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SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

EXECUTIVE SUMMARY

REPORT TO THE HEALTHCARE GOVERNANCE COMMITTEE MEETING

HELD ON 22 JULY 2013

Subject	Annual Safeguarding Children Report
Supporting TEG Member	Professor Hilary Chapman, Chief Nurse / Chief Operating Officer
Author	Ms Sara Thomas, Named Nurse for Safeguarding Children and Young People
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 ensure STHFT meets Sheffield Clinical Commissioning Group (CCG) assurance standards for safeguarding children.
- To demonstrate key achievements in safeguarding children over the last 12 months (2012/13)
- To identify the key priorities for 2013 -14 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 the 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 Healthcare Governance Committee are asked to note the contents of this report.

APPROVAL PROCESS

Meeting	Date	Approved Y/N
Trust Executive Group	03.07.13	
Healthcare Governance Committee	22.07.13	

Sheffield Teaching Hospital NHS Foundation Trust Safeguarding Children Report

April 2012 – March 2013

1.0 Introduction

In line with government policy as detailed in Working Together to Safeguarding Children (Department for Education (DfE) 2013, organisations must ensure there is senior board level leadership of the organisation's safeguarding responsibility.

This annual report reflects the structures, mechanisms and activity related to safeguarding children relevant within STHFT from April 2012 to March 2013. The report also includes a review of previous objectives set as part of the team's annual work programme and will identify the aims and objectives for the coming year, ensuring that STHFT continues to improve its services to safeguard and promote the welfare of children and young people.

2.0 Safeguarding Children Team

STHFT has a clear line of accountability to board level with the Chief Nurse / Chief Operating Officer, as the Executive Lead reporting to the Board of Directors. The statutory requirement of providing named professionals has been achieved and a consistent team has provided the opportunity to further build on the progress made in previous years.

There continues to be a well-organised and productive working relationship with the safeguarding adult's team, which has enabled effective sharing of resources and service development. This has proved beneficial with both teams participating in Domestic Homicide Reviews (DHRs) and in the provision of training.

3.0 Safeguarding Children Objectives 2012 - 2013

Table 3.1 identifies the key objectives for 2012-2013.

Key Objective for 2012-13	Achievements
1. Ensure STHFT achieves 100% attendance at all SSCB meetings and sub groups.	STHFT have attended 100% (25/25) of SSCB meetings and related sub-groups.
2. Contribute to serious case reviews, case reviews and learning lessons reviews as requested by Local Safeguarding Children Boards. As part of this objective, it is necessary to review professionals' roles in completing IMRs and develop additional staff that will be able to carry out this function as required.	All reviews completed in 2012-13 have been submitted to the Safeguarding Board within the agreed time scales. The newly appointed Named Nurse for safeguarding children has completed Sheffield Safeguarding Children Board (SSCB) IMR training. Positive comments have been received from SSCB manager about the engagement of both STHFT managers and practitioners at the recent Child T Significant Incident Learning Process (SILP) review.
3. Improve the percentage compliance with all levels of safeguarding children training. To increase the compliance the team will review training and	Percentage compliance has increased in Level 2 but slightly decreased in Level 3 training. Level 2 - increased from 86% to 88% Level 3 - decreased from 94% to 90%

