Portsmouth Hospitals NHS
NHS Trust

TRUST BOARD PUBLIC – JUNE 2016

Agenda Item Number: 84/16
Enclosure Number: (5)

Subject:	Safeguarding Children Annual Report 2015/16
Prepared by: **Reviewed by:** **Sponsored by:** **Presented by:**	Dr Simon Birch, Named Doctor Safeguarding Children and Lead Doctor for Child Deaths Diane Urquhart, Named Nurse Safeguarding Children, Women & Children, Clinical Service Centre Women & Children (W&C) Clinical Service Centre Management Team (this includes Lesley Coles, HoN) Cathy Stone, Director of Nursing, Executive Lead for Safeguarding Children Cathy Stone, Director of Nursing, Executive Lead for Safeguarding Children
Purpose of paper	• Annual Safeguarding Children Report • The Trust Board is requested to note the contents of the report to facilitate discussion surrounding key areas
Key points for Trust Board members *Briefly summarise in bullet point format the main points and key issues that the Trust Board members should focus on including conclusions and proposals*	• The annual report reviews the Safeguarding Children activities undertaken by the Trust in the period April 2015 to March 2016. • The report details the safeguarding children arrangements and corporate responsibilities within the Trust and multi-agency work undertaken. • Meets the Commissioners Contact • Safeguarding children training, support, advice and supervision for Trust staff undertaken during 15/16 is outlined. • The objectives for 2016/17 are also presented.
Options and decisions required *Clearly identify options that are to be considered and any decisions required*	• The Board is asked to receive, discuss and approve this report
Next steps / future actions: *Clearly identify what will follow the Trust Board's discussion*	• To implement actions planned for 2016-17 • Continue to develop and promote safeguarding children practice across the Trust. • Ensure children & young people remain safe in our care.

Consideration of legal issues (including Equality Impact Assessment)?	• There is a legal requirement to ensure that children are safeguarded (*Children Act 2004*) as outlined in HM Government Department for Education' "Working together to safeguard children" (March 2015) and the Care Quality Commission through Key Lines of Enquiry for the 5 domains (Safe, Effective, Responsive, Caring, Well Led). • Failure to comply with the legal requirements of safeguarding children could risk the Trust's registration with the Care Quality Commission. • Safeguarding children has implications for all service users and the public, and requires public and patient involvement to ensure improvements in delivering equitable and safer care to all who access our services and who live within the local areas the Trust serves.
Consideration of Public and Patient Involvement and Communications Implications?	• The report will be shared with Commissioners. • Declaration of safeguarding children compliance is available on PHT website.

Links to Portsmouth Hospitals NHS Trust Board Strategic Aims, Assurance Framework/Corporate Risk Register	
Strategic Aim	• Deliver an effective safeguarding children service within PHT. • Develop and engage a workforce fit for purpose. • Provide first class patient experience, safe and high quality services.
Annual objectives	• Annual Safeguarding Children report
CQC, regulatory requirements	• CQC inspection February 2015, findings included in report • Children Act 2004 (Safeguarding people who use services from abuse) • Working Together (2015), RCPCH Intercollegiate Document (2014) Safeguarding Children Policies and procedures (aligned to LSCB) and NICE guidance
Impact	
Patient experience	• Essential progression in respect of safeguarding children experiences and improvements
Quality and safety	• Robust Governance arrangement's in place
Financial	• A robust review of the Safeguarding Children Team completed in November 2015 with future delivery of the Safeguarding Children Agenda
Workforce	• Training aligned to RCPCH intercollegiate Document (2014) in respect of ensuring staff receive training appropriate to their needs. All PHT staff should recognise vulnerable children and

	adults.
Equality and diversity	• Ensuring safe and effective services to children and young people
Estates	• Preferably the Safeguarding Children Team to be located in one office - raised via Women & Children Management Team
IM&T	• Safeguarding Children monitored through W&C Management Team, Safeguarding Committee and when appropriate PSQC
Communications-engagement	• Continual monitoring to ensure communications-engagement within and external to the Trust
BAF/Corporate Risks/Risk Register Reference (if applicable)	• Safeguarding Children training across the organisation is a risk for children and inhibits PHT meeting the Quality Contract.
CQC Reference	• Section 3, Standard 7

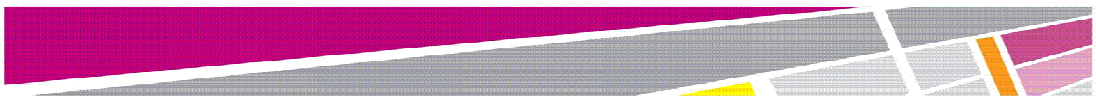
Committees/Meetings at which paper has been approved:	**Date**
Women & Children's Clinical Service Centre Management Team	18 May 2016
Safeguarding Committee (Children and Adults)	20 May 2016

Portsmouth Hospitals NHS
NHS Trust

SAFEGUARDING CHILDREN

ANNUAL REPORT for PERIOD ENDING

31 MARCH 2016



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1. Introduction

1.1 The management and care of safeguarding children and young people has continued to be high profile, both nationally and locally. The implementation of the national drivers for safeguarding is mainly directed through Portsmouth and Hampshire Safeguarding Children Boards. This in turn is driven through the Trust's Safeguarding Committee, Operational Group and Safeguarding Children Team.

1.2 Portsmouth Hospitals NHS Trust (PHT) has continued to put in place measures at all levels within the organisation to ensure that it is doing everything it can to prevent the abuse and neglect of the children and young people who use its services. The Trust has established processes and systems to ensure there is a timely and proportionate response when allegations of abuse are identified.

