

**SAFEGUARDING CHILDREN
ANNUAL REPORT 2014 – 2015**

1. Executive Summary

This is the 5th annual report on Safeguarding Children to the Board of Hertfordshire Community NHS Trust. This report supports the regular reports provided to Healthcare Governance Committee and the Board that are submitted on a quarterly basis throughout the year. The purpose of this report is to provide assurance that Hertfordshire Community NHS Trust (HCT) complies with the regulations set out in:

- The Care Quality Commission (CQC) Essential Standards for Quality and Safety (Outcome 7: Safeguarding people who use services from abuse)
- Section 11 of the Children Act 2004
- Working Together 2015

This report demonstrates the scope of the work undertaken by the Safeguarding Children Team, in collaboration with HCT staff, Hertfordshire Safeguarding Children Board and Essex Safeguarding Children Board.

The report outlines the uptake of training and supervision by HCT staff to provide assurance that effective support to Safeguarding Children is in place across Hertfordshire and West Essex.

Throughout 2014/15, HCT continued to contribute to effective multi-agency working by participating in three Serious Case Reviews, two Domestic Homicide Reviews and actively engaging in the steering group to develop the Multi-Agency Safeguarding Hub (MASH).

The Safeguarding Team has worked closely with partners in regard to policy development, training, Rapid Response to Unexpected Child Death and multi-agency audit. This is in addition to the core business of the Safeguarding Team which includes staff supervision, training, audit, advice and provision of the Rapid Response Service. This reflects the Safeguarding Team's commitment to further develop safeguarding children practice across the multi-disciplinary teams of HCT to improve patient safety, patient experience and the quality of care provided.

Key achievements:

- Increase in overall safeguarding training achieving 90% uptake across all services at end of year
- Safeguarding supervision levels consistently above 95%
- CQC inspection acknowledged some 'very good' practices within HCT in regard to training and supervision
- Revision of Children Safeguarding Supervision Policy increasing the frequency of Supervision for Health Visitors and School Nurses from four months to three months
- Rapid Response team successful in nomination for Health Service Journal Award in the category of Compassion reaching the final awards ceremony
- Rapid Response Team recognised by colleagues and nominated for Leading Lights Award
- Safeguarding Nurse Specialist leading on the update of the Bruising Guidance protocol ensuring there are clear pathways, multiagency sign up and a parental information leaflet
- Developed Safeguarding tracker to effectively monitor the progress of outcomes for all audits and actions taken Introduced safeguarding duty system enabling any practitioner to access safeguarding advice within the hour during working hours

- Safeguarding Nurse Manager leading on improved HSCB Graded Care Profile tool and introduction of mandatory training for Health Visitors and School Nurses in response to learning from SCR
- Developed School Nurse and Safeguarding Prioritisation document which has reduced the amount of time that School Nurses spend in CP meetings where there are no active health needs, freeing time for active involvement in the early help agenda
- Developed information leaflet for staff new to the Trust provided on first day of employment to re-enforce safeguarding practice
- Developed aide memoire flow chart posters for referrals enabling staff to have a constant reminder in office
- Achieved successful outcomes following external Section 11 audits to provide assurance to HSCB and ESCB
- Agreement by partners for Named Nurse to join the CDOP panel
- Presentation by Named Nurse at University of Hertfordshire Children's Conference
- Creation of Meridian audit to monitor the quality of safeguarding records quarterly
- Alignment of training to intercollegiate levels with associated training strategy
- Active partner in the MASH steering Group, creating and now hosting the health representative roles in the MASH
- Named Nurse a member of the Safeguarding Vulnerable Adolescents group which has developed close links with HALO
- Compliance with CQUIN requirements and sharing of client stories to staff and the Board
- Maintaining 3 monthly safeguarding peer review for paediatricians
- Maintaining out of hours safeguarding medical examinations
- Implementation of day time safeguarding medical rota for assessment of children suspected of safeguarding concerns

2. Strategic Context

HCT is committed to delivering 'high value healthcare' which provides excellent clinical outcomes, an outstanding patient experience, consistent and improving patient safety and is highly efficient and cost effective. Assurance of robust Safeguarding Children practice is presented at the Safeguarding Children Group reporting to both the Patient Safety & Experience Subcommittee and Healthcare Governance Committee on a regular basis throughout the year. Assurance that HCT is fulfilling its obligations in regard to the Children Act is monitored through the Safeguarding Children Board and Section 11 audits for both Hertfordshire Safeguarding Children Board and Essex Safeguarding Children Board have been successfully completed.

3. Safeguarding Governance Arrangements

Accountability for delivering the corporate Safeguarding Children function is held by HCT's Director of Quality & Governance / Chief Nurse.