Key Objective for 2012-13	Achievements
delivery methods to ensure that it is offered in an accessible, varied and effective manner.	The introduction of a new Training Needs Analysis (TNA) in 2012 increased the number of staff requiring training. Moreover, following the integration of community services, additional training is required by many staff in this care group to be compliant with STHFT TNA.
4. Ensure that STHFT's safeguarding children policies reflect the Trust's new role in the provision of community services since completion of the transforming community services programme.	STHFT policies continue to be updated in line with controlled document guidance. A number of local safeguarding policies have been reviewed from the Community Services Care Group and work is now in progress to incorporate these in to the Trust wide safeguarding policy or if essential, having local guidance that complies with STHFT controlled document guidance and format.
5. Provide focused training in adult areas that highlight their role in multi-agency communication when working with vulnerable families.	There has been a positive uptake in training this year due to the update and dissemination of the Safeguarding Children TNA. Training presentations were updated in November 2012 to reflect current changes and more detail about the roles and responsibilities of those who do not have direct contact with children but work with vulnerable families. Provision of on-site level 3 training allows the use of real case scenarios to aid learning. Literature has been sent to participants about the themes from case reviews in Sheffield.
6. Continue the work carried out in 2011-2012 in improving staff access to safeguarding children supervision.	The named nurses continue to offer supervision to selected individuals and staff groups dependent on their level of involvement with safeguarding children cases. Additional groups and staff have been identified to receive supervision within the last year. Further work is required to ensure that safeguarding supervision becomes embedded into midwifery practice. The additional training of safeguarding children supervisors in 2011/12 has currently not improved midwives access to this supervision. Although it is important to note that midwives working with complex safeguarding cases have a high level of support from the specialist midwives working in the Jessop Wing Vulnerabilities Team.

4.0 Key Achievements 2012 – 2013

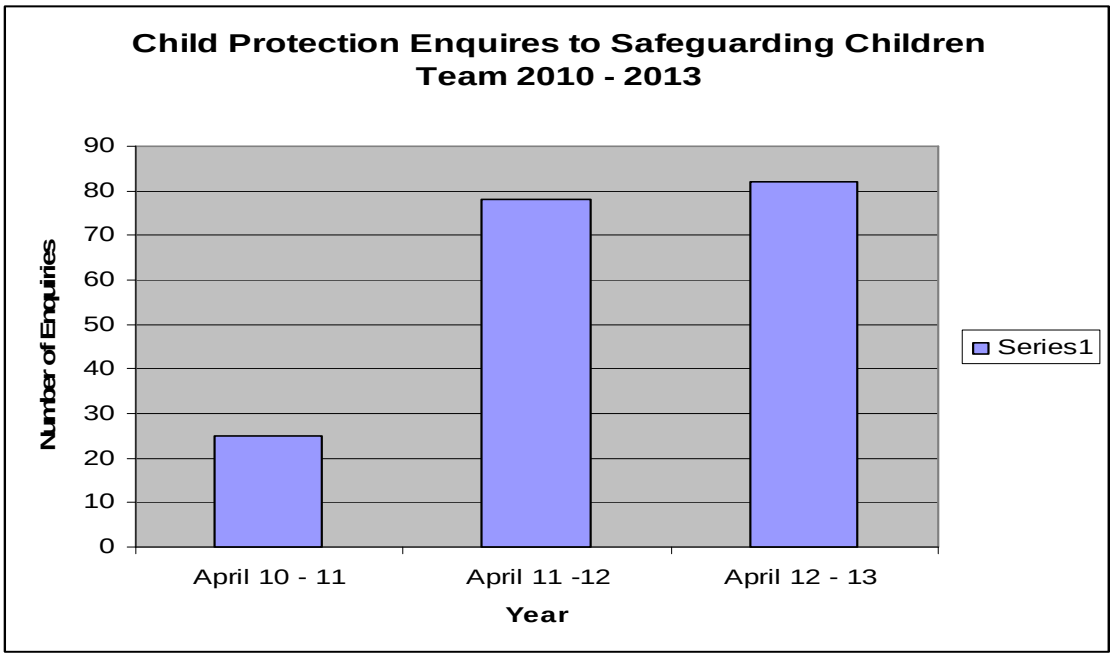
As an NHS Foundation Trust, STHFT is compliant with Section 11 of the Children Act (2004). An essential part of the team's role is in ensuring STHFT continues to meet the requirements of the Sheffield Clinical Commissioning Group safeguarding children assurance declaration. Since September 2012, STHFT is now required to review and declare compliance on a quarterly basis. (Appendix 1 – STHFT provider annual declaration). Although this continues to be a standard document, a number of additions have been made within the last year to reflect national policy and in response to high profile incidents and investigations.

Section 4 aims to identify the key achievements that have taken place in relation to safeguarding children in the last year in addition to the work required to ensure the trust complies with Section 11 of the Children Act (2004).