1.3 The purpose of this annual report is to inform Commissioners, Local Safeguarding Children's Boards, W&C CSC Management Team and PHT's Safeguarding and Governance Committee on progress made in delivering the Safeguarding Children Agenda during the period April 2015 - March 2016.

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

1.5 The objectives of this annual report are:

- To provide assurance to PHT's Trust Board that the Trust continues to fulfil its statutory responsibilities in relation to safeguarding children as stated in section 11 of the *Children Act 2004*.
- Key to this is the implementation of actions from the section 11 audit, recommendations from Serious Case Reviews, internal reviews of incidents relating to children and acknowledgement of national drivers within the safeguarding children work plan.
- To provide an update on service developments, any existing or potential areas of risk in relation to safeguarding children and young people.

1.6 During the 2015/16 period there have been several changes within the Trust's established Safeguarding Children Team. An external review was completed and this enabled the restructuring of the Safeguarding Children Team workforce and has resulted in the appointment of a new Named Nurse Band 8 WTE (March 2016), new Named Midwife band 8 WTE to commence June 2016. The team will have 2 band 7 WTE. Consisting of a specialist midwife for safeguarding children (currently in post) and specialist nurse for safeguarding children (awaiting recruitment).

1.7 The Trust continues to work in partnership with the statutory and voluntary agencies across Portsmouth and Hampshire to discharge its responsibilities in relation to the safeguarding of children and adults.

1.8 Recommendation

The Trust Board is requested to note the contents of the report, to facilitate discussion surrounding key areas and approve the recommended areas of activity for the coming year.

2. Overview

2.1 PHT provides services to ensure children and young people remain safe in its care, receive services which promote their wellbeing, help develop their full potential and have their needs met.

2.2 The Care Quality Commission requires Health Organisations to take reasonable steps to ensure that commissioned services are compliant with essential healthcare standards relating to arrangements to safeguard and promote the welfare of children across the following areas:

- Those arrangements for children and young people are provided under Section 11 of the *Children Act* 2004;
- Working with partners to protect children and participate in reviews as set out in Working Together to Safeguard Children (HM Government 2015);
- Agreed systems, standards and protocols in place in regard to sharing information about a child and their family, both within the organisation and with outside agencies.

2.3 Corporate Responsibilities

Section 11 of the *Children Act* 2004 places a statutory duty on key people and bodies to make arrangements to safeguard and promote the welfare of children. All NHS Trusts, NHS Foundation Trusts and CCGs providing services for children are expected to identify named professionals who have a key role in promoting good professional practice and provide advice and expertise for fellow professionals. The Trust Board/Board of Directors recognises its responsibility of overseeing its safeguarding children arrangements.

2.4 The Chief Executive is the Accountable Officer of the Trust and as such has overall responsibility for ensuring it meets statutory and legal requirements and adheres to guidance issued by the Department of Health, Department for Education and Skills, Commissioners and Portsmouth and Hampshire Safeguarding Children Boards.

2.5 Safeguarding Children Lead Director the Director of Nursing is accountable to the Chief Executive and has delegated responsibility for safeguarding children and young people. The Director of Nursing oversees effective safeguarding children arrangements within the Trust and is the named person on its Local Safeguarding Children Board.

2.6 Named Doctor and Lead for Child Deaths (2PAs) a Consultant Paediatrician is the Named Doctor and Lead Doctor for Child Deaths for the Trust and is line managed by the Clinical Director for Paediatrics and supervised regarding safeguarding practices by the Designated Doctor.

2.7 Named Nurse (1wte) the Named Nurse for Safeguarding Children is line managed by the Head of Nursing (Women and Children's Clinical Service Centre) and accountable to the Director of Nursing. The Named Nurse is the hospital wide lead for ensuring staff are aware of their roles and responsibilities in relation to safeguarding children and other relevant Government and external documents and works closely with the adult safeguarding lead and governance team within the organisation to ensure that all services are aware of their responsibilities.

2.8 Named Midwife is the clinical lead for safeguarding within midwifery, responsible for developing, participating and contributing to policy and practice in relation to child protection issues associated with pregnancy and the post-natal period. They are accountable to the Deputy head of Midwifery and Director of Midwifery**.**

2.9 The Specialist Midwife (1wte) is accountable to the Named Midwife and supports the Named Midwife/Nurse in liaison with the Community Health Teams, Social Care and Police, assisting in the delivery of training and carrying out safeguarding children audits.

2.10 Specialist nurse advisor role for Safeguarding Children (0.72 WTE) is accountable to the Named Nurse, supports the Named Nurse/Midwife in liaison with statutory and non-statutory partners assisting in the delivery of training and carrying out safeguarding children audits. The role is currently banded at band 6.As part of the team restructuring the role, will be developed into band 7.

2.11 Safeguarding Children within the Emergency Department (ED) within the department there is a lead doctor and nurse responsible for the delivery/facilitation of day-to-day safeguarding children and young people. The department meets quarterly with external partners to report on, discuss progress of any national and local agendas that affect the working of the department and welfare of children, young people and adults**.** The lead nurse currently delivers internal bespoke training under the guidance of the Safeguarding Children Team (SCT).

2.12 Safeguarding Children Administrators (2wte) provide administrative support to the Safeguarding Children Team.

2.13 Portsmouth Hospitals NHS Trust Staff managers, clinical professionals, care workers and any other staff who consider or suspect that abuse has occurred are responsible for ensuring they are familiar with Trust policies and procedures and for implementing them, in association with their managers and other agencies. The Safeguarding Children Operational Group will monitor compliance and will be responsible for ensuring that any action plans to improve compliance and effectiveness are implemented.