The Safeguarding Children Forum provides reports to the Patient Safety & Experience Group which reports to Healthcare Governance Committee, a subcommittee of the Trust Board. The Safeguarding Children Forum meets bi-monthly and receives: group

- An operational overview of safeguarding activity, training data
- Performance against key performance indicators set by commissioners
- Reviews and learning from incidents

- Assurance of compliance with Statutory guidance, national and local recommendations
- Reviews and monitors local actions in regard to Serious Case Reviews, Domestic Homicide Reviews, CQC and HSCB/ESCB audits.
- Reviews risks in relation to safeguarding children in the Trust.
- Minutes of the HSCB and sub groups

Membership includes representation from Operational Services and Governance Directorate.

The Trust is represented at the Hertfordshire Safeguarding Children Board (HSCB) by the Director of Quality & Governance / Chief Nurse and safeguarding leads from the Trust attend all HSCB sub committees.

4. Safeguarding Children Team

The Safeguarding team supports all staff and services across HCT and Children's staff in WE who are employed by HCT. The team consists of:

- 1.0 wte Named Nurse
- 2.0 wte Safeguarding Managers
- 5.75wte Safeguarding Nurse Specialist Nurses, this includes 1.0 wte vacancy
- 0.2 wte Named Doctor safeguarding WH– vacancy currently partly covered by clinical director
- 0.2wte Named doctor safeguarding WE – only 0.1wte covered at present.01wte vacancy

The Safeguarding Nurses offer a county wide service which includes:

- Training to all staff
- Immediate advice and support
- Support and supervision of staff.
- Auditing to ensure safeguarding process and procedures are effective
- Rapid Response service

Each safeguarding supervisor supports approximately 60 members of staff. This has increased from 40 and is due to team restructure, increase in health visiting numbers and the addition of other staff who need supervision.

Since the end of 2014 the team has been working closely with HSCB on the formation of the Multi Agency Safeguarding Hub (MASH). Two posts have been funded by both Hertfordshire commissioners and Public Health to support the new service. The MASH brings together a team of multi-disciplinary professionals from partner agencies. Information is collated to assess risk and decide which agency is the most appropriate to take the lead with the family. As a result, agencies are able to act quickly, in a coordinated and consistent way, ensuring that vulnerable children and families receive help in a timely way.

Despite a challenging year for the team which has included new staff, vacancies, long term sickness, restructuring and the death of a team member, the team has remained strong and continued to provide a robust Safeguarding service to HCT staff via supervision, both 1-1 and group, training and immediate advice and support to clinicians when an urgent safeguarding children concern arises. This framework serves to ensure that HCT staff are

able to identify, assess and provide the relevant support available within the scope of their job role and where this is not sufficient to refer children at risk of harm to the appropriate agency.

In addition to their roles within HCT, the team has provided additional support and strategy development to ensure that multi-agency working is robust, that challenge and the escalation processes are considered and any newly developed safeguarding processes are not compromised.

A close working relationship with Children's Universal Services is being developed. This requires the safeguarding team to work with the wider teams to develop prioritisation documents, multi-agency protocols, robust reporting of safeguarding incidents and work in regard to compliance to the Lampard recommendations resulting from the Saville enquiry. The team are also involved in embedding lessons from SCR/DHR in practice and auditing compliance and working closely with HSCB in the implementation of the Families First agenda which will ensure that families receive support at the earliest point from the correct professionals. This will hopefully continue to reduce the number of children subject to a child protection plan.

The Safeguarding Children Team have ensured that staff are kept informed of relevant safeguarding advice, disseminated through HCT communication systems, staff resource area and via the Children's Service Bulletin. Guidance tools, leaflets and posters have been produced by the team throughout the year to share good practice.

5. Safeguarding Children

Effective safeguarding arrangements take place within a multi-agency framework. HCT works well with its partner agencies at both an operational and strategic level. The Senior Safeguarding Nurses represent HCT on HSCB subgroups and all the Safeguarding Nurses are members of the HSCB training pool and provide their expertise to a wide range of training events and sessions across Hertfordshire.

Since the last annual report there has been a significant decrease in the number of children subject to a plan this currently stands at 911 down from 1034, this is reflective of the Governments plans to offer help to families at an earlier stage. However this is neither reflective nor indicative of the work that the safeguarding team do. The early help agenda encourages multi professional work with families at an earlier stage in the hope that children will not enter the statutory arena. Health Practitioners are therefore required to undertake more robust risk assessments to ensure that the child remains the focus of the work and that any potential increase in risk is acknowledged at the earliest possible time. In turn this requires practitioners to be highly skilled, receive robust supervision and have ready access to specialist advice, especially for newly qualified practitioners.

