SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

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EXECUTIVE SUMMARY

REPORT TO THE HEALTHCARE GOVERNANCE COMMITTEE (HGC) – 20 OCTOBER 2014

Subject	Annual Safeguarding Children Report
Supporting TEG Member	Professor Hilary Chapman, Chief Nurse
Author	Sara Thomas, Named Professional for Safeguarding Children and Young People
Status[1]	**N**

PURPOSE OF THE REPORT

- To inform the Trust Executive Group and Board of Directors of the current arrangements for safeguarding children at Sheffield Teaching Hospitals NHS Foundation Trust (STHFT).
- To ensure STHFT meets NHS Sheffield Clinical Commissioning Group (SCCG) assurance standards for safeguarding children.
- To demonstrate key achievements in safeguarding children over the last 12 months (2013/14).
- To identify the key priorities for 2014 -15 to improve the processes, policies and audits, training and assurance for safeguarding children.

KEY POINTS

- Achievement of key objectives.
- Responsibilities to the Sheffield Safeguarding Children Board (SSCB) and associated sub-groups.
- External reviews and audits.
- Policies and procedures.
- Education and training.

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 are asked to note the contents of this report.

APPROVAL PROCESS

Meeting	Date	Approved Y/N
Trust Executive Group	1 October 2014	Y
Healthcare Governance Committee	20 October 2014	

[1] Status: A = Approval
A* = Approval & Requiring Board Approval
D = Debate
N = Note

[2] Against the five aims of the STHFT Corporate Strategy 2012-2013

Sheffield Teaching Hospitals NHS Foundation Trust Safeguarding Children Report

April 2013 – March 2014

1.0 Introduction

'All health providers are required to have effective arrangements in place to safeguard vulnerable children and adults and to assure themselves, regulators and their commissioners that these are working' (NHS Commissioning Board, 2013, p17). The purpose of this report is to provide assurance and evidence to Sheffield Teaching Hospitals NHS Foundation Trust (STHFT) Board of Directors, that the Trust is meeting its statutory requirements for safeguarding children.

This report provides a review of the work undertaken to demonstrate the activities of the Safeguarding Children Team in ensuring that the Trust remains compliant with Section 11 of the Children's Act 2004 (Department for Education & Skills (DES), 2004) and the Care Quality Commission Standard 7 (CQC, 2010). Furthermore, this report will evidence the work that STHFT is doing in partnership with the Sheffield Safeguarding Children Board (SSCB) to support and promote the welfare of the children and young people who use our services. A review of the previous year's objectives will be undertaken and consideration will be given to the team's priorities for the coming year.

2.0 Safeguarding Children Team

The Chief Nurse is the Executive Board member responsible for safeguarding children, ensuring there is a clear line of accountability to the Board of Directors. The Trust meets its requirements in ensuring that there are named professionals responsible for safeguarding children, including a Named Doctor, Named Nurse and Named Midwife for Safeguarding Children. Each care group has a nominated safeguarding lead to ensure that there are clear processes in place to disseminate information and training effectively across the Trust.

The Safeguarding Children Team continues to work closely with colleagues in the Safeguarding Adults team. This relationship continues to provide effective sharing of resources and service development in related activities.

3.0 Safeguarding Children Objectives

Key Objective for 2013-14	Achievements
1. Ensure STHFT is compliant with Working Together to Safeguard Children, 2013 (Department for Education (DfE), which will necessitate a review of current policy, procedures and training needs analysis.	STHFT policies updated in line with controlled document guidance. STHFT Safeguarding Children policy is due for a significant re-write in June 2014 to reflect both national and local policy and changes made by the local authority in how services are accessed. The Royal College of Paediatrics and Child Health (RCPCH, 2014) have just published their updated guidance on suggested roles and competencies for healthcare staff in relation to safeguarding children. Although not statutory guidance, national policy (DfE, 2013) now cite the RCPCH document as the agreed standards for all healthcare settings, and their guidance is used by regulators as a guide to ensuring health care staff are trained appropriately. Previously, STHFT have not complied fully with this guidance, but applied a measured approach to implementing the guidance, depending on the level of contact staff have

