeguarding training (Level 1-3). STHFT will continue to respond to national and local guidance regarding FGM and it will continue to be included in all training sessions.

- In 2016/7 the Safeguarding Children Team implemented a process to improve information sharing with the Child Death Overview Panel (CDOP). Although information sharing processes have been in place with the Jessop Wing for a number of years, information about child contacts with the wider Trust was not routinely shared. From April 2016 the Safeguarding Children Team are now routinely reviewing all CDOP notifications and reviewing any contact the child may have had with the Trust. A total of 46 CDOP notifications were reviewed, resulting in five reports from the Trust being sent to support the CDOP investigations.

4.5 Serious Case Reviews (SCR), Case Reviews and Domestic Homicide Reviews (DHR)

Serious Case Reviews remain a statutory requirement when a child dies or suffers serious harm as a result of abuse or neglect. Working Together to Safeguard Children (HM Government, 2015) recommends that each Local Safeguarding Children Board (LSCB) has in place a local learning and improvement framework. However, the Wood Report (2016) highlighted how Serious Case Reviews in their current format do not facilitate the most effective learning and produce a defensive culture. The government response to the Wood Report indicates that the current

system of SCRs and miscellaneous local reviews will be replaced with a system of national and local reviews, within a national learning framework. This will include legislation to establish an independent National Panel which will be responsible for commissioning and publishing national reviews. Additionally, LSCBs will be required to conduct and publish the lessons from local reviews, which relate to a child or children in the local area, where there is significant learning for service providers (Department for Education, 2016). As a key partner of SSCB, STHFT continue to cooperate fully with all requests to participate in Serious Case Reviews and Learning Lessons Reviews as required.

4.5.1 Serious Case Reviews

Child J SCR (joint Serious Case Review with Rotherham Safeguarding Children Board).

This case concerned the non-accidental injuries to a 3-year-old whilst in the care of her mother and her mother's partner. The mother of Child J was pregnant at the time of injuries and had contact with Jessop Wing maternity services. The Independent Management Review (IMR) was completed by the Deputy Named Midwife and was submitted within the required timescale. The review identified that:

- The support provided for women with complex needs is of paramount importance. Where additional needs and potential vulnerabilities have been identified, on-going referrals should be completed in a timely manner to ensure appropriate services are provided.

- The importance of gathering a background history and considering this information when completing initial and on-going risk assessments.

- Where women have complex needs, particular attention is made to the assessment and support of the father/significant male in the household to enable targeted services to be offered.

- Midwives and doctors involved in this case on occasions failed to share potentially vital information.

- There was evidence of some positive changes to practice in recent years that improve services for vulnerable women.

- In order to maintain and develop future services, midwifery managers must ensure that midwives are supported by clear guidance and policies to assist them in their decision-making.

The IMR produced eleven recommendations for service improvements within STHFT. The action plan is being implemented with 9 of the 11 recommendations having been completed and the remaining recommendations within timescale. The action plan is monitored both internally at the quarterly Safeguarding Leads meeting and externally by the SSCB and Sheffield Clinical Commissioning Group. The final report has not yet been published by Rotherham Safeguarding Children Board, although it is expected imminently.

4.5.2 Case Reviews / Learning Lessons Review

Although there were no new case reviews in 2016/17, the Safeguarding Children Team has continued to work on the actions arising from the Family B Learning Lessons Review which was detailed in the 2016/17 annual report.

4.6 Key Performance Indicators and Audits

STHFT continues to provide assurance to both NHS Sheffield Clinical Commissioning Group and SSCB by engaging in both single and multi-agency audits and the submission of quarterly key performance indicators. Additionally, in 2016/17 the Named Professionals have worked with the SSCB to develop reports to support the development of the Board's Data Dashboard, specifically focusing on the themes of dental neglect and sexual exploitation.

4.6.1 Key Performance Indicators

The safeguarding children key performance indicators are collated on a quarterly basis for NHS Sheffield Clinical Commissioning Group. All submissions have been completed within the required time scales. Any issues identified with the submissions are discussed at the quarterly Safeguarding Leads meeting.