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

5.1 There have been two Serious Case Reviews commissioned by the HSCB during the year and HCT has also been asked to contribute to a SCR commissioned by Bradford for an ex-Hertfordshire resident. The purpose of a serious case review is to:

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; Improve intra and inter-agency working
- Better safeguard and promote the welfare of children

Current themes emerging include:

- the need for more supervision scrutiny on cases that are in Universal plus (targeted) caseloads
- Consideration of the length of time that an individual practitioner cares for a family to prevent the potential of collusion or loss of professional curiosity
- Impact of organisational change on Practitioners and their teams
- The effect that family culture and practitioner expectation can have on children's outcomes
- The creation of a more supportive network to ascertain the effect that perceived or actual threat from the family has on the practitioner

There have also been two Domestic Homicide Reviews (DHR) commissioned by Hertfordshire Constabulary. These reports review the circumstances in which:

The death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

- a person to whom he was related or with whom he was or had been in
- an intimate personal relationship
- a member of the same household held with a view to identifying the lessons to be learnt from the death

Themes emerging from the reports include:

- record keeping and the need for on-going scrutiny at supervision
- identifying increasing risk in domestic violence cases and what cases should be brought to supervision
- The need for robust risk assessment including raising awareness of the use of risk assessment tools
- Better recording of family groups and relationships

In response to the emerging themes the Supervision policy has been refreshed and updated to address the issues of practitioner selected cases being brought to supervision.

Best practice guidelines for Health Professionals working with children and families in identifying and responding to domestic abuse (2009) are currently being updated to include a risk assessment that will assist practitioners to identify increasing risk. This will be further supported by the newly created Child Protection Policy and the use of the Graded Care Profile.

On-going audits and regular meetings with the Safeguarding Managers and Locality Managers will help strengthen the implementation of the recommendations from these reports.

6. Key Areas of Work during 2014/15

6.1 Performance and management

The principles of an effective and safe service are the identification, assessment and management of risk. The Safeguarding Children Team supports, enables and challenges staff to make safe and effective decisions to safeguard and protect vulnerable children. Measurement of performance and outcomes is therefore complex and includes a variety of factors which include:

- Performance indicators related to training and supervision uptake
- Audit of safeguarding practice
- Risk management
- Review of serious/complex cases
- Responding to HSCB multi-agency action plans
- Reviewing policies to ensure that they are in line with local and national guidance

6.2 Clinical guidelines, best practice and staff education

Training

The Safeguarding Children Team provides well evaluated training programmes which meet local and national requirements, thus ensuring that staff are competent and confident to identify and manage safeguarding concerns safely and effectively.

Training programmes have been aligned with the levels and frequency recommended in the intercollegiate document 2014. In conjunction with this the training strategy and training pathways have also been redesigned to ensure compliance with national and local guidance.

The safeguarding training programme is delivered at different levels and is dependent on the level of contact with children that the staff member has in their daily work. Levels of staff training are aligned to the Intercollegiate Document 2014 (RCPCH 2014).

Staff are encouraged to attend HSCB multi-agency training to raise their awareness of the importance of a multiagency approach to protecting children, support networking and promote effective information sharing. Both training programmes are flexible and are adapted according to local or national requirements and in response to findings from Serious Case Reviews, Partnership Case Reviews, Domestic Homicide Reviews and local and HSCB audit.

There is the on-going need to empower adult workers to complete the level 1 safeguarding training either on line or at adult services staff meetings. The safeguarding team continue to work closely with the adult General Managers to increase compliance and promote a greater awareness of e learning.

There is evidence to suggest there has been an increased awareness of safeguarding concerns and commitment to the child protection process by Allied Health Professionals (AHPs). This has been in response to group supervision and training which has raised awareness of the factors that increase risk to children. This has been demonstrated in the involvement of AHPs seeking advice following safeguarding supervision, increased referrals and the provision of reports and where appropriate, attendance at case conference.

The Trust achieved a good uptake of staff attending the appropriate training in line with the KPI., 90% compliance against a target of 95% for HCT during the period 2014/15 and 97% for WE was achieved. This was against a base line of 83% and 90% respectively.