Key Objective for 2013-14	Achievements
	with children. Following publication of the updated guidance, it will be necessary to review the current training needs analysis and determine if additional staff require safeguarding children training. A re-write of STHFT safeguarding children supervision policy is planned following completion of the Safeguarding Team's audit of the Trust's supervision arrangements.
Ensure STHFT continues to be compliant with safeguarding children training targets. Safeguarding children training targets are set and monitored by Sheffield Clinical Commissioning Group using a RAG (Red Amber Green) rating scale. Current targets are – Red - < 80% Amber - 80 – 95% Green - 95 – 100%	Percentage compliance for training has decreased in both level 2 and 3 training Level 2 – 80% Level 3 - 88% Despite increases in the provision of training, and additional support for some care groups, training compliance has fallen in the last year. As a result, the team will be working with a number of directorates and their safeguarding leads to draw up monitored action plans to ensure that staff achieve and maintain compliance. This issue was highlighted to Care Groups at the Directorate reviews held with the Trust Executive Group at the end of the year.
3. Develop a robust system for the recording and monitoring of safeguarding children training for rotating medical personnel.	Little progress has been achieved with this action. Despite some improvements by a number of directorates in training senior medical staff, uptake and compliance of safeguarding training by medical personnel remains patchy. Once fully implemented, the Personal Achievement Learning Management System (PALMS) will provide a robust method for recording and monitoring training of all staff, including medical staff, and therefore significant improvements are expected in this area in the coming year.
4. Review the current system of Trust wide reporting of child protection concerns to accurately report safeguarding activity.	Work is still ongoing at improving reporting issues, and although there has been an increase in reporting through Datix, this still does not provide a full picture of safeguarding activity within the Trust, mainly because of compliance in the internal reporting of safeguarding children incidents. Whilst the team have made some enquiries about other systems, they have not currently identified a viable alternative system, however some planned improvements and simplification of the data collection process within the Datix System should encourage reporting and assist the safeguarding team in ensuring accurate data is available.
5. Introduce SSCB Threshold Needs Guidance Training within the Trust to ensure staff are able to promote the 'early intervention and prevention' philosophy of safeguarding.	A number of 'Thresholds of Needs' sessions were delivered to staff in key areas of the Trust supported by colleagues from SSCB which were well attended. Further sessions were delivered but due to limited bookings for future sessions, these were discontinued. The team are currently reviewing how best to educate and train staff in early intervention.

6. Complete a service evaluation of safeguarding supervision within the Trust to determine the current policy's effectiveness.	Due to delays in accessing electronic data collection tools beyond the team's control, the audit was delayed from November 2013 to March 2014. Data collection is now complete. Upon completion and dissemination of the findings, a review of safeguarding supervision practices within the Trust will be undertaken.

4.0 Key Achievements 2013 – 2014

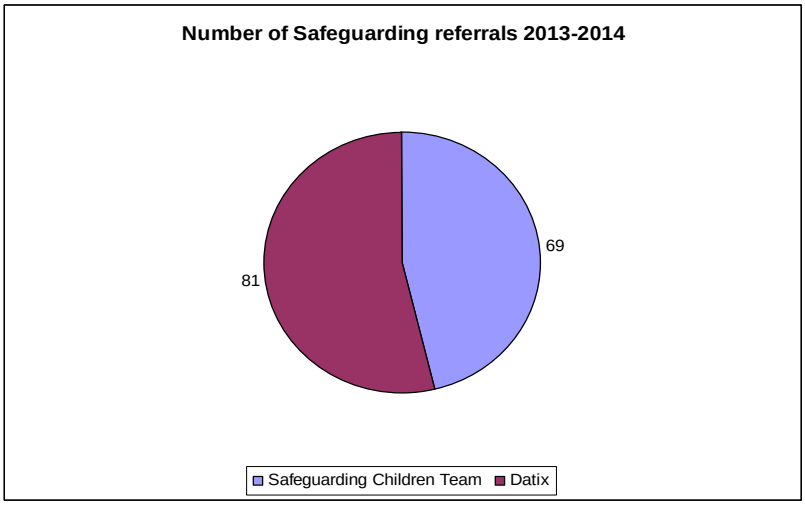
Safeguarding children continues to feature highly on the national agenda. As the largest healthcare provider in Sheffield, STHFT plays a key role in ensuring that its policies, procedures and practices safeguard and promote the welfare of children.