4.1 Safeguarding Children Activity

The safeguarding team record and monitor all safeguarding children activity in which they have actively been involved. Since the reorganisation of the team in 2010, we have been able to gather data that shows a year on year increase in the number of enquiries that have been dealt with by the team.

Table 4.1.1 – Activity Figures for Safeguarding Children Team

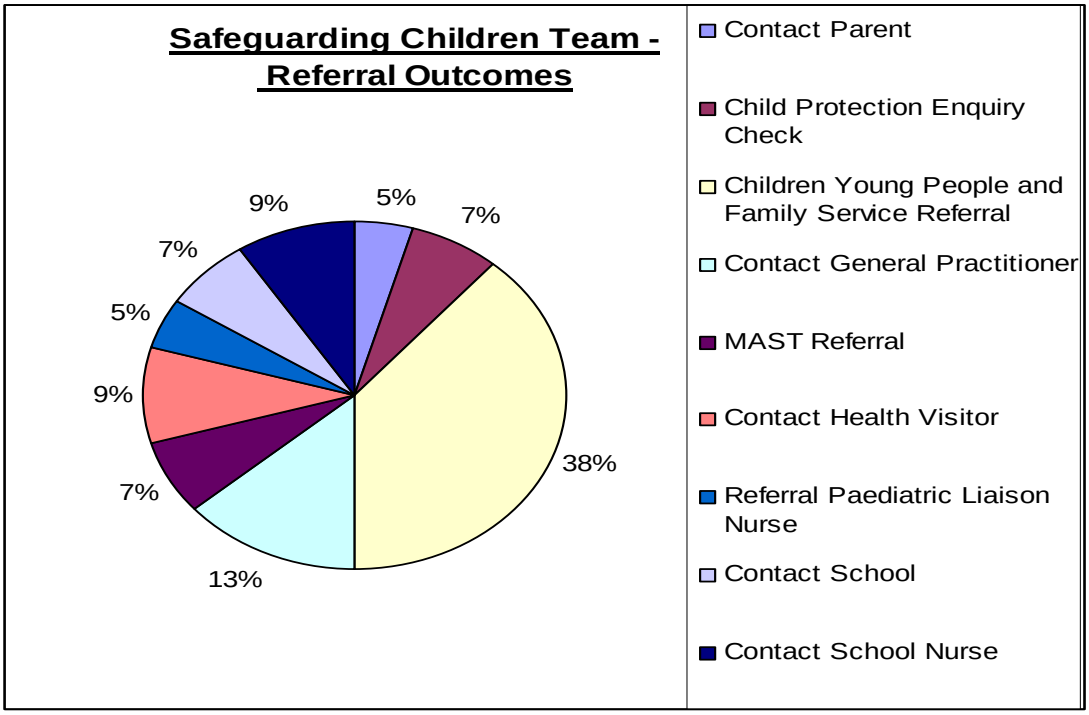


It is pleasing to note a small year on year increase in safeguarding activity for the team. Although there has been a national trend in increased demand for child protection services, these figures are also likely to reflect improved staff engagement in training and their ability to recognise and respond to children at risk of abuse and neglect.

It is important to note that safeguarding cases can vary in their level of complexity, and difficult cases often present staff with many challenges in trying to achieve the necessary outcome in busy clinical environments. Through the introduction of a database in October 2012 the team have been able to collect additional information about the outcome of enquires.

Table 4.1.2 Activity Figures by Outcome (Oct 2012 – March 2013)

Number of cases referred Oct 2012 – March 2013 = 34
Total number of outcomes Oct 2012 – March 2013 = 53



It is clear to see that the requirement for multi-agency working and improved communication often means that a single case has multiple outcomes, which may necessitate referrals to one or more of the appropriate agencies. This has a particular impact on those providing acute and emergency care services where there is high turn over of patients, and highlights the importance of having a paediatric liaison nursing service in such areas. The Named Nurses continue to work with the Paediatric Liaison Nursing Service to ensure that appropriate referral pathways are in place for effective information sharing in these areas.