In quarter 3 of 2016/17 the Named Professionals commenced sharing data with Sheffield Safeguarding Children Board regarding the number of referrals made from Sexual Health Sheffield where children have been identified as at risk of sexual exploitation, and from CCDH, where children have missed planned dental appointments. It is anticipated that monitoring these data will identify trends and support the future planning of developments to safeguarding services in these areas.

4.6.2 Action Plans

Throughout 2016/17 the Safeguarding Children Team has continued to work on a number of action plans in place. Action plans completed or on-going in 2016/17 include:

- Care Quality Commission (CQC, Dec 2016) Sheffield Teaching Hospitals NHS Foundation Trust Quality Report. Published 09/06/16

- The Independent Inquiry into Child Sexual Abuse (Jarrett, 2015)

As part of the independent inquiry into child sexual abuse, in May 2016 all public authorities were asked to take a pro-active stance in retaining documents that may be relevant to the inquiry. Within STHFT this process was led by the Assistant Chief Executive. A paper was presented to the Trust Executive Group (13/07/16) and Healthcare Governance Committee (25/07/16) outlining the details of the inquiry and implications for STHFT. The paper also included lessons learned from the Bradbury Investigation at Cambridge University Hospitals NHS Foundation Trust (VERITA, 2015) and the actions required for STHFT to meet the resultant recommendations for all staff working with children.

4.6.3 External Audits.

- Section 11 Audit

STHFT completed a Section 11 Audit for the Sheffield Safeguarding Children Board in 2016. All components of the Section 11 audit were completed and sent in within the required deadline. The Trust will be attending a Section 11 challenge event led by

the SSCB in October 2017 to provide assurances in relation to the Trust's safeguarding arrangements.

4.6.4 Internal Audits

- Evaluation of Emergency Department Referrals to the Paediatric Liaison Service.

This service evaluation was completed in 2016 and reviewed the Emergency Department's (ED) referrals to the PLN Service. The report for this audit is currently being completed. The initial findings of the audit demonstrate:

- 13% (13/100) of cases reviewed had all 3 safeguarding questions completed on attendance. This demonstrates that staff within the ED are not routinely asking and documenting patients' caring responsibilities, which may result in missed opportunities to identify children at risk.
- 50% (2/4) of cases were correctly referred to the PLN Services.
- Incomplete or poor assessment in 7% (7/100) of cases made it difficult to assess if a PLN referral was required.

The results of this audit demonstrate that a previously agreed action of making the questions mandatory was not implemented correctly. Steps have been taken to ensure that this is rectified as soon as possible. The development of supervision/reflective practice within the department via quarterly 'Safeguarding Breakfast Clubs' should improve upon this current performance.

In addition to the audit conducted by the Safeguarding Children Team other directorates have been encouraged to complete audits within their areas to provide assurance of appropriate safeguarding children activity. Support is offered as required by the Named Professionals for Safeguarding Children.

- Audit to access compliance with Safeguarding Supervision within Midwifery Services (Obstetrics, Gynaecology and Neonatology).

This audit was completed in January 2017 by a senior midwife within the Jessop Wing to support her role in providing supervision to midwifery and neonatal family care staff. Findings from this audit will be used to reinforce the importance of supervision in improving safeguarding outcomes and enhancing the skills and confidence of the community midwives to share information in complex cases.

The audit findings concluded that:

- 90.5% of community midwives and neonatal family care nurses had attended a 1:1 safeguarding supervisory review in the preceding 12 months (target 100%).
- 83.3% of the teams involved were able to provide five group supervision sessions per year (target five sessions per year)
- 33% of community midwives attended the required three group supervision sessions per year (target 100%).

As a result of the audit an action plan is in place to improve the compliance in attendance at supervision, including work to identify the barriers to staff attending the required supervision. Significant improvements have been made since the audit was completed with the Trust meeting its KPI in relation to midwifery staff receiving safeguarding supervision.

