MEETING DATE:	14th August 21014	NHS North Lincolnshire Clinical Commissioning Group **REPORT TO THE** **CLINICAL COMMISSIONING GROUP** **GOVERNING BODY**
AGENDA ITEM NUMBER:	Item 8.4	
AUTHOR: **JOB TITLE:** **DEPARTMENT:**	Catherine Wylie Director of Risk and Quality Assurance	

SAFEGUARDING ANNUAL REPORTS

PURPOSE/ACTION REQUIRED:	To Receive & Note
CONSULTATION AND/OR INVOLVEMENT PROCESS:	Both reports have been to the NLCCG Quality Group
FREEDOM OF INFORMATION:	*Is this document releasable under FOI at this time? If not why not? (decision making guide being developed) - yes* Public

1. PURPOSE OF THE REPORT:

The purpose of the report is to provide the North Lincolnshire CCG Governing Body with the assurance on safeguarding arrangements across North Lincolnshire

2. STRATEGIC OBJECTIVES SUPPORTED BY THIS REPORT:

Continue to improve the quality of services	**X**
Reduce unwarranted variations in services	
Deliver the best outcomes for every patient	**X**
Improve patient experience	**X**
Reduce the inequalities gap in North Lincolnshire	

3. ASSURANCES TO THE CLINICAL COMMISSIONING GROUP

Please list out the assurances being given to the CCG from both internal sources, e.g. CSU, and external sources, e.g. CQC/Auditors, as they relate to your terms of reference.

This report has been reviewed by the North Lincolnshire CCG Quality Group. Provides assurance to the Governing Body that it is following its duties in relation to safeguarding responsibilities

4. IMPACT ON RISK ASSURANCE FRAMEWORK:	**Yes**		**No**	**X**
5. IMPACT ON THE ENVIRONMENT – SUSTAINABILITY:	**Yes**		**No**	
N/A				
6. LEGAL IMPLICATIONS:	**Yes**	**X**	**No**	
Supports the CCG compliance with statutory duties				
7. RESOURCE IMPLICATIONS:	**Yes**		**No**	**X**
8. EQUALITY IMPACT ASSESSMENT:	**Yes**		**No**	
N/A				
9. PROPOSED PUBLIC & PATIENT INVOLVEMENT AND COMMUNICATIONS:	**Yes**		**No**	
N/A				
10. RECOMMENDATIONS:				
The CCG is asked to: - • Receive and note				

Safeguarding Vulnerable Adults

NHS North Lincolnshire CCG Annual Report

2013-2014

Contents

1 Introduction

1.1 All Vulnerable Adults have a right to live lives free from abuse and neglect. CCGs have a duty to take measures to safeguard patients who are unable to protect themselves from abuse and neglect in their commissioned services. This includes working within a multi-agency framework to take measures to reduce the risk of neglect and abuse and responding where abuse has occurred or is suspected of occurring.

1.2 Local Safeguarding Adults Boards are the multi -agency partnerships, led by the Local Authority, that lead local safeguarding arrangements. CCGs should be active members of this partnership.

1.3 CCGs have duties to take additional measures in establishing effective structures for safeguarding within their organisation. This includes the development of a clear strategy, robust governance arrangements and Leadership across the local health economy.

1.4 Due to changes of key personnel, this Annual Report sets out NHS North Lincolnshire's achievements in meeting its responsibilities for Safeguarding Vulnerable Adults for the period October 2013 to March 2014.

2 Current Context

2.1 The draft Care and Support Bill (July 2013) sets out how health, in partnership with the care and support system, will work within a clear framework to protect Vulnerable Adults from abuse or neglect. It is anticipated that the Commencement Order for this Bill when it receives Royal Ascent will be 1st April 2015. Key Legislation and guidance supporting Safeguarding Adults during transition from the current position of "No Secrets" (2000) the draft Care and Support Bill (2013) to the implementation of the Care Act (2014) are the Mental Capacity Act (2005), No Secrets (2000), Health and Social Care Act (2012), Human Rights Act (1998) and Deprivation of Liberty Safeguards (2007). The NHS Constitution through the Health and Social Care Act (2012) provides a statutory duty to continually seek to improve the quality of care to patients and to treat individuals with dignity and respect in accordance with their Human Rights.

2.2 It will become a legal requirement of each Local Authority to set up a Safeguarding Adults Board (SAB) formalising the arrangements already existing in North Lincolnshire. In addition:

- The Boards must include the Local Authority, NHS and Police who will discuss and act upon any local safeguarding issues
- They must work with the local people to develop plans to protect the most vulnerable adults
- They must publish plans and review them annually and report on progress, allowing different organisations to ensure they are working together in the best way possible.
- The objective of the SAB is to help and protect adults in North Lincolnshire and the way in which a SAB must seek to achieve its objective is by co-ordinating and ensuring the effectiveness of what each of its members does.
- A SAB may do anything which appears to it to be necessary or desirable for the purpose of achieving its objective.

2.3 A SAB should arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if it meets the criteria within the Care and Support Bill (2013).

2.4 Each member of the SAB should co-operate in and contribute to the carrying out of these reviews with a view to:

- Identifying the lessons to be learnt and
- Applying those lessons to future cases.