Safeguarding is considered an integral part of the role of a NHS Foundation Trust, and as such, the Trust is required to submit a number of declarations and performance against Key Performance Indicators to both NHS Sheffield Clinical Commissioning Group (SCCG) and the SSCB. Much of the work undertaken by the team ensures that the Trust continues to meet the standards required of it. Section 4 will provide an annual review of activity and achievements related to specific themes, including key achievements and challenges.

4.1 Safeguarding Children Activity

Collating robust safeguarding activity figures for the Trust continues to present a challenge to the team due to the complexities of the Trust's information technology infrastructure. The safeguarding team and the Jessop Wing Vulnerabilities Team have databases to record cases where they have been directly involved. In other areas, staff are expected to complete a Datix incident form, however it has previously been established that this practice is not always adhered to and therefore the system is unable to provide useful data in terms of activity. In order to address this the team explored utilising software from an independent provider, however this was felt to offer little improvement on the current processes and would not resolve current issues. A process mapping exercise was completed with colleagues from Information Technology, which highlighted the difficulties currently experienced by the team and led to a discussion about possible solutions. Some of the issues identified will be resolved when the single electronic patient record is developed and implemented however this solution may not be available for 2-3 years. The team are currently reviewing other possible solutions with the Healthcare Governance Team.

Table 4.1.1 Activity Figures for Safeguarding Children



There was a slight decrease in the number of referrals the safeguarding team recorded in the last year, down 16% from 82 to 69. However, overall there was a considerable increase in reporting of safeguarding activity when Datix figures were included. The team consider that there remains a significant potential for the under reporting of safeguarding activity from across the Trust due to staff compliance with the reporting process, as detailed in the safeguarding children referral pathway. Encouragingly, compliance this year with Datix reporting has improved, the figures generated are mostly from the Emergency Care Group, suggesting that there is the potential for greater reporting in other areas. Following discussions with the Patient Safety Manager, some planned improvements and simplification of the data collection process within the Datix System should encourage reporting and assist the safeguarding team in ensuring accurate data is available.

Table 4.1.2 Activity Figures by Outcome

Number of Cases referred to the Safeguarding Children team 2013/14 = 69
Number of Outcomes from 69 cases 2013/14 = 123