2.14 Trust Board receives monthly safeguarding children information by way of a monthly quality report and an Annual Report on Safeguarding Children.

2.15 Safeguarding Committee is chaired by the Executive Lead for Safeguarding Children and Adults. The Committee members meet quarterly to report on and discuss progress of any national and local agendas that affect the working of the organisation and welfare of children, young people and adults, for example, meeting Commissioner Contracts and Trust Priorities around safeguarding.

2.16 Safeguarding Children Operational Group is a sub-committee of 2.15. The group is represented by all Clinical Service Centres, monitors the effectiveness of policy and practices, oversees the implementation of any action plans, recommendations from serious case reviews; identify any changes required in service provision and provides assurance on compliance with legislation and national standards.

3. Multi-agency Working

3.1 Portsmouth and Hampshire Safeguarding Children Boards are statutory strategic inter-agency forums with the primary responsibility for determining how the different agencies and professional groups should co-operate to protect children from abuse and neglect and for ensuring the arrangements work effectively to achieve good outcomes for children and young people (C&YP) in the local area. In addition, both Boards have responsibility to ensure the effectiveness of arrangements made by agencies to safeguard and promote the welfare of children. Therefore, in addition to its key tasks, the Board has a co-ordinating, monitoring and performance management role in relation to a wider safeguarding agenda.

3.2 PHT is represented on Portsmouth Safeguarding Children Board (PSCB) by the Director of Nursing (Executive Lead for Safeguarding Children), who may on occasions delegate this responsibility to the Head of Nursing for the Women & Children's CSC or the Named Nurse. PHT is represented on all relevant PSCB committees and sub groups by the Named Nurse or delegated safeguarding children team member.

A representative from PHT attends the following meetings of the Boards and relevant sub-groups

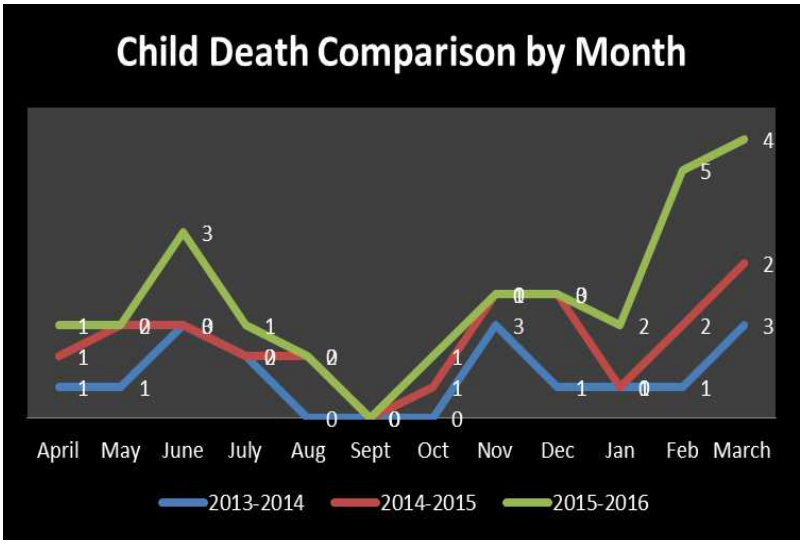
Meeting title /Area	Frequency	Representatives
HSCB board meetings		Executive leads
HSCB (Hampshire) Multi-agency safeguarding forum (South East)	Quarterly	Named professionals/ team delegate.
CCG – Health forum Sub-group	Quarterly	Named Nurse
Hampshire safeguarding Board task & finish groups	Monthly	Allocate to team member to lead.
Child Sexual Exploitation (CSE) & MET missing, exploited, trafficked		Specialist midwife (alternate months-conference calls)
FGM – Female Genital Mutilation	Bi- monthly	Specialist midwife
Was Not brought -WNB	Bi-monthly	Named Nurse
Children's Trust Board	Quarterly	Executive leads.
Portsmouth Safeguarding board		
PSCB Board meeting		Executive lead.
Executive Committee	Bi-monthly	Named Nurse
Training Committee	Bi-Annually	SCT representative to be confirmed
CDOP – Child death overview panel	Quarterly.	Named midwife
Operational multi –agency liaison meeting		Specialist midwife/nurse

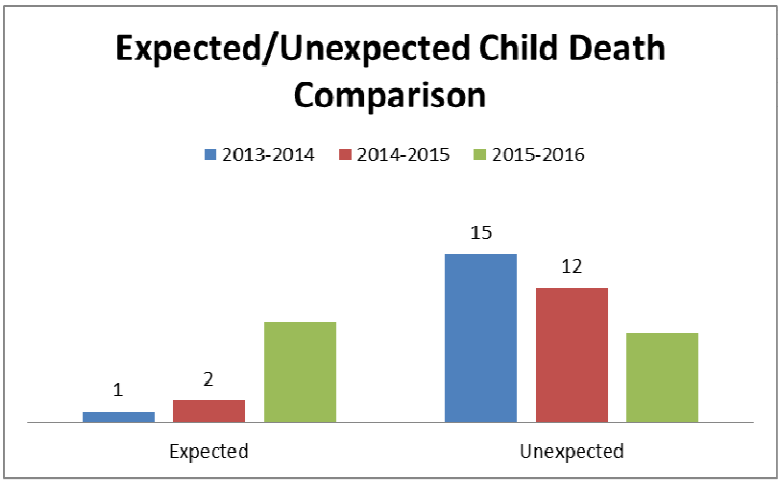
4. Governance: Quality and Performance

4.1 Section 11 *Children Act 2004 (*self-assessment audit), the hospital remains fully compliant with section 11 and with CQC, Standard 7. The 2015/16 Standard NHS Contract for All Services: Schedule C, Part 7.2 has also been met and the contract for 2015-16 has been agreed. The Trust will continue to report quarterly on their progress.