The Jessop Wing Vulnerabilities Team continues to see the most activity in relation to safeguarding children and vulnerable families. In 2012 the specialist midwifery services for vulnerable women (safeguarding and substance misuse) were brought together to form the Vulnerabilities Team as a way of improving and managing services for vulnerable pregnant women with complex social needs. More recently, a substantive post has been incorporated into the team working with women with mental health issues and acting as a formal link with the perinatal psychiatry service. Additionally, in the last year the Jessop Wing Maternity Information System (JMIS) has been introduced that has seen a number of positive developments in the recording, monitoring and information sharing about vulnerable patients within maternity services.

Significant Challenge – Safeguarding Children Activity.

One of the key challenges for the safeguarding children's team has been to collate Trust wide figures for safeguarding activity. Although we are able to gather data for cases where the team have actively been involved, the current system of using DATIX has proved to be an ineffective way of collating safeguarding activity across the trust despite this clearly being identified as part of STHFT's safeguarding children policy. Feedback from the Trust's Safeguarding Leads and individual practitioners is that the DATIX system does not lend itself

to the reporting of safeguarding concerns. It has also been questioned whether safeguarding issues should even be reported as 'incidents' as much of the safeguarding activity within the Trust is now an integral part of many practitioners day to day work. Moreover, it is well known that the reporting of incidents by healthcare staff is low in comparison with the actual number of incidents, with the DH (2000) citing that incident-reporting systems do not provide the full scale and nature of incidents within healthcare settings. In order to address this issue, the safeguarding team are currently exploring alternative options for the recording and monitoring of safeguarding children activity across the Trust. This has been identified as a key priority for the team in the coming year.

4.2 Sheffield Safeguarding Children Board (SSCB)

STHFT continues to work in co-operation with SSCB ensuring that we are a key partner agency in promoting the welfare of children in Sheffield.

Key Achievements in 2012-2013

- The Trust has maintained its excellent representation by attending all SSCB meetings and Sub-Groups.
- Members of the safeguarding team continue to be involved in the development and maintenance of SSCB safeguarding children policies and audits as requested.
- The Lead Nurse for Children and Young People was involved in a working group that has devised the key principles for transition between children and adult services in education, social care and health services.

4.3 Serious Case Reviews, Case Reviews and Domestic Homicide Reviews

Learning lessons from serious safeguarding incidents continues to be a requirement for all agencies within Sheffield, and as such, STHFT have been involved in a number of reviews. In 2012-13, we have participated in one case review, one Significant Incident Learning Process (SILP) review and a Domestic Homicide Review. Additionally we have submitted a number of information reports to outline specific agency involvement in cases where SSCB require more information to determine if a review is necessary. With recent changes to the Working Together guidance on how and when Local Safeguarding Boards conduct reviews (DfE, 2013) there is likely to be an increase in the number of requests for information reports in the coming year.
In the last year, Independent Management Reviews (IMRs) have been submitted for the identified cases and actions plans formulated as part of the Trust's commitment to learning lessons and improving practice.

Case Review - Child B

Involving the Obstetrics and Gynecology Care Group, this case review related to the injuries sustained by a 3-year-old boy whilst in the care of his parents and a lodger. Some common themes from previous case reviews were noted in this review including improving communication and information sharing relating to child protection concerns. Additionally, it highlighted the need for practitioners to make prompt ongoing referrals for support services and the need to record the outcomes of referrals to children, young people and family services.

Significant Incident Learning Process - Child T

Sheffield Safeguarding Children Board trialled the Significant Incident Learning Process (SILP) for conducting case reviews. The SILP is thought to be a more efficient and effective way of conducting a review that involves practitioners throughout the process. Child T SILP review commenced in November 2012 and involves the case of a 1-month-old baby who was found unresponsive, face down in his cot. At the time of the incident, the child was the subject of a child protection plan. The parents were known to multiple agencies and the review focused on the decision made to leave the child in the family home and whether appropriate plans had been made for discharge from hospital following a premature birth. STHFT IMR involved Obstetrics, Gynecology, Neonatolgy and Emergency Care Groups, and highlighted the need to have clear multi-agency discharge plans in place for all children at risk. Furthermore, it demonstrated the need to review discharge documentation to ensure that all safeguarding concerns are clearly identified within these documents.