2.5 Safeguarding Adults: The Role of NHS Commissioners (DH 2011) sets out the core responsibilities in making safeguarding adults part of commissioning. Lessons learnt from inquiries at Mid Staffordshire Foundation Trust and Winterbourne View highlighted the need to make safeguarding integral to care. Prevention and effective responses need to be addressed within all aspects of commissioning including:

- Make Safeguarding a strategic objective
- Put patients first in how services are commissioned and assured
- Lead a culture that safeguards patients
- Use systems and processes that support safeguarding and connect aligned areas
- Develop partnerships with patients, public and multi-agency partners.
- Use robust assurance to understand and improve safeguarding adults arrangements.

2.6 Safeguarding Adults: An Aide Memoire for Clinical Commissioning Groups (2013) provides guidance in relation to commissioner duties to safeguard adults in all aspect of their commissioning. This includes establishing effective structures for safeguarding within their service with a clear strategy, robust governance and a competent workforce that can lead and develop safeguarding across the local health community. In order to ensure that safeguarding is integral across their commissioning cycle, CCGs must ensure all their commissioned services:

- Support patients to reduce risks of neglect and abuse – according to the patients' informed choices
- Reduce risks of abuse and neglect occurring within their service through the provision of high quality, person centred care
- Identify and respond to neglect and abuse in line with local multi-agency safeguarding procedures

3 Key Professionals

3.1 Different arrangements existed between April 2013 and October 2013 within the CCG. The Chief Officer for Quality took the lead for Safeguarding for the CCG and was the CCG representative on the SAB. The Designated Officer for Safeguarding Adults was a joint appointment with North Lincolnshire and Goole Hospitals Trust. The split in allocated time for this post was 0.6 WTE for North Lincolnshire and Goole Hospitals Trust and 0.2 WTE for NHS North Lincolnshire.

3.2 In October 2013 the Chief Officer for Quality and Safeguarding Adults Lead retired and a new appointment was made to Director of Risk and Quality Assurance with the Leads for Safeguarding Adults and the Mental Capacity Act. The role also encompassed being the NHS North Lincolnshire representative on the SAB.

3.3 In April 2013 North Lincolnshire PCT was dissolved in line with the new NHS Architecture and NHS North Lincolnshire CCG became responsible for commissioning NHS services within North Lincolnshire. As part of the action planning for the transition from PCT to CCG it was decided to employ a Designated Nurse for Safeguarding Adults, hosted by North Lincolnshire CCG, across both North and North East Lincolnshire. This role would mirror that of the Designated Nurse for Safeguarding Children across the region. Whilst funding and agreements were obtained the Designated Officer continued in his capacity as 0.2 WTE Designated Officer for North Lincolnshire. In October 2013 the Designated Nurse for Safeguarding Adults was employed working 0.5 WTE in both North and North East Lincolnshire. This purpose of this role was to:

- Provide Clinical Leadership across the health community
- Ensure safeguarding is embedded within the commissioning process
- Provide Clinical Advice to the SAB
- Provide Assurance to CCG Boards on CCG and Multi-agency processes in safeguarding adults.

4 Accountability and Structure

4.1 NHS North Lincolnshire CCG's Chief Officer has the overall accountability for Safeguarding Vulnerable Adults with the responsibility for ensuring the contribution by health services to safeguarding and promoting the safety of adults at risk and vulnerable people.

4.2 The Director of Risk and Quality Assurance, reporting to the CCG Chief Officer, is the Executive Lead for Safeguarding Adults across North Lincolnshire. As a member of the SAB and CCG Board they take the responsibility for ensuring that Safeguarding is embedded across the health community, operationally delivered through local commissioning

arrangements. As part of the Quality Group they are responsible for the monitoring of Safeguarding Adults Governance processes, reporting any risks or achievements to the CCG Board and Chief Officer.

4.3 The Designated Nurse for Safeguarding Adults, reporting to the Director of Quality, provides clinical advice to the SAB and its sub groups. This role provides Clinical Leadership across the health community giving assurance on CCG and multi-agency processes via the CCG Quality Group

4.4 The Named GP for Safeguarding Adults sits within the CCG to ensure appropriate arrangements are in place within primary care service and the distribution of any lesson learnt.

5 Governance and Statutory Arrangements

5.1 As from October 2013, the Executive Lead for Safeguarding Adults sits on the Local Safeguarding Adults Board in North Lincolnshire, Chairs the Quality Group of the CCG and sits on the CCG Board. In addition both the Executive Lead and Designated Nurse for Safeguarding Adults contribute to the operational work of the SAB, attend its appropriate sub groups and report back to the CCG to disseminate any lessons learnt or to influence any agreed commissioning decisions.

5.2 As from October 2013, the Designated Nurse for Safeguarding Adults sits on the Serious Case Review Sub Group. This Group meets on a monthly basis but can be called when needed. Referrals to this group are taken from any source. A decision is made, on behalf of the SAB, as whether or not the case meets the criteria currently in the Care and Support Bill (2013) to go forward for a Safeguarding Adults Review. This decision is then presented to the SAB.

5.3 The Designated Nurse for Safeguarding Adults attends the Safer Neighbourhoods Operational Group. The decision would be made at this meeting to conduct a Mental Health Homicide Review or Domestic Homicide review.