Child Deaths

All deaths are dealt with under the Child Death Procedures: Portsmouth Safeguarding Children's Boards and Hampshire Safeguarding Children's Boards have separated and each are developing their own Child Death Overview Panel processes; these are still to be embedded in the Boards and partner agencies.





	Q1	Q2	Q3	Q4
2013-14	5	1	4	3
	Q1	**Q2**	**Q3**	**Q4**
2014-15	2	0	4	4
	Q1	**Q2**	**Q3**	**Q4**
2015-16	4	1	1	11
NB – Q4 Increase due to updated recording system by SCT and notifications.				

Quarter	On-going work	Comments
1	CDOP: Review of process by 4 Local Safeguarding Children Boards (LSCB); finding of review not yet known. CDOP: Annual report 2014-15 not yet received. Trust: No concerns.	
2	CDOP review near completion. West Hampshire CCG will be introducing a local quality requirement for unexpected child deaths. Trust: No concerns.	Once known will cascade ie any changes affecting the Trust
3	One unexpected death in Q3 – this case did not go through the CDOP process in PHT. Plus one expected death (Cancer related). NB: 4LSCB CDOP disbanded from 01/11/15, each LSCB now making own arrangements. Portsmouth CDOP will have representatives from health (Consultant Paediatrician - Community) and Maternity Services (Specialist Midwife Safeguarding Children).	The unexpected death was a child transferred to PICU (UHS) so assume UHS will follow due process.
4	Child Death/Rapid Response and Child Death Overview Panel processes and paperwork all updated to reflect Portsmouth and Hampshire having separate CDOPs now and different contacts and pathways. ***** Improved collection of data by SCT has resulted in increased number of child deaths being reported rather than an increased occurrence of deaths.**	Currently working on updating guides for staff and approach to data collection.

Southampton, Portsmouth, Hampshire and Isle of Wight (the four Local Safeguarding Children Boards) have divided the previous 4LSCB CDOP panel into separate panels for each area.

4.2 Allegations/Local Authority Designated Officer (LADO)

During the period 2015-16 – two cases reported.

Both cases deemed low risk to children and young people under the care of PHT.

Case 1: Safety plan was devised and in place for reported to currently have no direct access to children as part of job description.

Case 2: Assessed as low risk to the patients within PHT- staff member no longer employed by PHT dismissed due to long-term sickness not directly related to allegation.

5. Serious Case Reviews (SCR) (IMRs) Portsmouth Safeguarding Children Board (PSCB)

.1 Portsmouth Safeguarding Children Board (PSCB)

- **September 2013**: **Child D** SCR has been **published** by PSCB. An audit of maternity notes was a recommendation from this review and currently the Specialist Midwife for Safeguarding Children is involved in work being undertaken to develop new maternity notes that will incorporate the safeguarding indicators and social assessment highlighted as missing in the Child D SCR.

- **January 2015:** Committee requested the Trust contribute to a review of a case being considered for a SCR (child died following a head injury). The Trust completed an IMR and identified good multi-agency working, challenge and working to 4LSCB procedures. The Trust IMR identified one lesson, to call Security if a domestic incident occurs on a ward to assist in de-escalation. In February 2015 the case progressed to a SCR **(Child E)** and an Independent Reviewer was appointed by the Board. The second draft has been approved and publication of the final SCR is anticipated in the next 3-6 months.

- **September 2015: CS** Reflective Practice Meeting (RPM) requested by Portsmouth Children's Services Department (CSD) in March 2015 in regards to multi-agency working in respect of an unborn baby/mother with learning disability. RPM held September 2015 and lessons learnt are:
  - Communication: improving information sharing between agencies
  - Understanding agencies roles and expectations; making it clear and no ambiguity
  - Escalation
  - Professionals working in isolation; improving access to supervision

- **JM September 2015**: Reflective Practice Meeting requested by Trust in September 2015 in regards to multi-agency working in respect of a 13 year old girl. RPM held October 2015 and lessons learnt are:
  - CSD process when cases closed and stepped down Early Help
  - PHT Were Not Brought Policy - Underpinning administrative processes

- **L-M F October 2015**: Reflective Practice Meeting requested by Trust in October 2015 in regards to multi-agency working in respect of a new-born baby. RPM held November 2015 and lessons learnt are:
  - Importance of professional challenge
  - Importance of confirming telephone referrals in writing

- **September 2015**. CS Reflective Practice Meeting (RPM) requested by Portsmouth Children's Services Department (CSD) in March 2015 in regards to multi-agency working in respect of an unborn baby/mother with learning disability. RPM held September 2015 and lessons learnt are:
  - Communication: improving information sharing between agencies
  - Understanding agencies roles and expectations; making it clear and no ambiguity
  - Escalation

- **March 2016 KJ-** PSCB SCR Committee requested that the Trust provide a scoping report to contribute to the decision making process as to whether a SCR should be commissioned. The scoping report was submitted to PSCB on behalf of the Trust in March 2016.