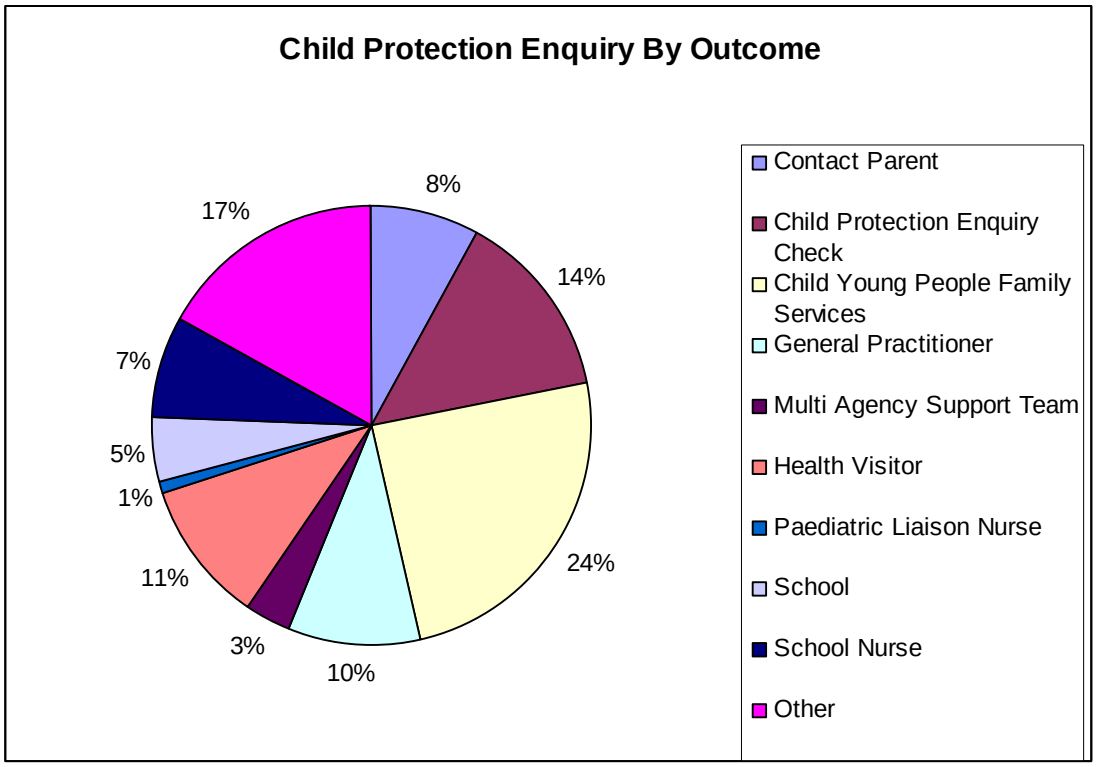


Table 4.1.2 demonstrates how each case referred to the Safeguarding Children Team may have multiple outcomes. It is pleasing to note that the current safeguarding processes ensures that staff fulfil their responsibilities for information sharing with a range of professionals which enables holistic care to be provided to the children and young people who use our services.

Unfortunately, due to the quality of the data that has been entered into Datix, we are unable to gather outcome information from cases reported within that system. With the introduction of the new electronic Datix system in 2014 that allows tailored questions to be asked and recorded, it is envisaged that with some modifications, the system could be used as a single database for recording and monitoring of safeguarding cases. The safeguarding team will continue to work with the Patient Safety Manager to progress this work.

4.1.3 Paediatric Liaison Nurse (PLN) Referrals

STHFT continues to have an effective working relationship with the Paediatric Liaison Nursing Service (provided by Sheffield Children's Hospital NHSFT). The Paediatric Liaison Nurse based in Accident and Emergency is a key member of the A&E safeguarding team and with effective joint working this department has seen a number of service improvements specific to safeguarding in the past year (see 4.6). There are robust processes in place for referring to the PLN, and with continued education and training of the staff there has seen a steady rise in the number of referrals made to the service year upon year.

Paediatric Liaison Nursing was introduced in Charles Clifford Dental Hospital (CCDH) in 2012 and has continued to develop over time. Since its introduction, there has been a significant increase in information sharing between CCDH and community care providers, particularly Health Visitors and School Nurses. It is pleasing to note that community care providers are also contacting the PLN for information sharing about children who are attending the department. This relationship has seen significant improvements in the service, with a greater ability to engage children who have repeatedly missed outpatient appointments.

4.2 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. STHFT's continued engagement with SSCB has meant that we have had an active role in developing and achieving the goals set out within the SSCB business plan.

Key Achievements in 2013-14

- Completion of the SSCB Section 11 Audit and subsequent evidence challenge day.
- Named Doctor and Named Nurse represent STHFT in the multi-agency case review meeting introduced in 2013. This meeting monitors and evaluates local practice in delivering services to children and their families. This is achieved by all agencies completing an audit of a case nominated by SSCB that focuses on the child's journey, highlighting areas of good practice, and areas that require development or improvement.
- The Lead Nurse for Children has continued to work with the SSCB improving the transition arrangements for children moving from children to adult services. This led to the launch of the new SSCB transition guidelines in the last year.