5.4 Should a Safeguarding Adults Review, Domestic Homicide Review or Mental Health Homicide Review be conducted the Designated Nurse for Safeguarding Adults is responsible for the completion and submission of any Health Overview Report or Health Summary document needed by NHS England.

5.5 The Executive Lead attends the Regional Quality Surveillance Group.

5.6 The Executive Lead and the Designated Nurse for Safeguarding Adults attend the Regional Safeguarding Forum led by the NHS England Area Team.

5.7 The Designated Nurse for Safeguarding Adults attends the Regional Designated Nurses Forum.

6 Safeguarding Monitoring

6.1 "No Secrets" (DH 2000) gave the Local Authority lead responsibility for coordinating local multi agency systems, policies and procedures to protect vulnerable adults from abuse. "Clinical Governance and Adult Safeguarding; *An Integrated Process*" (DH 2010) (Appendix 1) sets out guidance to encourage organisations to develop local robust arrangements to ensure that safeguarding becomes fully integrated into NHS systems. The outcome of this would be to create greater openness and transparency about clinical incident, learn from safeguarding concerns that occur with the NHS, clarity on reporting and more positive partnership working.

6.2 In North Lincolnshire all Safeguarding Alerts are directed through the Local Authority Adult Protection Team. Alerts are triaged at this point against the Association of Directors of Adult Social Services (ADASS) criteria. Where cases meet certain criteria a multi-agency Strategy Meeting is called of all involved agencies. A decision is made at this meeting to proceed to investigation and the roles and responsibilities of participating agencies within that investigation. Following investigation a multi-agency Case Conference is called to determine the outcome of the investigation. The outcome is either, unsubstantiated, partially substantiated or substantiated.

6.3 The Designated Nurse for Safeguarding Adults attends both the Strategy Meeting and Case Conferences as appropriate. Where cases of abuse are substantiated, the Designated Nurse for Safeguarding Adults takes responsibility to ensure any Health associated actions for improvement identified are monitored, completed and outcome measured.

7 Safeguarding Adults Reviews

7.1 During the period October 2013 to March 2014, North Lincolnshire has not commissioned any multi agency Safeguarding Adults Reviews, Domestic Violence Reviews or Mental Health Homicide Reviews.

7.2 Following a cluster of Suicides with North Lincolnshire Mental Health Services provided by RDaSH a referral was made for consideration by the Serious Case Review Sub Group. Whilst acknowledging that the referral did not meet the criteria within the Care and Support Bill (2013) (Appendix 2), further reports were requested to establish if any themes and trends identified would meet the criteria for an alternative review.

8 Commissioned Services

8.1 All commissioned services are required to have current Safeguarding Vulnerable Adults Policies and Procedures in place adhering to DH and/or ADASS guidance and best practice.

8.2 Work has commenced, via NHS England and the Safeguarding Adults Network, to agree core contractual standards to be included in the 14/15 Contract round. These are included as Appendix 3.

8.3 Core Providers within North Lincolnshire have Named Nurses to lead on Safeguarding Adults. Monthly one to one meetings take place between the Named Nurses and the Designated Nurse for Safeguarding Adults.

9 Independent Providers (Nursing/Care Homes)

9.1 Responsibility for the commissioning of Nursing/Care homes within North Lincolnshire rests with the Local Authority. NHS NL CCG have a shared responsibility for the quality within these homes.

9.2 Monthly meetings take place with the Local Authority Safeguarding Lead, Local Authority Quality and Performance Team, Designated Nurse for Safeguarding Adults and CQC to share local intelligence and actions on failing homes. Multi agency plans are put in place at this meeting to drive up the quality of any failing home. Where unsuccessful multi agency plans can be put in place to decommission places within those homes.

9.3 Within North Lincolnshire there have not been any closures or decommissioning of places within Nursing/Care Homes during the period October 2013 to March 2014.

10 Independent Providers Primary Care Services

10.1 Responsibility for the commissioning and contracting of Primary Care Services moved from NHS NL PCT to NHS England as from 1st April 2013. NHS NL CCG have a shared responsibility for the quality of these services.

10.2 The Named GP for Safeguarding Adults ensures appropriate arrangements are in place within GP Practices and the distribution and monitoring of any lessons learnt.

10.3 The Designated Nurse for Safeguarding Adults liaises with NHS England to ensure any alert regarding Primary Care Services follows due process as per the North Lincolnshire Safeguarding Adults Board multi agency policy and procedures.

11 Safeguarding Training

11.1 It was recognised that the regional Computer Based Learning System module on Safeguarding Vulnerable Adults was not fit for purpose. The Designated Nurse for Safeguarding Adults has commenced work jointly with other Designated Nurses, to review this module to bring it up to date with current guidance and legislation to be rolled out in 14/15.

12 Future Objectives/Challenges

12.1 During 2014/15 work will continue to ensure that NHS NL and their Commissioned Services have robust and fit for purpose, policies, processes and procedures to implement the requirements of the Care Act 2014 and it subsequent Safeguarding Adults Guidance.

12.2 The Care Act 2014 sets out a statutory framework for adult safeguarding which stipulates the responsibilities of the Local Authority in establishing a Safeguarding Adults Board of which the CCG is a statutory member.

12.3 The Safeguarding Adults Board must publish a strategic plan after consultation with the Local Healthwatch organisation and the Community. The strategic plan must detail what each member must do to implement that strategy.