Supervision

- Robust supervision processes are in place in Hertfordshire and West Essex and uptake continues to be monitored to ensure that this continues to increase
- The Safeguarding Children Supervision policy has been ratified by the Patient Safety & Experience Subcommittee. Supervision frequency had been increased from four monthly to three monthly for Health Visitors and School Nurses and four monthly from six monthly for Allied Health Professionals. In line with the national Service Specification for Health Visiting and recognised best practice 2014/15
- The team have managed to absorb this within current capacity, although this has been a challenge. However the increase in Health Visitor numbers and new services that require safeguarding supervision will need to be addressed in 2015/16 as the volume of supervision is starting to impact on the quality of the supervision and scrutiny that is offered, this was identified in the recent CQC inspection
- A Meridian record keeping quality audit has been developed to look at the standard of safeguarding records. This will be developed further to incorporate the quality of supervision to ensure that the focus remains on the child and that the child's voice is heard

The Trust achieved a good uptake of staff attending supervision at the required level with 98% compliance against a target of 90% for HCT and 99% for West Essex against a target of 80% for 2014/15

Audit of clinical practice

A number of audits have been undertaken by the team against recommendations from national and local reviews, a sample of these can be seen below.

- **Safety Information given by Health Visitors**
This audit looked at information given by health visitors regarding safety issues to mothers at New Birth Visits. This was in response to findings from a SCR. The audit showed the correct advice had been given and documented in 70% of cases. The findings of the audit have been discussed with the Children's Universal Teams. Further audit is planned to ensure compliance with recommended practice.
- **Referral Information to GP**
The audit identifies that 70% of staff had not informed the GP of their referral to social care. The results of the audit have been communicated to all Health Visitors and School Nurses by their Team Leaders. Further joint audit is planned regarding referrals to Children's Services, to check compliance against standards.
- **Movement out**
Due to recent Boundary changes and the increase in transfer of children and recommendations from a recent SCR an audit was completed to look at whether families who had a Child Protection Plan (CPP) and moved out of HCT area were handed over to the new area. This had occurred in 64% of the records accessed; the findings have been discussed with the CUS teams and will be re audited following the recent update of the transfer in/out guidelines.

- **Groups and Relationships**

Audit of groups and relationships and those adults who have Parental Responsibility (PR) for children was completed. This is an issue that had been highlighted from Serious Case Review (SCR). The Father was named on 75% of the records accessed. Of this number 82% were linked to their child's records through groups and relationships and 18% were identified as having Parental Responsibility. The findings have been discussed with the CUS teams will be included in training and re audited.

- **School Nurse Prioritisation Document**

In January the School Nurse Prioritisation document was introduced, this changed the way in which School Nurses worked with children subject to a plan in order to free school nursing time to work with a larger cohort of vulnerable children. An audit was completed at the beginning of June and the data is currently being analysed to ascertain the difference that the prioritisation document has made to the School Nursing Workload. This work was completed at the request of the Commissioners.

- **Audit against SCR/DHR recommendations**

This included a repeat of the 'asking the question' these are a series of questions that are asked to the mother at the maternal mood assessment visit. The aim is to open a forum in which the mother can disclose any concerns in regard to her relationship which may pose a risk to her child. This audit was initially undertaken to test compliance against best practice when working with families experiencing Domestic Abuse as it was raised as an issue in a DHR in 2013. The most recent audit showed that 9% of women countywide are now asked about domestic abuse by their health visitor during the antenatal period, where only 1% had been asked in previous audit. 64 % were seen by a health visitor for a maternal mental health visit six weeks after delivery; this had been 39% before.

The increase in compliance is incremental with the increase in Health Visitors. This has now been included in the 4, 5, 6 elements of the Healthy Child Programme¹ The maternal mood assessment visit is also considered as an opportunity to ask women about domestic abuse. The findings and an action plan have been shared with Children's Universal Service as although there has been an increase there is still room for improvement and this will be re audited during 2015/16.

HCT has participated in multi-agency audit initiated by the HSCB regarding disabled children. Following this a multiagency action plan was developed and HCT has completed all the recommended actions and have been active partners in ESCB peer reviews

Audits have also been undertaken to assure compliance against the Did Not Attend (DNA) Policy and Privacy and Dignity Policy, the raw data is currently being analysed and the results reported back to the Practitioners.

CQUIN

In 2014/15 the Safeguarding Team achieved 100% compliance with the safeguarding CQUIN, Learning from safeguarding concerns. The safeguarding team were required to provide ten patient stories which included evidence of how the patient's voice was sought and heard through the episode of care and the actions that were taken to ensure that lessons learnt were implemented and embedded in practice. There was also a requirement

¹<http://www.england.nhs.uk/ourwork/qual-clin-lead/hlth-vistg-prog/>

to present a story to the Trust Board, present emerging themes and monitor lessons at the Safeguarding Children Committee and to disseminate lessons learnt to a wider staff audience.