Adult 2 Domestic Homicide, Serious Incident Review.

Sheffield Safer and Sustainable Partnership undertook a multi-agency serious incident review in October 2012. Adult 2 sustained life-threatening injuries whilst known to the Domestic Abuse Service, Police Protection unit, and had been discussed six times at Multi-Agency Risk Assessment Conferences (MARAC). As part of the serious incident review an IMR was completed on the victim; the perpetrator did not give consent for medical records to be shared and therefore confidential information about the perpetrator was not included within the Trust IMR. STHFT IMR involved Obstetrics, Gynaecology and Emergency Care Groups. The report has highlighted positive practice in the development of domestic abuse guidance and performing routine enquiry into domestic abuse. The recommendations include integrating forced marriage into domestic abuse training and STHFT safeguarding adults basic awareness training.

The key themes identified from the reviews that STHFT have been involved in during 2012-2013 are;

- A continued emphasis on the need for clear and accurate information sharing.
- The necessity for prompt assessment of need, referral and follow-up in all safeguarding children cases.
- Ensuring staff are aware of their role and responsibilities to in relation to performing full and accurate assessments.
- A need for increased awareness in recognising and responding to domestic abuse concerns.

Bi-monthly monitoring of all action plans has resulted in successful implementation of recommendations, and allows for early identification of issues that may cause slippage and unnecessary delay. The safeguarding team have continued to provide education and training relating to the SCRs that took place in 2012-2013 through regular training provision.

From STHFT's involvement in the above reviews, it is pleasing to note the good progress that has been achieved and maintained as a result of previous case reviews. It is apparent that prior recommendations have been embedded into practice and have had a positive impact in promoting the welfare of children and families who use STHFT services. Specific examples include;

- Successful introduction and maintenance of routine enquiry in domestic abuse in gynaecology.

- Midwifery and neonatology staff delivering and reinforcing best practice in relation to safe sleep guidance issued by SSCB.
- Timely identification and appropriate referral of children known to be at risk following the introduction of child protection plan alerts within the Patient Centre system in 2011.

4.4 External and Internal Audits

External and internal audits have a significant role in the assessment of STHFT's compliance with Section 11 arrangements. Audits completed in 2012-13 continue to demonstrate STHFT's commitment to not only improving standards, but also maintaining these standards by ensuring that all changes have been embedded into clinical practice.

Achievements relating to external and internal inspections.

- STHFT submitted its annual provider declaration to NHS Sheffield in March 2013.
- A Care Quality Commission inspection in December 2012 highlighted how the Trust had met its standard in safeguarding people who use STHFT from abuse.

The named nurses for safeguarding children have completed the following audits/ service evaluations in 2012-2013;

- Audit of Trust compliance in recording electronic alerts for children subject to a child protection plan in Sheffield.
- Evaluation of Common Assessment Framework (CAF) Training undertaken by community midwives.

Additionally the named nurses have supported other care groups to ensure changes made as a result of development or case reviews have been embedded into practice by advising and supporting in the completion of the following audits;

- Follow-up audits for children who do not attend outpatient appointments in Ophthalmology (completed) and Paediatric Dentistry (ongoing).
- Follow-up audit of Early Pregnancy Assessment Centre's compliance with routine enquiry into domestic abuse (completed).
- Service evaluation to determine if changes to the maternity hand held records had had a positive impact in recording paternal information (completed).

As a result of the audits, recommendations and action plans have been produced to further reinforce safeguarding arrangements in these areas.

4.5 Domestic Abuse

The safeguarding children team have continued to work in collaboration with other key individuals in the Trust to improve services for victims and children when there have been episodes of domestic abuse. The increasing number of Multi-Agency Risk Assessment Conferences (MARAC) meetings and the requirement to perform Domestic Homicide Reviews has meant an increase in the workload and resources for both the safeguarding adult and children teams. Information gathering, attending MARAC meetings and conducting reviews all present new challenges for both teams. Moreover, the increased participation in these reviews has resulted in additional action plans, training, and policy development in this area, all of which has had a significant impact on the team's resources.