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

Learning and improvement from safeguarding has been a key theme during the last year with changes to national policy highlighted in Working Together to Safeguard Children (DfE, 2013). During 2013, a national independent panel of experts was introduced to support Local Safeguarding Boards in considering the instigation of a Serious Case Review and to assist with the appointment of reviewers. There is also a requirement that all Serious Case Review reports are published in full to support national sharing of lessons learnt.

Working Together (DfE, 2013) states that all Local Safeguarding Boards should have a learning and improvement framework in place. As a member of SSCB, STHFT have a key role in assisting the Board to implement its framework by participating in reviews, audits, and learning lesson activities. In 2013/14 STHFT have supported SSCB by completing two information reports and a Domestic Homicide Review (DHR). Additionally, the Lead Nurse for Children has been a member of the SCR panel for the Child H SCR, although on this occasion STHFT were not actively involved in the review.

- **Serious Case Review – Child H**

SSCB commissioned the review of the care of Child H, after her death in 2012. The subsequent police prosecution resulted in the mother's partner being convicted of murder. In completing an information report for SSCB it was established that STHFT staff involved had provided a good standard of care, adhering to practice at the time of the child's birth. It was also noted that significant changes have already taken place within the Trust prior to this case that have improved the data collection and information sharing in relation to fathers and other men in a child's household. There was also a significant improvement noted with routine enquiry into domestic abuse. It is pleasing to report that because of the good practice identified in the STHFT information report, STHFT were not required to participate in this SCR. Although not involved in the review directly, having representation at the SCR panel meetings has ensured that STHFT are aware of the issues raised in the case and can ensure that any relevant learning can be disseminated to staff.

- **Domestic Homicide Review – Adult E**

Sheffield Safer and Sustainable Communities Partnership commissioned a review following the fatal stabbing of Adult E in June 2013. From multi-agency information, it was apparent that there were issues of possible sexual exploitation and forced marriage in this case. The Named Doctor for Safeguarding Children completed a review of STHFT involvement as both the victim and alleged perpetrator had contact with Emergency Care, and Integrated Sexual Health Services. The care provided to both the victim and perpetrator was deemed to be of a good standard. Staff were alert to the risks of sexual exploitation of the victim and she was appropriately referred to Sheffield's Sexual Exploitation Service. Four recommendations were made to improve procedures in the Trust related to this case.

4.4 External and Internal Audits

The Safeguarding Team continue to work with the Trust's Clinical Audit Effectiveness Unit (CAEU) to support a robust programme of audits to provide assurance that the systems and processes used within the Trust are effectively safeguarding children.

A key feature in the last year has been the increase in the number of safeguarding related audits that the Trust has been required to participate in. A request has been made to both SSCB and SCCG to coordinate audits to ensure that the Trust can continue to support their work and reduce the impact of repeated audits on staff. The process was also reviewed with the Trust Safeguarding Leads to ensure that all audits conducted by non-STHFT employees are registered with CAEU. During 2013-14 it was identified that two audits had been planned which had not been through the correct registration process.

- Implementation of recommendations from serious case reviews for Community Midwives (Health Visitors and School Nurses) – Audit led by Sheffield Clinical Commissioning Group.
- Case note review, Primary Care Addiction Service. – Audit led by Safeguarding Children Substance Misuse Service.

Whilst completion of these audits is necessary to identify that appropriate systems and process are in place in relation to safeguarding across the Trust; it is equally essential that approval be sought to ensure that the appropriate safeguards are in place respecting patients' rights and confidentiality. Following intervention from the safeguarding children team, both audits have now progressed after registering with the CAEU.