- **April 2016 AK** – Paediatric Unit reviewed the recommendations to ensure this event does not occur in PHT. The recommendations have been discussed at the Paeds Governance and Management meeting and the department is piloting a handover sheet for complex patients/parents from one hot week to the next (being trialled) and a trainer was brought in to update the MDT around dealing with 'Challenging Families'. This training event occurred on 12 April 2016 and feedback is awaited.

5.2 Hampshire Safeguarding Children Board

- **June 2014** (Child L) HSCB SCR Committee requested the Trust to contribute to review of a case considered for a SCR. The Trust has submitted their report. SCR and HSCB Response to recommendations published 28/01/16. No recommendations specifically for PHT.

  Actions planned:
  - Basic homelessness awareness and associated risk factors for children and their families to be incorporated into PHT SC training for 2016/2017.
  - Importance of the role that housing plays in safeguarding children to be incorporated into PHT SC training for 2016/2017.
  - HSCB multi-agency programme to be advertised on SCT Website as part of the planned update.
  - HSCB multi-agency programme to be promoted at PHT SC Level 3 Updates 2016/2017.
  - Current work being done to develop a robust Domestic Abuse action plan will include training to frontline practitioners, where the importance of not asking the routine domestic abuse question when anyone else is present, can be reiterated.

- **September 2014**: (Child P) The Trust made a referral for a SCR. A Multi Agency Review was commissioned and the Trust submitted their agency report and chronology April 2015. The Board have now appointed an independent reviewer and this review is being progressed. The board requested further information in relation to this review, which was provided on 24 February 2016.

- **July 2015:** (Child W) HSCB SCR Committee requested the Trust to contribute to review of a case considered for a SCR. Child on a Special Guardianship Order, initially subject to a Child Protection Plan under the category of emotional abuse, then as a child in need with Children with Disability Team. Trust informed formally on 2 February 2016 that a Multi-Agency Review has been commissioned and agency report and chronology was submitted on behalf of the Trust on 16 March 2016.

- **July 2015:** (Child O1) The Trust requested HSCB SCR committee to consider whether a Serious Case Review (SCR) or Multi Agency Review (MAR) should be undertaken in respect of a new-born baby that sustained significant injuries, where multi-agency working appeared not to work well. We were informed in October 2015 that the case did not meet the criteria for an SCR or MAR. A Reflective Practice Meeting was held on 22 March 2016 and the summary of lessons learnt is awaited.

- **July 2015:** (Child U) HSCB SCR Committee reviewed a case being considered for a SCR. The initial review identified the Trust was involved in the antenatal care of the child's mother (up to 30 weeks gestation), delivery out of area. The infant died following a catastrophic head injury. The Trust has submitted their report. Recommendations have been sent out to Gynaecology, ED Child and Maternity Governance leads for action plans to be developed.

6. Safeguarding Children Training

Safeguarding Children Training is in line with the 'Safeguarding Children and Young people: roles and competences for health care staff, Intercollegiate document' (RCPCH 2014), and meets the CQC and Commissioner Contract requirements. Training incorporates emerging recommendations from Serious Case Reviews and changes in national and local practice and is directed by key issues from 4LSCB targets.

Local Safeguarding Children Board Training

Safeguarding Training and Compliance: Training of staff is a major part of the Safeguarding Children's Team's work and from April 2014 level 2 became the minimum level for all Trust staff. This is currently covered for all staff within the essential skills booklet. The booklet has been expanded to cover al the key themes in safeguarding and questions are updated annually.

The Safeguarding Children Training Strategy 2014/15 was reviewed and matched against the newly published Roles and Competencies for Health Care Staff 2014. The strategy is due for review 2015-16 as following review it is recommended that staff attend a classroom session every three years, irrespective of their role.

A robust programme of training has been introduced and the team plan to offer bespoke training in high risk areas.

The evaluation of training sessions has been updated and these will form part of the on-going audit of impact in the clinical areas.

The Named Nurse is currently compiling training plans with each CSC to address compliance.

6.1 Safeguarding Training and Compliance

The Trust continues to show on-going commitment in ensuring that all staff receive appropriate safeguarding children training. As a result of increased operational pressure within the Safeguarding Team, on-going training and maintaining the required standard remains a challenge.

The recent intercollegiate document (RCPCH 2014) amended recommendations requires the majority of medical staff and extended staff groups to undertake Level 2 training.

This will create a transitional period for reporting as a result of the implementation of the new recommendation.

The Safeguarding Children Team is prioritising key staff against operational pressures.

Training Compliance - Quarter 4 -2015/16

	Level 1	Level 2	Level 3
Essential Skills Compliance - Trust (%).	99.1%	89.8%	64.40%
CHAT CSC	99.4%	92.1%	
Clinical Support CSC	99.6%	92.8%	
Corporate Functions	99.5%	91.8%	
Emergency Care CSC	99.6%	88.4%	42.7%
Head and Neck CSC	98.4%	84.3%	37.0%
Medicine CSC	98.3%	83.5%	4.8%
MOPRS CSC	99.2%	88.6%	
Muscular Skeletal CSC	98.9%	84.6%	46.4%
Renal CSC	100.0%	94.0%	
Surgery and Cancer CSC	97.9%	87.4%	15.4%
Women's and Children's CSC	99.2%	93.4%	80.7%

6.2 Evaluation of Training

Overview of Current Training Results.pdf

Some key points:

Majority of staff received training via Essential skills booklet at level 2. Comments from many staff stated they do not have direct contact with patients (the booklet approaches level 1 & 2). This demonstrates that the essential skills booklet is a useful tool to assist the Trust in delivery of the correct level and method of training. On-going assessment and training need analysis by team leaders required to identify correct level.