Key achievements related to Domestic Abuse (Safeguarding Children team);

- Completion of the DHR IMR for Adult 2 – see section 4.2 above
- Working with other key individuals in the Trust, the safeguarding children team attend the Multi-Agency Risk Assessment Conference (MARAC) meetings to ensure the Trust achieves 100% representation.
- Support in the development of an updated Jessop Wing domestic abuse guideline for nurses and midwives.

4.6 Policy Review and Developments

Government Policy continues to be updated following the publication of the Munro Report (DfE, 2011). The third edition of Working Together (DfE, 2013) was published in March 2013 and will have a significant impact for safeguarding children within the Trust; notably in the updating of STHFT's polices and procedures and the identification of a significant number of staff across all staff groups who will require additional safeguarding training.

STHFT's representation at SSCB Practice Review and Policy Group ensures that we are up to date with new policy developments. Furthermore, the team continue to review related published documents to ensure that STHFT is up to date with local and national guidance.

Key Achievements relating to Policy in 2012-2013

- Safeguarding children policies continue to be updated in line with controlled document guidance.
- Development of the Operational Policy for Children and Young People Requiring Surgery.
- The Deputy Chief Nurse completed an internal review of the procedures for volunteers and celebrities visiting the trust in the light of the 'Savile' allegations in 2012. The review highlighted how STHFT has robust arrangements in place for the recruitment, training, monitoring and support of volunteers within the Trust.
- In partnership with the Sheffield Community Youth Team and the Paediatric Liaison Nursing Service (SCH) a new referral pathway has been introduced to support 16 to 18 years old attending the Accident and Emergency department where substance misuse or anti-social behaviour has been a factor in their admission. This was highlighted as an excellent practice development at a recent SSCB training event.

4.7 Staff Awareness and Training

Clear structures remain in place to raise staff awareness of safeguarding children within the Trust. The Children and Young People's Group sets the strategic direction for providing services for children within the Trust; together with the Safeguarding Leads meeting we are able to disseminate and collate information as required across the Trust. The Primary and Community Services Care Group is now represented within the arrangement which has resulted in a positive uptake of training and engagement in this care group.

The safeguarding children training needs analysis was updated and forms part of the Trust's mandatory training programme. The named nurses continue to provide on-site level 2 and 3 training which is well attended. A rolling programme of evaluation ensures that the training is effective and meets the needs of staff.

Significant Challenges for Safeguarding Children Training

The recording of child protection training compliance continues to be a labour intensive process undertaken by the safeguarding children's team. Although there has been development of the Electronic Staff Record (ESR), the current system does not yet allow for the accurate recording and monitoring of safeguarding children training compliance. Although development of this system is on going, significant time and resource is currently required by individual care groups to monitor and maintain local records and for the safeguarding children's team to accurately input and collate training data to establish Trust wide compliance figures.

The monitoring of safeguarding children training compliance for rotational medical staff is inherently difficult due to the short rotations between multiple NHS Trusts in the Yorkshire and Humber region. The Named Doctor for Safeguarding Children has been working with the Director of Postgraduate Medical and Dental Education, to include safeguarding children in a generic induction passport, which is currently in development. She is also working with the Senior Programme Director for Sheffield General Practitioner Specialist Training Programme (GPSTP) to identify those trainees who have received level 3 training prior to entering STHFT. At present, there is no system for recording safeguarding children training compliance for rotational medical staff. This issue has been identified as a key objective for the forthcoming year.

Key Achievements relating to training in 2012-2013

- Improving the percentage compliance for safeguarding children level 2 training despite a significant increase in the number of staff requiring training.
- STHFT completed a SSCB training standard compliance document, which was shared with other agencies in Sheffield as an example of good practice.
- The provision of on-site training for senior staff about the role and purpose of Sheffield Local Authority Designated Officer.
- Increase in the provision of training for staff, including off-site training for community services staff.
- Working with SSCB managers to deliver Threshold Guidance Training on-site as a way of improving staff engagement and attendance.
- Quarterly peer reflective supervision has been introduced to the Hepatitis C service and Tuberculosis service.