Key achievements on 2013-14

- STHFT successfully completed SSCB Section 11 audit. The audit required the submission of data and policies to SSCB auditors for examination. The Lead Nurse for Children attended a challenge day in which attendees were asked to discuss aspects of the audit and assist in identification of areas that SSCB should focus on to help organisations overcome some common difficulties. STHFT was fully compliant with Section 11 Audit and awarded a 'Green Rating'.
- Service evaluation of the effectiveness of STHFT level 2 safeguarding children training has been completed. The results demonstrated that staff who attended the training found it to be valuable and it had resulted in positive changes to their clinical practice in safeguarding children.
- The Trust procedure for the recording of electronic alerts for children who are subject to a child protection plan was re-audited. The results showed a 99% compliance with the recording of alerts. The 1% missing data was attributed to a clerical error which happened following the last audit, and therefore was unlikely to happen again. The results demonstrate that STHFT have robust procedures in place for the recording of children on a child protection plan in Sheffield.
- A service evaluation is in progress to review the effectiveness of the Trust's safeguarding children supervision policy. Focusing on areas in the Trust that see high numbers of children, the aim of the evaluation is to identify if staff are supported by effective supervision and feel supported in their work with children and families.
- The Hepatitis C team completed an audit to review the effectiveness of the changes implemented following the team involvement in the Child T Significant Incident Learning Process (2012/13). The audit clearly demonstrates that changes made in the collection of additional data from patients using their service has resulted in improved information sharing with other professionals which has enabled effective multiagency working to safeguard children. Case studies reviewed show how the changes implemented have already had a significant impact on the patients and families the team provide a service for.
- The Named Nurse for Safeguarding Children has assisted the Designated Nurse for Safeguarding Children (SCCG) with an audit reviewing the 'Implementation of Recommendations from Serious Case Reviews for Community Midwives' which was completed in January 2014. Although the response rate was low, those staff that completed the survey identified that STHFT supports their practice in working with safeguarding children cases. Additionally, the survey highlighted that the methods in place for the implementation of Serious Case Review recommendations are well established and that there are good processes in place for information sharing between health care professionals when dealing with safeguarding concerns. The audit identified four recommendations for STHFT related to training and dissemination of Domestic Homicide Review recommendations. The Lead Nurse for Children has developed an action plan to assist in the implementation of the recommendations.

4.5 Domestic Abuse

Domestic abuse continues to be key theme in safeguarding related activity across the Trust. A number of Domestic Homicide Reviews (DHR) have been completed in Sheffield since their introduction in 2012, which have resulted in significant improvements in the identification of domestic abuse cases where children are deemed to be at risk.

Key achievements on 2013-14

- The Named Doctor completed a DHR into the case of Adult E (see section 4.3)
- STHFT are represented at all Multi Agency Risk Assessment Conferences (MARAC) for high-risk victims of domestic abuse. Due to the increase in the number of meetings held per month, there is now a weekly commitment to send a representative from STHFT. Moreover, the increase in the number of cases

discussed per week has meant a substantial increase in the administration required for data collection and preparation time. STHFT MARAC members are currently reviewing the process to ensure that STHFT representation continues to be sustainable.
- Working with colleagues from safeguarding adults, new guidance has been produced for STHFT staff to support colleagues who disclose domestic abuse.

4.6 Policy Review and Developments

As discussed in section 3.1, many of the safeguarding children policies are due for updating in 2014 to reflect national and local policy and recent organisational and procedural changes. Representation at SSCB Learning and Improvement Group (formerly the Practice Review and Policy Group) ensures that STHFT actively participate in the development and review of new policies and remain up to date with national and local guidance.

Throughout the Trust, there have been a number of developments in the past year that demonstrate how the organisation continues to strive to improve services for vulnerable children and families.

Key achievements in 2013-14

- The Substance Misuse Pathway for 16-18 year olds was implemented by staff in Accident & Emergency in conjunction with colleagues from Sheffield Children's Hospital in early 2013. During the past year, work has continued to ensure that this pathway has become embedded into clinical practice within the department. The pathway has received widespread recognition for good practice which including it being presented at the Royal College of Nursing Conference in October 2013. Furthermore, the pathway was submitted to the Youth Justice Board Effective Care Library and was nominated for the Youth Justice Effective Practice Evidence Award.
- STHFT's Integrated Sexual Health Service are one of a small number of Trusts in the country who are working with the British Association for Sexual Health and HIV (BASHH) in trialling a new screening tool to identify victims of sexual exploitation. This work had led to the publication of 'Spotting the Signs', a national toolkit for the early identification of sexual exploitation in young people (BASHH, 2014).
- The Human Resource Department (HR) has been identified as an 'early adopter' for trialling a new system for the monitoring of employees utilising the Disclosure and Barring Service records. Although it is in the early stages, the HR department are already exploring if this development is feasible to implement in the longer term.