Themes emerging from the stories indicated that there was a need to revise the multiagency bruising procedure, communication challenges within the rapid response procedure and with social care. Equally there was clear evidence of good communication in rapid response, communication with Social Care and the safeguarding adult team.

Lessons in regard to the bruising procedure resulted in one of the Safeguarding Nurses taking the lead in the procedure rewrite and parent leaflet. This case was presented to the Trust Board as the baby's mother had contributed to the CQUIN and has subsequently been asked to help in the creation of the parent information leaflet. The CQUIN is attached at Appendix 1 and the presentation is attached at Appendix 2. Lessons and actions from the CQUINS were also shared at the Market Place event that was held as part of the transition process of Health Visitors to the Local Authority.

All actions resulting from the CQUINS are on track to be completed and the regular update in the Children's Service Bulletin continues.

Section 11 Audit / Care Quality Commission

HCT completed two Section 11 audits during the year. These audits were carried out by the Clinical Commissioning Group (CCG) to monitor the strength of provider safeguarding children services against arrangements to safeguard children under Section 11 of the Children Act 2004. Audits were carried out for Hertfordshire and Essex Safeguarding Boards.

Section 11 audits are divided into the following domains: Staffing, Training, Supervision and peer review, Governance, Quality and Risk Management, each of these are further divided into 29 sub sections with comments and supporting evidence.

The findings from this will be incorporated into the 2015/16 audit and work plan for the Safeguarding Children's team.

Hertfordshire Section 11

The Commissioners noted the restructure of the safeguarding children service, which used skill mix to create two band 8A posts across the county who lead on Rapid Response and audit and training, this allowed increased resourcing in adult safeguarding and enables a better joined up service with a greater 'think family' approach. They also commented positively on the band 7 identified practice areas including Child Sexual Exploitation, FGM and the MASH.

The Named Doctor sessions have increased from 1pa to 2pa's per week, HCT were asked to monitor the increased sessions to ensure that they are sufficient to cover the function adequately. The Commissioners were happy with HCT lines of accountability and that the Named Doctor and Nurse have direct access to the Board.

The audit highlighted the number of open SCRs/PCRs, and the impact that this is having on the safeguarding children's team, health visiting team and individual practitioners and there were discussions in regard to key cases in WelHat. Lessons learnt from these reviews were discussed and the Commissioners were reassured that HCT had immediately implemented actions such as changing the transfer-in policy, updating the health visitor plan, additional

external and internal support for the WelHat team including opportunities to de-brief and extra supervision.

Overall the audit found HCT to be compliant with its Section 11 duties and the areas that did present challenge have actions assigned to them, these will be monitored through the Safeguarding Children Forum to ensure compliance during 2015/16.

West Essex Section 11

This electronic audit was completed in December and followed the same domains as the Hertfordshire audit but responses were submitted on line and showed that HCT were 93% compliant with the requirements. Areas of challenge:

- Data base for staff that had undertaken safer recruitment training.
- Ensure that safeguarding training is evaluated.
- Learning from SCR and safeguarding information is cascaded on a regular basis

The above areas have been reviewed and actions assigned to them. Monitoring of compliance takes place via the Children Safeguarding Group and all but one area has been completed.

Care Quality Commission (CQC)

All the actions from the CQC inspection of Safeguarding and Looked after Children 2013 have been successfully completed and agreed with Hertfordshire commissioners.

The recent Care Quality Commission inspection in February 2015 recommended the development of a HCT specific Safeguarding Children Policy.

HCT has historically followed HSCB and SET procedures via the intranet and there are direct links to these policies on the intranet. A new policy is currently being written and will incorporate all the recent changes in Working Together with links to the respective Boards. However it was noted by the CQC that a high quality of training and supervision was provided to staff, further concerns were raised about the standard of record keeping including issues in regard to the quality of safeguarding records. The quality of safeguarding records is tested at each supervision session by the Supervisor, however a formal reporting mechanism was not in place but this will be developed for 2015/16. . A Meridian audit has been created to test the quality of recordkeeping which will be reported quarterly via the trust quality report. Once this is embedded this will be expanded to include the quality of safeguarding supervision.

7. Rapid Response Service

The Rapid Response service is a nurse-led, multi-agency response to enquire and evaluate each unexpected child death. This information is then shared with and forms part of the Child Death Overview Panel (CDOP) process. The focus of the Rapid Response service is to work with partners to help gather information that will assist the investigation to identify how the child died and to provide support to bereaved families. The Safeguarding Children Team are trained as case clinicians in this process and the service is provided from 8am to 8pm every day of the year.

The Rapid Response guidance was updated in May 2015 and has incorporated a Matrix to reduce confusion as to when a Rapid Response should occur and when other aspects of the

process should be considered. Information sharing check list has also been incorporated within the guidance.