Currently the Trust offers E-learning modules at level 1 to 3, feedback clearly states that these are better aimed at paediatric staff. Generally all staff found some impact on practice and the classroom setting appears to be the preferred method of receiving training.

47% staff stated yes definitely/probably the training had some impact on their clinical practice.
70% were unable to implement learning in the clinical setting – however It needs to be highlighted that a large proportion of staff completing survey were non clinical and/or stated they do not see children in there department. (Further highlighting that better analysis of level required for staff will be needed).
78% stated yes definitely/probably confident in recognising signs of maltreatment.
83% stated yes/definitely felt able to make the decision to refer to Children's social care or to their line manager.

7. Safeguarding Children Audit

Audits undertaken during the 2015-16 period consist of:

- "Was Not Brought" audit- Analysis of practitioners' understanding of the new process.

- To feed back at the HSCB task and finish group**.**

- Repeat / review Domestic Violence Audit - the outcomes include:
  - A review of in-house training for midwifery
  - A new flow chart ie what to do if you have a concern
  - Domestic abuse folder available on the K drive for midwives
  - Domestic Violence Policy and advice for staff

This audit has been shared with the Domestic Violence Forum Portsmouth.

- Recruitment audit: no actions required.

- Mock CQC inspection: feedback from an assessor undertaking the review, "I was impressed with the level of knowledge and passion all of the members of staff I met with for safeguarding. I came away feeling very assured that they were all competent and confident in their roles from a safeguarding perspective".

  NB: Audits are presented to the Safeguarding Children Operational Group and Safeguarding Committee.

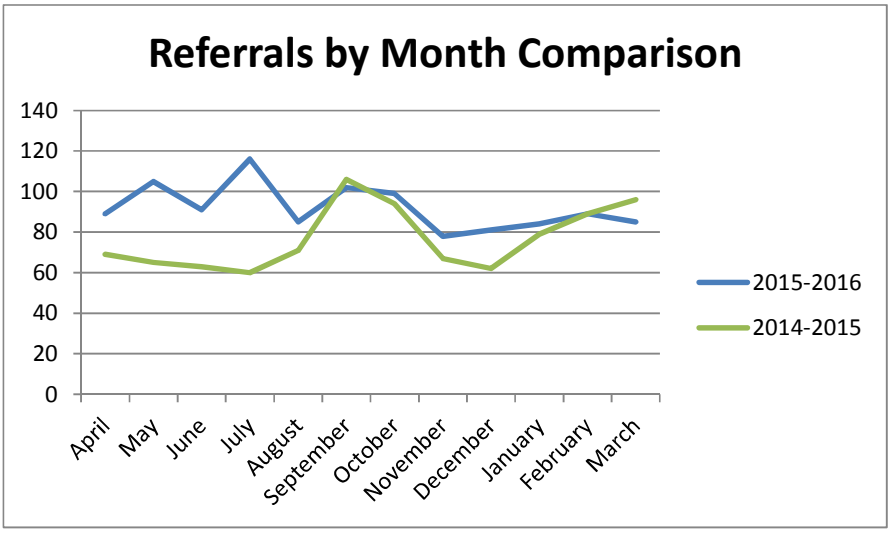
8. Policies and Procedures

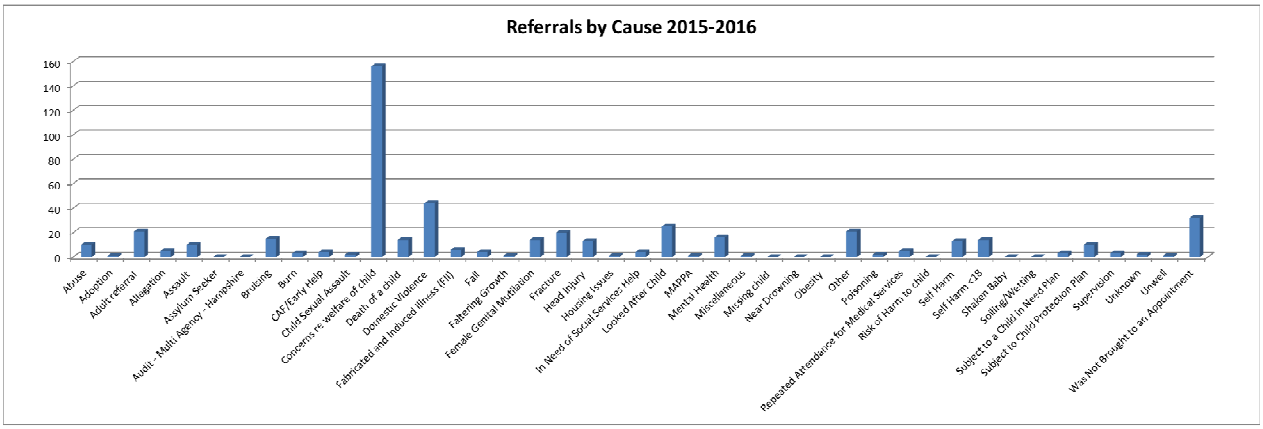
All policies, guidance and procedures were updated in line with Working Together (2015).