- Community Paediatric Dentistry 'Was Not Brought Pathway'

Nationally there has been growing support to re-conceptualise 'Did Not Attend' (DNAs) to 'Was Not Brought' to encourage health professionals to take a proactive and child-centred approach to missed appointments. The aim of this is to re-frame the thinking of professionals to consider why a child was not brought to their appointment by their parents/carers, rather than why the child did not attend themselves. The Named Professional for Safeguarding Children has been supporting the work of a Leadership Fellow in Charles Clifford Dental Hospital, Community Dentistry to develop a 'Was Not Brought' pathway. The pathway was introduced in 2016 and further developed in 2017. Initial feedback to the pathway has been positive with an audit now underway. Additionally, there has been considerable interest in the tool at a regional and national level, with presentations and publication planned. Consideration of the new pathway and audit findings will be taken into

account when updating the Trust wide policy in relation to children who are not brought to appointments, which is planned in early 2018.

4.7 Development of Safeguarding Children Service within STHFT.

Work in 2016/17 included:

- The development of the Safeguarding Children Lorenzo Form, ensuring that safeguarding information can be seen within the electronic patient record.
- Increasing the availability of safeguarding children supervision and reflective practice for the Specialist Diabetes Nurses working with children and young people and Community Paediatric Dental Services. From early 2017 and continuing for the coming year further reflective practice sessions are planned for the Paediatric Dentistry and Orthodontics departments within Charles Clifford Dental Services.
- Aligning STHFT guidance and policies to support the implementation of Sheffield Safeguarding Hub. Launched in February 2017, and operational from April 2017, the Sheffield Safeguarding Hub provides a single point of access for all safeguarding children referrals within Sheffield. These changes required the Safeguarding Children Team to update current safeguarding pathways, procedures and training. Work will continue in 2017 to ensure that these and other on-going changes to service provisions made by the Local Authority are reflected in STHFT policies.

4.8 Staff Awareness and Training

4.8.1 Mandatory Training Compliance

The team continues to update training as required, however the growing number of emerging safeguarding themes has required the team to be innovative and resourceful in its delivery of training. In the last year, a modular approach to level 2 training has been trialled in two directorates with positive feedback. The team continue to work with the Learning and Development department and the Directorate Mandatory Training Leads to improve mandatory training compliance.

4.8.2 SSCB Training Requirements

The Safeguarding Children Team continues to support the training priorities of SSCB, implementing and updating training where required. Attendance at the SSCB sub-groups ensures that the team is well placed to respond to emerging issues and can influence training priorities and plans. In 2016/17 the Named Professionals have supported the SSCB training plans on the themes of neglect and Female Genital Mutilation. In 2017/18 the Safeguarding Children Team plan to implement a rolling programme of training, based upon the SSCB training priorities.

5.0 Safeguarding Children Team Objectives 2017/18

Key Objectives for 2017/18

The Safeguarding Children Team has decided to focus on two specific objectives for the coming year, in addition to statutory and mandatory activity. This will enable progress to be made within the service, whilst ensuring that the team can continue to deliver an effective day-to-day safeguarding service, in a climate of rising demand for safeguarding services.

Objectives for 2017/18

Objective 1 - Support the completion of a Trust-wide action plan to develop services in the identification and management of Victims of Trafficking and Modern Slavery.

Objective 2 - Develop and improve support and safeguarding pathways for children and young people presenting with mental health concerns.

6.0 Conclusion

STHFT provides a high quality and effective safeguarding children service which supports children, young people and families within Sheffield. This report demonstrates the breadth of safeguarding activity across the Trust and the assurance processes that are in place, ensuring a safe and effective service is provided.

Despite increased safeguarding activity within the Trust and personnel changes in 2016/17, the team has been able to evidence the work undertaken to ensure that STHFT continues to meet national and local standards for safeguarding children.

7.0 References

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