4.7 Staff Awareness and Training

Ensuring that staff are able to recognise and respond appropriately to safeguarding children concerns is of paramount importance in ensuring that children are protected from abuse or harm. Accessible via the intranet, STHFT has a training needs analysis that supports the training and development of staff to support their statutory responsibility for safeguarding children.

STHFT are represented at SSCB Learning and Improvement Group which ensures active participation in training developments. Working in partnership with colleagues from SSCB we have again this year, been able to offer additional Safeguarding Board training sessions on site promoting staff engagement in training.

There are effective links with STHFT Learning and Development department to ensure that the information provided in the Trust's Central News Update and other communications are current. As part of the STHFT audit programme, a service evaluation was completed to determine the effectiveness of STHFT level 2 training (CAEU, project number 5500). The results demonstrate that the training offered meets the needs of staff attending and has a positive impact on their practice.

As identified in section 3.0, training compliance continues to be a challenge and despite the efforts of the team to increase training options and availability, compliance has reduced overall this year. The monitoring of training continues to be completed by the Safeguarding Children Team, as at present there is no alternative system for recording and reporting of mandatory training compliance. The Trust will be moving to the Personal Achievement and Learning Management System (PALMS) in 2014, which should lead to significant improvements in this area in the coming year.

Key achievements in 2013-14

- The community midwifery safeguarding supervision strategy was implemented in October 2013 to increase access and staff engagement with safeguarding supervision.
- The Emergency Department have developed a departmental safeguarding strategy to enable safeguarding practices to be embedded into clinical practice.

5.0 Key Objectives for 2014 - 2015

Due to the significant challenges faced by the team this year in implementing the previous year's objectives, the team have decided that further work is required on last year's objectives to ensure that progress can be achieved in these areas. In particular, the team will be focusing on three recommendations from last year:

- Improving safeguarding children training compliance for all staff.
- Improving the engagement of medical staff in completing safeguarding children training, which can be recorded and monitored effectively.
- Reviewing reporting systems for safeguarding children activity.

Additionally the team this year have identified two further objectives linked to national and local developments.

- Initiate a project group to oversee the development and implementation of the Child Protection Information Sharing System (CP-IS). This is a national development programme led by NHS England that will share information about children at risk of abuse or harm with all NHS emergency care providers and maternity services. Following consideration by the Chief Nurse, it has been agreed that STHFT will be in the 2nd phase of the development that is due to commence in May 2014.
- Continue with the work of SSCB in raising awareness of child sexual exploitation. The team will continue to deliver training in accordance with the training plan but additional specific sessions will be offered covering child sexual exploitation.

6.0 Conclusion

2013/14 has been a challenging year for the Safeguarding Children Team. Many of the service developments require collaboration with other areas, including Information Technology and Learning and Development. The team continues to strive to improve safeguarding processes and procedures across the Trust. STHFT continues to fulfil its statutory duty to safeguard people who use our services. Robust arrangements are in place across the Trust to ensure that staff are able to respond to safeguarding concerns appropriately. Despite increased pressures on resources within the Safeguarding Children Team and the wider Trust, gradual service development has seen positive improvements in safeguarding children activity within the last year.

7.0 References

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DfE (Department for Education), 2011. **The Munro Review of Child Protection; Better frontline services for Child Protection.** Accessed at The Munro Review Final Report (Accessed 14.4.14)

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RCPCH (Royal College of Paediatrics and Child Health) (2014) **Safeguarding children and young people; roles and competencies for health care staff. Intercollegiate Document.** Accessed at RCPCH 2014 (Accessed 19/9/14)