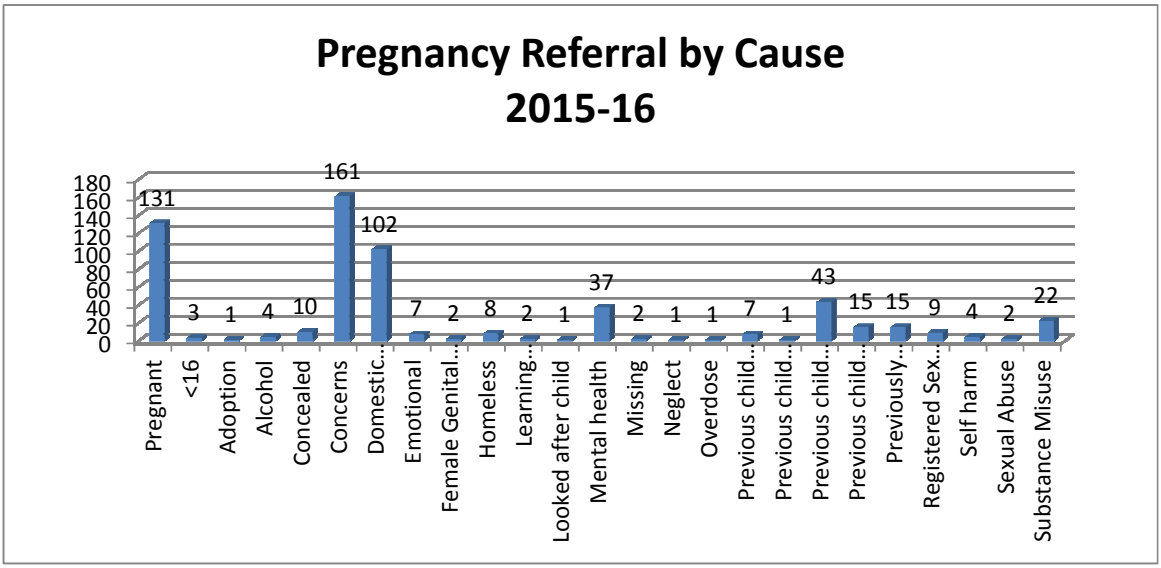
- Safeguarding Children Operational Policy/Guidance: Due for completion in November 2016. Minor amendments approved at Safeguarding Committee 30 March 2016.
- Review of the Trust Allegations Policy: due to be reviewed in October 2016.
- Safeguarding Children Training Strategy: review on-going due to changes in the following guide: Roles and competencies for health care staff. Intercollegiate document third edition: March 2014.
- Safeguarding Children Supervision Policy: Review July 2016.
- Management of Sex Offenders: next review November 2017 (however, review commenced September 2015 to add a flow chart for unborn babies/risk assessments –still outstanding).
- Children who do not attend outpatient appointments (Was-not-Brought): next review November 2017.
- ED review paper work: review Aug 2016. OCEANO is a more robust electronic system for viewing previous attendances through ED Child. MDT continues to fill out 'Cause for Concern' forms to ensure that all Health Visitors and School Nurses have access to the electronic reports.
- Trust wide FGM procedure/policy: under on-going development in line with DH guidance.

9. Monitoring and Analysis of Safeguarding Children Team Activity

On-going pattern of increasing referral numbers year on year as seen below:







- The Safeguarding Children Team (SCT) is copied into all referrals made by Trust staff to Children's Social Care. Referrals can be made by any member of staff across the Trust, but referrals to Children's Social Care are in the majority made by midwifery, staff from the Paediatric Unit and the Emergency Department.
- The SCT also receive enquiries/notifications of concerns regarding an unborn baby or child from the Police/Multi Agency Safeguarding Hubs (Portsmouth from November 2015). Other Multi-agency Public Protection Arrangements (MAPPA) enquiries can be received from other agencies i.e. Probation/Police. MAPPA communication is through the Duty Manager and therefore not recorded by the SCT.
- All referrals, notifications received by the SCT are triaged and appropriate actions taken, including feedback to the referrer.

SCT attendances at meetings i.e. conferences, strategy meetings (section 47)

2013-14	**Q1**	**Q2**	**Q3**	**Q4**
Combined notifications of concern received by the SCT	213	174	180	174
2014-15	**Q1**	**Q2**	**Q3**	**Q4**
Combined notifications of concern received by the SCT	197	236	223	263
2015-16	**Q1**	**Q2**	**Q3**	**Q4**
Combined notifications of concern received by the SCT	283	210 and 9 LAC notifications Sept figures	258	243

Conference Invites – by area and type

	Total	P/mth	F&G	Havant	Other	SG Team	Midwife
April	96	45	23	28		12	53
May	105	42	37	26		10	55
June	97	39	32	24		15	45
July	145	87	25	32		34	59
August	132	54	45	29		23	47
September	137	66	36	35		24	36
October	170	84	48	38		23	48
November	148	72	47	29		21	56
December	150	68	38	42		10	52
January	151	65	50	33		18	51
February	147	71	47	29		15	33
March	158	86	45	25		14	63
Totals	**1636**	**779**	**473**	**370**	**14**	**219**	**598**

Date	Strategy	TAC/SAF	CIN	Prof	Planning		ICPC	RCPC
April	3	9		1	19		30	22
May	8	8			18		41	20
June	8	11			15		38	16
July	13	17		1	27		44	34
August	11	7	1		27		53	26
September	10	7	2	1	25		38	49
October	5	11	4		28		42	80
November	13	7	6		30		31	58
December	6	4	8		34		47	51
January	9	3	15		25		28	68
February	8		6		23		48	59
March	7	6	13		21		32	76
Totals	**101**	**90**	**60**	**3**	**303**		**497**	**581**

10. Changes in external processes that have taken place in the last year

Hampshire

- Constitution updated
- CDOP changed from '4LSCB' combined to four separate areas
- Change in reporting requirements for conferences

Portsmouth

- Established Multi-agency safeguarding hub (MASH)
- New referral threshold document (under review)
- Constitution produced and signed off
- New Head of Safeguarding and Patient Safety role appointed

11. Human Resources (Recruitment, Employment, Allegation and Whistle Blowing)

11.1 Allegations - Local Authority Designated Officer (LADO) Referrals

Two concerns were raised
- One deemed low risk; safety plan in place
- One has direct contact with children; currently not working within PHT

11.2 'Prevent'

Children's Safeguarding team becoming trainers to deliver health WRAP training across Women and Children's CSC. Recent changes in trainer guidance relaxed.