12.4 The Safeguarding Adults Board must publish an Annual Report detailing what it, and each of its individual members, has done to achieve its objective and implement the strategy. As part of the Annual Report the Safeguarding Adults

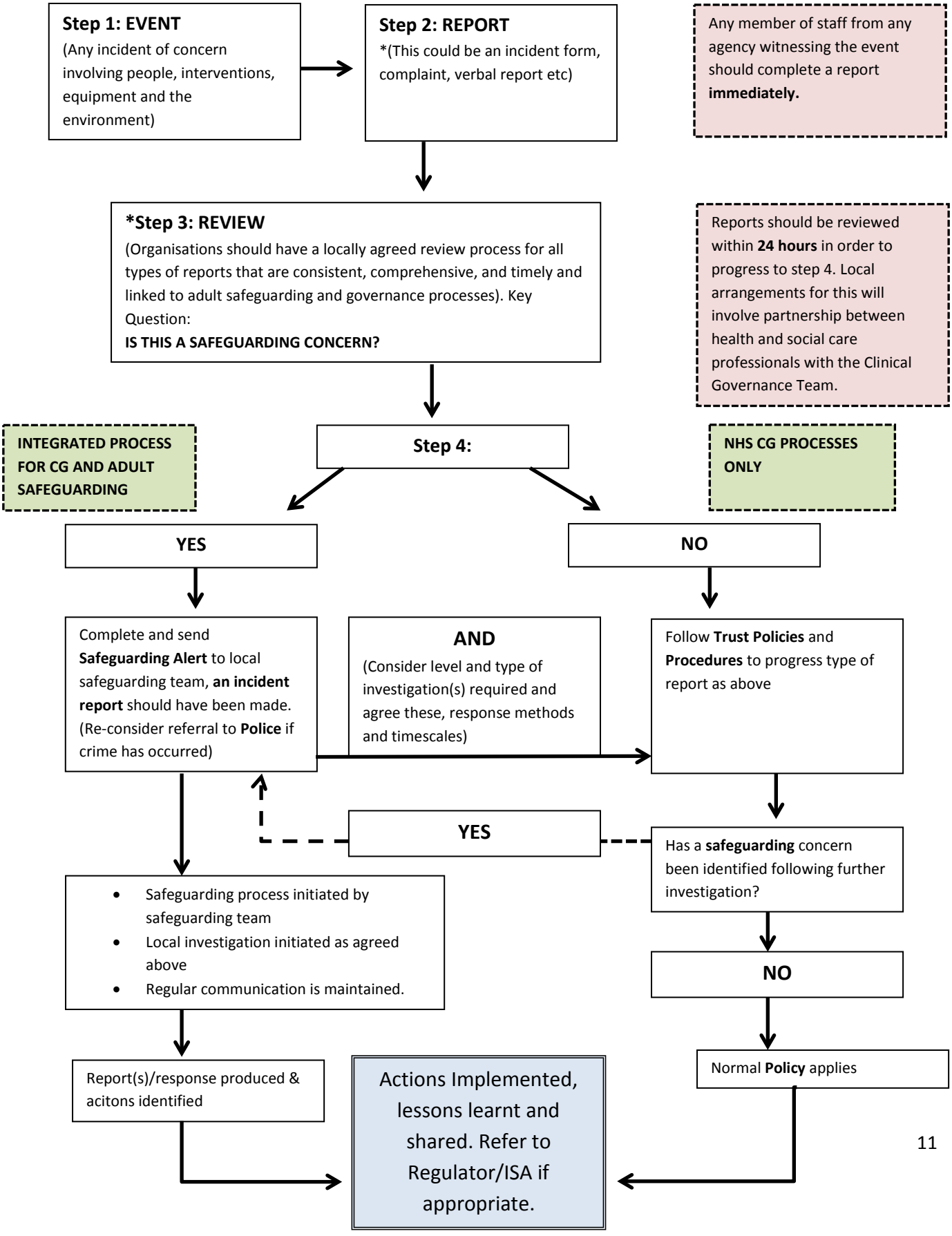
Board must detail any Safeguarding Adults Reviews that have concluded in that year or are on-going at the end of the year. It must detail what it, and its members, have done to implement any findings of Reviews and where a decision was taken not to implement those findings the reason for that decision.

Deborah Pollard
Designated Nurse for Safeguarding Adults
NHS North Lincolnshire CCG
9th July 2014

APPENDIX 1

Clinical Governance and Adult Safeguarding – An Integrated Process

(DH 2010)



APPENDIX 2

Care and Support Bill (2013)

44 Safeguarding adults reviews

(1) An SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

(2) Condition 1 is met if—

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) Condition 2 is met if—

(a) the adult is still alive, and

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

(4) An SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

(5) Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to—

(a) identifying the lessons to be learnt from the adult's case, and

(b) applying those lessons to future cases.

APPENDIX 3

SELF DECLARATION : SAFEGUARDING ADULTS AND CHILDREN and PREVENT

These standards are regularly reviewed by the Yorkshire and Humber Safeguarding Adults and Children Networks and take account of relevant contemporary reports and guidelines. This includes Winterbourne View, Francis enquiry recommendations and the Savile inquiry.