The continued quarterly Accident and Emergency safeguarding meeting brings together practitioners from safeguarding children, safeguarding adults, paediatric liaison, and the Independent Domestic Violence Advocates to improve safeguarding in this critical area. The group has seen significant improvements in safeguarding activity, performance, and training for nursing staff within the department, in what has been a very challenging year for the department.

5.0 Key Objectives for 2013-2014.

Our key priorities in the coming year will remain unchanged in focusing on responding to organisational changes and changes in safeguarding children's policy whilst ensuring that the trust continues to meet its statutory duties for safeguarding children.

The following objectives have been highlighted as priority work streams for 2013 -2014.

- Ensure STHFT is compliant with Working Together 2013, which will necessitate a review of current policy, procedures and training needs analysis.

- Ensure STHFT continues to be compliant with safeguarding children training targets.
- Develop a robust system for the recording and monitoring of safeguarding children training for rotating medical personnel.
- Review the current system of Trust wide reporting of child protection concerns to accurately report safeguarding activity.
- Introduce SSCB Threshold Needs Guidance Training within the Trust to ensure staff are able to promote the 'early intervention and prevention' philosophy of safeguarding.
- Complete a service evaluation of safeguarding supervision within the Trust to determine the current policy's effectiveness.

To achieve these key priorities the safeguarding children's team will need to continue to receive the support and co-operation of other corporate departments especially Human Resources and the Medical Director's directorate in addressing the identified challenges in safeguarding children training.

6.0 Conclusion

STHFT continues to fulfil its 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. Gradual service development despite increased pressures on resources within the safeguarding children team and the wider trust has seen positive improvements in safeguarding activity within the last year.

The coming year will undoubtedly present many new challenges, but through effective leadership, engagement and joint working with partner agencies, STHFT is well placed to respond to these challenges effectively.

7.0 References

DfE (Department for Education), 2013. Working Together to Safeguarding Children; A guide to interagency working to promote the welfare of children. Accessed at Working together to safeguard children 2013 (Accessed 9.4.13)

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 9.4.13)

DH (Department of Health) 2000 An Organisation With a Memory. Accessed at An organisation with a memory: Department of Health - Publications (Accessed 3.6.130

HM Government (2004) The Children Act 2004 Accessed at Children Act 2004 (Accessed 9.4.13)

(**APPENDIX 1)**

SAFEGUARDING CHILDREN PROVIDER ANNUAL DECLARATION - 2013
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

Categories	Indicators	
Governance Arrangements	• The Board reviews safeguarding children arrangements on an annual basis at minimum	✓
	• Action plans are in place from Serious Case Reviews and implementation is monitored	✓
	• A process is in place to share lessons learned	✓
	• The healthcare organisation identifies named doctor /named nurse/midwife/professional with specific roles and responsibilities for safeguarding children	✓
	• All commissioned providers have senior links to the LSCB	✓
	• All commissioned providers have formal links via an SLA with both a designated doctor and designated nurse	✓
	• A clear accountability framework for work on safeguarding children	✓
	• An up to date work plan in place	✓
	• An annual audit programme in place	✓
Training, Development and Supervision	• Training strategy budget in place	✓
	• Induction package in place for all staff and volunteers which includes safeguarding children	✓
	• All staff within organisation have accessed the appropriate level of safeguarding children training with a functional recording system	✓
	• The healthcare organisation contributes to the delivery of inter-agency training	✓
	• The healthcare organisation has a supervision policy	✓
	• The organisation ensures supervision standards are met ensuring regular safeguarding children supervision training	✓
Safer Working Practices	• A safer recruitment policy is in place to meet statutory requirements	✓
	• The healthcare organisation has a named senior officer for maintaining and monitoring allegation of abuse procedures	✓
	• The organisation has an effective whistle blowing policy	✓
Policies & Systems	• A board approved safeguarding children policy is in place (within the last 3 years)	✓
	• Assurance of the availability of this policy in all areas	✓
	• Policy/guidance is in place to follow up children missing appointments in all provider services	✓