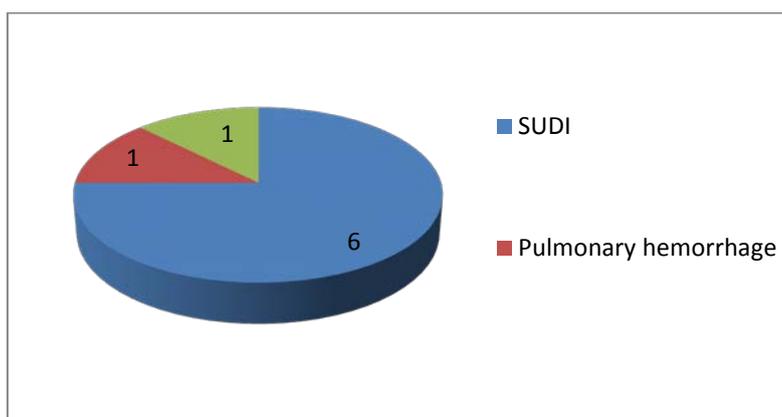
To ensure the clinician's skills are continually updated training on the Rapid Response process was delivered in October 2014 to the whole multi-agency team and was very successfully evaluated. Since this training, the lead has had regular meetings with the Police and an annual Rapid Response update has been agreed and will take place towards the end of the 2015. Training is planned for acute staff and this will be extended to Community Children's Service Locality and Team Managers to ensure they are updated.

Information from the team is collated with that of other agencies; this helps form trends and themes which emerge from the Child Death Overview Panel (CDOP) as lessons learnt and recommendations for the Safeguarding Board. An example of this is the Safe Sleeping leaflet which has been updated to reflect current evidence based best practice. The leaflet will be taken to the CDOP in June 2015 for sign off and funding request. The Named Nurse has recently been asked to join the CDOP.

The table below (generated from HCT Rapid Response data), shows the number of unexpected child deaths over the last 4 years referred to the Rapid Response Nurses and those which were managed as a Rapid Response after assessment.

	2011/2012	2012/2013	2013/2014	2014/2015
Total number of unexpected child deaths reported to team	35	22	25	23
Number of unexpected child deaths managed as a Rapid Response	24	16	21	16
Deaths under 1-year of age	10	5	6	8

Deaths under 1-year of age:



8. Risks

There are currently five risks on the Quality Directorate Risk Register which these are in regard to:

- Safeguarding children training for adult staff, actions are in place to address this and it is anticipated that this risk will be able to be closed soon
- Long term sickness and vacancy in the team which has placed increasing stress on the remaining staff. Measures are now in place to mitigate this and this risk is reducing
- Increased number of staff requiring supervision and the increased frequency of supervision is also recorded; whilst the team can use measures to mitigate this locally, long term a business case will need to be created to increase the number of safeguarding supervisors for the Trust
- Safeguarding capacity issues in medical staff recruitment and these are monitored by the Named Doctor
- Difference in perceived thresholds between medical staff and social care

9. Key Areas for Development in 2015 - 2016

Clinical governance

- Revise and refresh Best Practice Guidelines for Practitioners working with Families where there is Domestic Violence and Abuse
- Work closely with HALO and School Nurses to develop and embed robust practice in the identification of Child Sexual Abuse
- Work with Human Resources to embed safer staff training and develop a data system
- Work with the Risk team to develop a robust pathway for the reporting of all safeguarding children incidents and data capture
- Develop a robust process to capture and report to commissioners on the trust's compliance with training and supervision with Business Intelligence
- Continue to work with Commissioners and HCC on the development of the MASH to ensure that the Health Contribution is robust
- Support and action the findings and recommendations made from SCR and DHR

- Develop strategies to assist Health Visitor and School Nurse team leads to undertake supervision of children subject to plans. This will enable the Safeguarding Children Nurses to focus on families that are held at a targeted level
- Develop a Safeguarding Children Hub in the North and East of the County to ensure that there is adequate supervision and support for the Safeguarding Nurses based in that area
- Work with Clinical Effectiveness Team to undertake an audit of wider Trust understanding and compliance to safeguarding practice.
- Develop closer working practice between Safeguarding Clinical Nurse Manager and CUS Locality Managers to ensure Safeguarding recommendations and work streams are embedded in practice

Policies and guidance

- Develop, review and update the Child Protection Policy in line with local and national guidance including Working Together 2015, Lampard Review 2014, Intercollegiate Document 2014 and other Local and National findings from SCR
- Review and refresh Best Practice Guidelines for Practitioners working with Families where Domestic Violence is an issue and develop a fact sheet, audit compliance
- Review capacity of the safeguarding Children team to undertake re-audits of clinical practice in regard to compliance lessons from SCR/DHR and increased number of practitioners requiring supervision
- Further develop audit programme, working with partners as required
- Continue to provide regular updates in Children Services Bulletin and updates on Notice Board
- Add GCP and CSE risk assessments to SystemOne processes
- Continue to develop and support Operational policies for MASH.