Provider ..... **Completed by.....** **Date .....**

RED: Not Compliant. AMBER: Partially Compliant. GREEN: Fully Compliant

1	**Policy and procedures**	**RAG rating**	**Summary of evidence if compliant**
1.1	The Provider will ensure that it has up to date organisational safeguarding children and adults policies and procedures which reflect and adhere to the Local Safeguarding Children Board (LSCB) and Local Safeguarding Adults Board (LSAB) policies		
1.2	The Provider will ensure that organisational safeguarding policies and procedures give clear guidance on how to recognise and refer child / adult safeguarding concerns and ensure that all staff have access to the guidance and know how to use it.		

1.3	The Provider will ensure that all relevant policies and procedures are consistent with and referenced to safeguarding legislation, national policy / guidance and local multiagency safeguarding procedures.		
1.4	The Provider will ensure that all policies and procedures are consistent with legislation / guidance in relation to Mental Capacity Act 2005 and consent, and that staff practice in accordance with these policies.		
1.5	The Provider will have an up to date 'whistle-blowing'/ Raising Concerns procedure, which is referenced to local multiagency procedures and covers arrangements for staff to express concerns both within the organisation and to external agencies. The provider must have systems in place to demonstrate that all staff are aware of their duties, rights and legal protection, in relation to whistle-blowing/Raising Concerns and that they will be supported to do so.		
1.6	The providers of care homes and hospitals will have an up to date policy and procedure covering the Deprivation of Liberty Safeguards 2009, and will ensure that staff practice in accordance with the legislation.		
1.7	NHS Trusts and all providers of hospitals and care homes will have an up to date policy(s) and procedure(s) covering the use of all forms of restraint. These policies and procedures must adhere to contemporary best practice and legal standards.		

1.8	The Provider will ensure that there is a safeguarding supervision policy in place and that staff have access to appropriate supervision, as required by the provider or professional bodies.		
1.9	All providers will ensure that they have relevant policies and procedures in place to ensure appropriate access to advocacy within the care setting, including use of statutory advocacy roles. These policies and procedures must adhere to contemporary best practice and legislation.		
1.10	The Provider must have a procedure which is accessible to all staff, consistent with the Prevent Guidance and Toolkit 2011. The procedure must clearly set out how to escalate Prevent related concerns and how to make a referral		
2	**Governance**		
2.1	The Provider will identify a person(s) with lead responsibility for safeguarding children and safeguarding adults. For NHS Bodies / Trusts, this will be a Board-Level executive Director with lead responsibility for safeguarding children and adults		
2.2	The NHS Bodies / Trusts will also have in post a named health or social care professional (s) for adult and children safeguarding with sufficient capacity to effectively carry out these roles		
2.3	The Provider will review the effectiveness of the organisations safeguarding arrangements at least annually and will identify any risks, service improvement requirements and learning points as well as areas of good practice.		
2.4	NHS Trusts / Bodies will identify a named health or social care professional with lead responsibility for ensuring the effective implementation of the Mental Capacity Act and Deprivation of Liberty Safeguards.		

2.5	The Provider must ensure that there is a system for monitoring complaints, incidents and service user feedback, in order to identify and share any concerns of abuse (including potential neglect), using multiagency safeguarding procedures.		
2.6	NHS Bodies / Trusts will ensure that there is an effective system for identifying and recording safeguarding concerns, patterns and trends through it's governance arrangements including; risk management systems, patient safety systems, complaints, PALS and human resources functions, and that these are referred appropriately according to multiagency safeguarding procedures.		
2.7	NHS Trusts should identify and analyse the number of complaints and PALs contacts that include concerns of abuse or neglect and include this information in their annual safeguarding or complaints report reviewed by their board		
2.8	The Provider must ensure that there are systems for capturing the experiences and views of service users in order to identify potential safeguarding and issues and inform constant service improvement.		
2.9	Providers of hospitals and care homes, will ensure that there are effective systems for recording and monitoring Deprivation of Liberty applications to the authorising body/Court of protection		
2.10	The Provider will review the effectiveness of the organisations safeguarding arrangements at least annually.		
2.11	NHS bodies / Trusts must have in place robust annual audit programmes to assure itself that safeguarding systems and processes are working effectively and that practices are consistent with the Mental Capacity Act (2005).		

2.12	All providers will have appropriate and effective systems in place to ensure that any care provided, is done so with due regard to all contemporary legislation. This includes, but is not restricted to, the Human Rights Act, Mental Capacity Act and Mental Health Act.		
2.13	The Provider will, where required by the local safeguarding board(s), consider the organisational implications of any Serious Case Review(s) and will devise and submit an action plan to the local responsible safeguarding board to ensure that any learning is implemented across the organisation.		
2.14	NHS Provider Trusts will identify an Executive Lead with responsibility for Prevent		
2.15	Providers will identify an Operational Lead for Prevent and ensure that they are appropriately authorised and resourced to deliver the required National and Local standards		
2.16	NHS Trusts and larger Independent Providers will ensure that implementation of the Prevent agenda is monitored through the audit cycle		
3	**Multiagency working**		
3.1	The Provider will cooperate with any request from the Safeguarding Boards to contribute to multi-agency audits, evaluations, investigations and Serious Case Reviews, including where required, the production of an individual management report		
3.2	The Provider will, where required by the local safeguarding board(s), consider the organisational implications of any multiagency review(s) and will devise and submit an action plan to the local responsible safeguarding board to ensure that any learning is implemented across the organisation.		