No direct referrals made this year.

12. Safeguarding Children Risk Register

12.1 Risks

1. Workload, Skill Mix and Safety of service (16)

2. Safeguarding Children Training (16) compliance Trust wide.
Both risks are being actively addressed. Workload risk will be downgraded in April 16. Board support to improve training compliance would be helpful.

13. Complaints

Three recent complaints.

- **Formal** - Feb 16 – RD re CS - complaint re Safeguarding Children practices during Maternity episode of care relating to management of early help process and escalation to Children's Social Care - no fault found.
- **Formal** - Mar 16 – IR re LR - complaint re Safeguarding Children practices during Maternity episode of care relating to the removal of a baby from mother's care under police protection due to severe acute mental health crisis in mother. Ongoing.
- **Informal** - Mar 16 – CH re AH – complaint re Safeguarding Children practices during Maternity episode of care relating to the bruising protocol. Staff involved undertaking reflective work.

  The 'Bruising protocol' (from LSCB rather than PHT) remains an area generating a number of official and unofficial complaints. We are in the process of developing a leaflet with clear information for families. Named Nurse is looking to involve family member to offer feedback and review as part of implementation.

14. Compliments

The team received a Paediatric Unit Extra Mile Award in March 2016 following a nomination by a consultant Paediatrician that acknowledged the expertise and support provided for complex cases.

15. Serious Incident Requiring Investigation (SIRI) (Amber and Red)

Serious Incidents Requiring Investigation (SIRIs) including Amber or Red incidents

	Month	Grade	CSC/Specialty	Incident	Status
Quarter 2	August	Red	Women and Children (Maternity Unit)	Maternal death, 11 months postpartum from an overdose.	Review completed by Maternity Service. Action plan in place
	September	**Red**	Women and Children (Maternity Unit)	Maternal Death (20 weeks pregnant) from an overdose. Safeguarding aspect of case as older siblings not in mother's care.	Review completed by Maternity Service. Action plan in place.
	December	Amber	Women and Children (Maternity Unit)	Patient had type 3 FGM and had an anterior episiotomy during delivery. The registrar then resutured the anterior episiotomy closed i.e. reinfibulated her.	On-going actions, progressing with input from the Medical Director.
Quarter 4	January		Women and Children (Maternity Unit)	Issue related to maternal mental health.	Review being undertaken by Maternity Service.
	January		Women and Children (Paediatric Unit)	Planned deinfibulation of FGM on a 15 year old girl resulted in a severe emotional reaction. Thought to be PTSD or a reaction to anaesthesia.	Panel help. Learning for this child nil but highlights there is no 'Counselling service' for this group of C&YP. HoN raised at C&YP Standards and Quality Committee.

16. Organisational Learning from Safeguarding Children incidents/s (not amber or red)

- New way of recording case conferences/planning meetings for midwifery
- 1:1s with Community Midwives, reviewing competencies/processes
- Implementing safeguarding children corporate paperwork to maternity
- Increasing liaison with MHT team within ED
- Paediatrics within ED working with staff on the Observation ward where there is a vulnerable child and or adult whose presentation may impact on a child
- Supervision being rolled out within maternity
- Recognition of good safeguarding practice
- Developing effective and efficient process with CAMHS

17. Child Protection Information Systems (CPIS) 2015-16

Overview

- Child protection information system (CPIS) is a project that will improve the way that health and social care services work together across England to protect vulnerable children. The implementation timescale will coincide with the decommissioning of the joint child protection register (JCPR), due to the hardware and software being out of support.

- The Trust signed up to implementing this is in late 2014, the system is now live and roll out has commenced nationally.

- PHT are due to go live end July 2016. Currently monthly conference calls to co-ordinate implementation.

- Staff currently identified in Emergency Department and paediatrics to be trained in use of new system.

18. Safeguarding Children Priorities for 2016/17

- Consolidate new ways of working and staffing structure as per external review.

- Deliver/facilitate training across the Trust to increase compliance and evaluate impact in clinical areas. To include clear assessment of levels required in each CSC. To report to Committee progress each quarter.

- On-going audit programme.

19. Equality and Diversity

The Trust ensures that racial heritage; language, religion, faith, gender and disability are taken into account when working with children and young people.

The Trust takes its responsibilities for safeguarding children seriously and would want to assure the public and service users, through the publication of its Safeguarding Children Declaration that the arrangements in place are robust and meet all statutory and good practice requirements. Portsmouth Hospitals NHS Trust will continue to review its arrangements for safeguarding children annually and as required.

20. References

Children Act 1989
Children Act 2004
HM Government (2004) *Every Child Matters, Change for Children.* Nottingham: Department for Education and Skills (DFES).
HM Government (2006) *Information Sharing: Practitioners guide*. London: DFES.
HM Government (2015) Working Together to Safeguard Children. A guide to inter-agency working to safeguard and promote the welfare of children. Nottingham: Department for Education (DfE). TSO
RCPCH (2014) *Safeguarding Children and Young people: roles and competences for health care staff intercollegiate document*. London: RCPC