Education and training

- Promote staff access to the local e-learning module in regard to Safeguarding Children
- Continue to monitor service level uptake of training via the Safeguarding Children Committee with a commitment to maintain uptake >95% in clinical staff through a targeted comprehensive training programme
- Review all Safeguarding Children training to ensure that lessons from Serious Case review and national and local guidelines are incorporated and the voice of the child is demonstrated
- Ensure that Safeguarding Children training is aligned to the national skills for health standards and review programme content for all levels to ensure it meets the appropriate competencies for Safeguarding Children
- Pilot implementation of a safeguarding children workbook for staff to record compliance with key competencies in regard to Safeguarding Children
- Work with Human Resources to develop a recording system for Volunteer training compliances in the Trust
- Work with Human Resources to develop a data base of staff who have received safer staffing training
- Work with HSCB in promotional campaigns to raise the awareness of FGM, CSE and PREVENT

- Refresh and maintain staff information pages on intranet, including safeguarding 'pop ups' newsletter and consider developing podcasts on basic safeguarding principles
- Further develop wider Trust understanding of the MASH
- Work with SAFA team to promote think family approach in training
- Develop robust training evaluation pathways which can demonstrate staff compliance

10. Implications for Quality (Patient Safety and Patient Experience) & Regulatory Compliance

HCT is compliant with Care Quality Commission (CQC) requirements and the Section 11 Children Act 2004 demonstrating that the essential quality and safety standards in regard to Safeguarding children and the training and supervision of staff are met. Where deficiencies have been identified these have been escalated and action plans are in place.

11 Conclusion

HCT has continued to demonstrate compliance with national and local directives including CQC regulations.

The work undertaken demonstrates our commitment to meeting the essential quality and safety standards enabling HCT to be registered to provide a high standard of care and work in partnership with other agencies.

Tricia Wren
Deputy Director of Quality & Governance / Deputy Chief Nurse

Dee Harris
Named Nurse Safeguarding Children

July 2015

Date	Report Version	Initials
26-06-15	1	DH
06-07-15	2	DH
30-07-15	3	DH

Appendix 1

SAFEGUARDING CQUIN 2014/15 SERVICE USER STORY PROFORMA

Please complete a separate form for each child or adult who is subject to a safeguarding concern and submit electronically.
In each of your answers you need to EVIDENCE the patient's involvement and how their needs were reflected.

**PLEASE NOTE THAT NO PATIENT IDENTIFIABLE INFORMATION
SHOULD BE GIVEN ON THIS FORM**

Person Completing Form: Health Visitor

Quarter: 3

Date: 22/9/14.

Adult or Child Subject of Safeguarding Concern (Anonymous)	Baby Bruise 1 with Parent story (BB1PS)
1. Please describe the safeguarding concern (include how the safeguarding concern was identified; assessed - what tools were used; & how the patient was involved)	
<p>During the physical examination of a new-born baby in the family home the Health Visitor (HV) noted 2 marks to the baby's abdomen. The parents had no explanation for the marks but felt they were new and looked like bruises. HV was unsure what the presenting marks were and could not rule out bruising as the cause equally there may have also been an underlying medical cause for the marks.</p> <p>The HV understood the need to safeguard the baby and to follow the HCSB bruising policy as this was a pre-mobile baby. She understood the necessity to remain subjective yet supportive to the parents who were clearly upset and concerned by events.</p>	
2. Did the safeguarding concern progress to a referral to the Local Authority? a) If yes, describe the outcome of the referral. b) If no, how was the concern managed?	
<p>(This Incident happened late one Friday afternoon).</p> <ul style="list-style-type: none">• HV informed team members of her intention to follow the bruising policy and also to ensure her own safety as per (lone workers policy).• Telephone referral made to Hertfordshire Children's Services.• Social worker liaison by telephone, Social worker was informed of HV finding. Social worker did not wish to follow the bruising policy and felt that the parents could attend A/E for assessment with the understanding that the parents would go without chaperone and update her on the outcome later that evening by telephone.• HV reiterated to the Social worker her responsibility to follow the HCSB bruising policy and that if she insisted on not following the policy then HV would inform the local Children Safeguarding lead• Team members informed the local Children's Safeguarding Nurse of the telephone conversation between HV and Social worker and that family would be making their own way to AE.• Body map completed in red book.	