3.3	The Provider will ensure that any allegation, complaint or concern about abuse from any source is managed effectively and referred according to the local multi-agency safeguarding procedures.		
3.4	The Provider will ensure that a root cause analysis is undertaken for all pressure ulcers of grade 3 or 4, and that a multi-agency referral is made where abuse or neglect are believed to be a contributory factor.		
3.5	The Provider will ensure that all allegations of neglect or abuse against members of staff (including staff on fixed-term contracts, temporary staff, locums, agency staff, volunteers, students and trainees) are referred according to local multi-agency safeguarding procedures.		
3.6	The Provider will ensure that organisational representatives / practitioners make an effective contribution to safeguarding case conferences / strategy meetings where required as part of multiagency procedures.		
3.7	The Provider will where required, ensure senior representation on the Local Safeguarding Children Board and Local Safeguarding Adults Board and contribution to their sub-groups.		
4	**Recruitment and employment**		
4.1	The Provider must ensure safe recruitment policies and practice which meet contemporary NHS Employment Check Standards in relation to all staff, including those on fixed-term contracts, temporary staff, locums, agency staff, volunteers, students and trainees.		
4.2	The Provider will ensure that Post recruitment employment checks are repeated in line with all contemporary national guidance and legislation.		

4.3	The Provider must ensure that their employment practices meet the requirements of the Disclosure and Barring Service (DBS) and that referrals are made to the DBS and relevant professional bodies where indicated, for their consideration in relation to barring.		
4.4	The Provider should ensure that all contracts of employment (including staff on fixed-term contracts, temporary staff, locums, agency staff, volunteers, students and trainees) include an explicit reference to staffs responsibility for safeguarding children and adults.		
4.5	The Provider will ensure that all safeguarding concerns relating to a member of staff are effectively investigated, and that any disciplinary processes are concluded irrespective of a person's resignation, and that 'compromise agreements' are not be allowed in safeguarding cases.		
5	**Training**		
5.1	The provider will ensure that all staff and volunteers undertake safeguarding children and adults training appropriate to their role and level of responsibility and that this will be identified in an organisational training needs analysis and training plan.		
5.2	The Provider will ensure that all staff, contractors and volunteers undertake safeguarding children and adults awareness training on induction, including information about how to report concerns within the service or directly into the multi-agency procedures.		

5.3	The Provider will ensure that all staff who provide care and/or treatment, undertakes training in how to recognise and respond to abuse (How to make an alert) at least every 3 years. This includes staff who undertake assessments and reviews of patients or their care.		
5.4	The Provider will ensure that all staff members (including staff on fixed-term contracts, temporary staff, locums, agency staff, volunteers, students and trainees) who provide care or treatment, have an understanding of the principles of the Mental Capacity Act 2005 and consent processes, appropriate to their role and level of responsibility, at the point of induction.		
5.5	The Provider will ensure that all staff and volunteers undertake Mental Capacity Act 2005 and consent training, including the Deprivation of Liberty Safeguards appropriate to their role and level of responsibility and that this will be identified in an organisational training needs analysis and training plan.		
5.6	The Provider will undertake regular training needs analysis to determine which groups of staff require further safeguarding children training in accordance with the intercollegiate document.		
5.7	NHS providers will undertake a regular comprehensive training needs analysis to determine which groups of staff require more in depth safeguarding adults training. As a minimum this will include all professionally registered staff with team leadership roles undertaking multiagency training in how to recognise and respond to abuse where this is available.		
5.8	The Provider will ensure a proportionate contribution to the delivery of multiagency training programmes as required by local safeguarding boards.		

5.9	The Provider must have a training plan that identifies the • Prevent related training needs for all staff • A programme to deliver HealthWRAP • Sufficient HealthWRAP facilitators		

Safeguarding Commissioners Standards: Remedial Action Plan				
Standard No.	Action(s) required to achieve standard	Person Responsible	Date Due	Comments / Progress

Annual Safeguarding Children Report 2013-2014

1. Introduction

1.1. Section 11 of the Children Act 2004 places a duty upon all NHS bodies along with partner agencies to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children.

1.2. NLCCG Governing Body has responsibility for ensuring that this duty is appropriately discharged. This report identifies the arrangements in place in order to provide the required assurance that the above duty is being effectively discharged.

2. Legislative and Statutory Framework for Safeguarding Children in place in 2013-2014

2.1. The underpinning legislation for safeguarding children arrangements in England is contained within the Children Act 1989, the Children and Adoption Act 2002 and the Children Act 2004. The Safeguarding Vulnerable Groups Act 2006 also has a significant impact in terms of the recruitment of staff and the need to establish procedures to meet the requirements of the Act.

2.2. The key document outlining the statutory duties to safeguard children is Working Together to Safeguard Children (Department of Education, 2013). This set out how all agencies and professionals should work together to promote children's welfare and protect them from harm. The guidance provides a national framework within which each organisation needs to agree local arrangements.

2.3. Safeguarding and promoting the welfare of children is defined, in 'Working Together to Safeguard Children' 2013 as:

- protecting children from maltreatment;
- preventing impairment of children's health or development;
- ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and
- taking action to enable all children to have the best outcomes.

2.4. Safeguarding Children is everyone's responsibility. Under section 11 of the Children Act 2004, and amended by the Health and Social Care Act 2012, Clinical Commissioning Groups, as a commissioners of services have a statutory duty to ensure that those who work on their behalf carry out their duties in such a way as to safeguard and promote the welfare of children. The key features of section 11 are:

- a clear line of accountability for the commissioning and/or provision of services designed to safeguard and promote the welfare of children;
- a senior board level lead to take leadership responsibility for the organisation's safeguarding arrangements;
- a culture of listening to children and taking account of their wishes and feelings, both in individual decisions and the development of services;
- arrangements which set out clearly the processes for sharing information, with other professionals and with the Local Safeguarding Children Board (LSCB);
- a designated professional lead (or, for health provider organisations, named professionals) for safeguarding. Their role is to support other professionals in their agencies to recognise the needs of children, including rescue from possible abuse or neglect. Designated professional roles should always be explicitly defined in job descriptions. Professionals should be given sufficient time, funding, supervision and support to fulfil their child welfare and safeguarding responsibilities effectively;
- safe recruitment practices for individuals whom the organisation will permit to work regularly with children, including policies on when to obtain a criminal record check;

- appropriate supervision and support for staff, including undertaking safeguarding training:
    - employers are responsible for ensuring that their staff are competent to carry out their responsibilities for safeguarding and promoting the welfare of children and creating an environment where staff feel able to raise concerns and feel supported in their safeguarding role;
    - staff should be given a mandatory induction, which includes familiarisation with child protection responsibilities and procedures to be followed if anyone has any concerns about a child's safety or welfare; and
    - all professionals should have regular reviews of their own practice to ensure they improve over time.
- clear policies in line with those from the LSCB for dealing with allegations against people who work with children. An allegation may relate to a person who works with children who has:
    - behaved in a way that has harmed a child, or may have harmed a child;
    - possibly committed a criminal offence against or related to a child; or
    - behaved towards a child or children in a way that indicates they may pose a risk of harm to children.

3. CCG Responsibilities and Statutory Duties

3.1. CCGs have statutory duties issued under s16 of the Children Act 2004. Guidance in respect to these duties is set out in Working Together to Safeguard Children (2013)[1.] Clinical commissioning groups as the major commissioners of local health services are responsible for safeguarding quality assurance through contractual arrangements with all provider organisations.

3.2. The role and responsibilities of CCGs are further clarified in the Safeguarding Accountability and Assurance Framework[2] published in March 2013.

- CCGs (along with NHS England) are statutorily responsible for ensuring that the organisations from which they commission services provide a safe system that safeguards children …. This includes specific responsibilities for looked after children and for supporting the Child Death Overview process, to include sudden unexpected death in childhood.
- CCGs (and NHS England) have a statutory duty to be members of Local Safeguarding Children Boards (LSCBs), working in partnership with local authorities to fulfil their safeguarding responsibilities.
- CCGs should ensure that robust processes are in place to learn lessons from cases where children […] die or are seriously harmed and abuse or neglect is suspected. This will include contributing fully to Serious Case Reviews (SCRs) which are commissioned by LSCBs and also, where appropriate, conducting individual management reviews. Health organisations should also consider carefully any requests from an LSCB for information which is relevant to a SCR.
- CCGs need to work closely with NHS England, and, in turn, with local authorities and LSCBs, to ensure there are effective NHS safeguarding arrangements across each local health community, whilst at the same time ensuring absolute clarity

[1] HM Government (2013) Working Together to Safeguard Children. HMSO, London

[2] NHS Commissioning Board (2013) Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework

about the underlying statutory responsibilities that each commissioner has for the services that they commission.

NHS England, in addition to their responsibilities as commissioners of services, are also responsible for ensuring that the health commissioning system as a whole is working effectively to safeguard and improve the outcomes for children and adults at risk and their families, and thus promotes their welfare. It provides oversight and assurance of CCGs' safeguarding arrangements and supports CCGs in meeting their responsibilities. This includes working with the Care Quality Commission (CQC), professional regulatory bodies and other national partners.

3.3. The role of CCGs and, indeed, the NHS CB is about more than just managing contracts and employing expert practitioners. It is about working with others to ensure that critical services are in place to respond to children and adults who are at risk or who have been harmed, and it is about delivering improved outcomes and life chances for the most vulnerable

CCG Arrangements

3.4. In order for CCGs to demonstrate they are discharging their responsibilities in respect to safeguarding children, they are required to have the following in place:

- Plans to train their staff in recognising and reporting safeguarding issues
- A clear line of accountability for safeguarding, properly reflected in the CCG governance arrangements
- Appropriate arrangements to co-operate with local authorities in the operation of LSCBs and health and wellbeing boards
- Ensuring effective arrangements for information sharing
- Securing the expertise of designated doctors and nurses for safeguarding children and for looked after children and a designated paediatrician for unexpected deaths in childhood

4. Safeguarding Arrangements in North Lincolnshire

Designated Professionals

Guidance

4.1. CCGs are required to employ, or have in place, a contractual agreement to secure the expertise of Designated Professionals, i.e. Designated Doctors and Nurses for Safeguarding Children and for Looked after Children (and Designated paediatricians for unexpected deaths in childhood).