- The Social worker would not agree to telephone the Hospital ahead of the family's arrival.
- HV made plans to contact the family on her next working day to discuss outcome and arrange future plan of care.
- HV returned to the office and informed the Children's Safeguarding lead of the above plan made by the social worker.
- Team members worked together to send the electronic follow up referral to Hertfordshire Children's services; this was also attached to system one records.
- System one Body map, icons updated.
- HV was advised by the Children's Safeguarding lead to contact the A/E sister and inform her of the need for a safeguarding medical ahead of the family's arrival.
- A/E contacted as advised.

3. Describe how best practice was achieved and how barriers were identified and managed (e.g. information sharing, multi-agency working, professional challenge, communication with patient and their family/carers).

HV felt confident that she managed the situation in a professional way following Policy and keeping Parents updated as to action required every step of the process.

This experience raised questions regarding having a bruising policy that is not always followed by all agencies. For a less experienced HV this could have influenced their discussion making process leaving them in a vulnerable position by not adhering to the policy

HV later completed a Datix incident form in relation to the HCSB bruising policy not being followed by the social worker.

HV utilised the safeguarding children's lead's support as required.

Team leader and line manager were informed of incident.

HV planned to obtain a patient story, details to be shared with the children's safeguarding team.

Effective Team work was demonstrated.

4. Demonstrate how you worked in partnership with other agencies that were supporting this child/adult?

HV Team worked together to ensure policy was followed and HV in charge of case was supported by her team whilst she was alone in the community setting.

HV did feel that as the policy was not followed this undermined the Health Visitors' professional's judgment and management of set policies and did not reflect a joint up approach to the parents.

5. Was the child/adult given an opportunity to express their wishes or feelings, and how was this captured? If not, why not? And how were their wishes used to influence the process?

Patient story.

lients experience following the Health Visitors need for implementation of the bruising policy on her 14 day old baby.

The Health Visitor explained her rationale for needing to follow the bruising policy. As parents we understood her reasons but did not expect to find ourselves in such a situation. It was difficult because we know that children need to be protected but as parents our main concern was that there was no underlying medical condition that needed attention.

We were concerned for our Daughter.

The Health Visitor was very clear regarding what she needed to do to ensure the policy was followed correctly and explained to us why it was important to follow and what would happen next. She explained that the Social Worker would need to escort us with the baby to have a Paediatric medical; this would then hopefully establish the cause of the marks to her tummy. However when the Social worker was contacted the plan of action appeared to change.

Despite the Health Visitor saying that the policy needed to be followed the Social worker had no intention of escorting us to the medical as suggested by the Health Visitor. The Social Worker said we could go on our own to the GP or A/E department. She refused to contact A/E ahead of our arrival as suggested by the Health Visitor. This was also a concern as we were worried, we would need to explain the background need for a medical upon our arrival. We were also asked by the Social Worker to update her on the outcome of the medical. I have agreed to share my experience as I would like to think it will improve services for others. Professions should be demonstrating a joint up approach to care so that there is no confusion over how these difficult situations are managed.

6. What was the result for the child/adult? And what were their and their family's or advocate's views on the outcome?

The outcome was recorded as a non-specific rash, (HV to establish if baby was seen by a Paediatrician trained to conduct Safeguarding medicals, as this was requested by telephone to the Nurse in Charge of A/E).

(See Patient story above).

7. Detail lessons learnt how have these lessons been shared/implemented with colleagues in your Trust?

HV reflected on this case and discussed in detail with team members.

HV completed a Datix incident form in relation to the HCSB bruising policy not being followed by the social worker; this can then be addressed with appropriate agency.

8. Were all staff concerned aware of the safeguarding processes to follow? Were there training issues highlighted? What actions were taken to address training issues?

The Health Visiting team followed the HCSB policy in this case the Social Work team did not. All HV staff are aware of the bruising policy and now feel happy to challenge Any professional that does not follow the policy.

Following several incidents of similar nature and conversations with Social Care the Bruising Protocol is being updated. The new protocol requires sign up from each agency lead to ensure that their part of the protocol works. The lead for this is a member of the Children's Safeguarding Team.

Signed off by Executive

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Name & Position

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Date:

**PLEASE REMEMBER TO SUBMIT YOUR ACTION PLAN
ADDRESSING ALL ISSUES THAT AROSE FOR ALL CASES
REVIEWED IN THE QUARTER**

Appendix 2



Powerpoint for
Board.pptx Marina.ppt