- Where a Designated Professional (most likely a Designated Doctor for Safeguarding Children or Designated Professionals for Looked after Children) is employed within a provider organisation, the CCG needs to have a Service Level Agreement with the provider organisation that sets out the practitioner's responsibilities and the support they should expect in fulfilling their Designated role.
- Whatever arrangements are in place for designated professionals, clear accountability and performance management arrangements are essential. Line management sits with the CCG's Executive Lead for Safeguarding.

4.2. Designated Professionals, as clinical experts and strategic leaders, are a vital source of advice to the CCG, NHS England, the local authority and the LSCB, and of advice and support to other health professionals in provider organisations.

4.3. CCGs need to demonstrate that their Designated Professionals are embedded in the clinical decision making of the organisation, with the authority to work within local health economies to influence local thinking and practice. It should also be recognised that they will be expected to give clinical advice, for example in complex cases or where there is dispute between practitioners.

4.4. The role of Designated Professionals for safeguarding children should always be explicitly defined in job descriptions, and sufficient time, funding, supervision and support should be allowed to enable them to fulfil their child safeguarding responsibilities effectively.

Local Arrangements

4.5. NLCCG employs a full time Designated Nurse for Safeguarding Children, who is shared with North East Lincolnshire Clinical Commissioning Group. The Designated Doctor for safeguarding Children is employed by Northern Lincolnshire and Goole NHS Foundation Trust with a Service Level Agreement in place to provide the Designated function for 1.5 PA per week for NLCCG. Details of the Designated Professionals for Safeguarding Children in North Lincolnshire in 2013-2014 can be found at Appendix 1. During the 2013-14 year it was recognised that additional nursing capacity was required to work across the 2 localities. At 31st March 2014, NLCCG, in collaboration with NELCCG, had begun the process for the recruitment of a full-time experienced nurse to work with the Designated Nurse across the two health economies.

4.6. As per paragraph 4.1, NLCCG has also secured the expertise of Designated Professionals for Looked after Children, and Designated Paediatrician capacity for unexpected deaths in childhood.

- Details of arrangements for Looked after Children are not included in this report, but in the Annual Report for Looked after Children arrangements
- Arrangements for paediatric capacity for unexpected deaths are included at Section 6 of this report.

Named Professionals

Guidance

4.7. All providers of NHS funded health services including NHS Trusts, NHS Foundation Trusts and public, voluntary sector, independent sector and social enterprises should identify a Named Doctor and a Named Nurse (and a Named Midwife if the organisation provides maternity services) for safeguarding. In the case of NHS 111, ambulance trusts and independent providers, this should be a named professional. GP practices should have a lead and deputy lead for safeguarding, who should work closely with Named GPs. Named Professionals have a key role in promoting good professional practice within their organisation, providing advice and expertise for fellow professionals, and ensuring safeguarding training is in place. They should work closely with their organisation's safeguarding lead, designated professionals and the LSCB.[3]

4.8. The role of Named Professionals for Safeguarding Children should always be explicitly defined in job descriptions, and sufficient time, funding, supervision and support should be allowed to enable them to fulfil their child safeguarding responsibilities effectively.

Local Arrangements

4.9. There has been sustained capacity in the Named Nurse, Doctor and Midwife functions for all providers in 2013/2014.

4.10. Northern Lincolnshire and Goole NHS Foundation Trust has Named Nurses, and a Named Doctor for North Lincolnshire

- NLaG has Specialist Nurses who support the Named Nurse functions.

4.11. RDaSH has both Named Nurse and Named Doctor.

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[3] Model job descriptions for designated and named professional roles can be found in the intercollegiate document *Safeguarding Children and Young People: roles and competences for health care staff*.

4.12. The Named Doctor for Primary Care has 1 session per week in this role. There has been a need to prioritise the actions required of this role.

4.13. East Midlands Ambulance Service have an identified Safeguarding Lead (both adult and children) with 5 deputies (who act as Named Professionals) to support activity across their area. The Named Professional for North Lincolnshire is shared with North East Lincolnshire and the County of Lincolnshire.

4.14. Full details of the Named Professionals in North Lincolnshire in 2013-2014 are included in Appendix 1.

Executive Lead for Safeguarding

4.15. The responsibility for safeguarding children rests ultimately with the Chief Officer. However, as with the majority of health organisations, an Executive Lead for Safeguarding is identified in NLCCG. In 2013-2014, the Executive Lead for Safeguarding was:

- Senior Officer for Quality and Assurance (April – August 2013)
- Director of Risk and Quality Assurance (September 2013 – March 2014)

and provided strategic safeguarding children advice to the Governing Body.

4.16. The Executive Lead for Safeguarding was a member of North Lincolnshire Safeguarding Children Board throughout 2013-2014.

NLCCG Governance and Assurance Arrangements

4.17. The Quality Group (QG) has the lead responsibility for monitoring commissioning safeguarding children arrangements and met monthly. Exceptional events were reported via the QG and where appropriate included on the Risk Register, and if had been necessary would have been added to the Board Assurance Framework.

4.18. The Designated Nurse has reported to each QG meeting and highlighted issues where they have arisen. From January 2014, the Designated Nurse has provided a monthly briefing report to the Quality Group.

4.19. The Designated Nurse facilitated a Governing Body workshop on Safeguarding Children Arrangements in June 2013.

4.20. Until March 2013, the Designated Nurse for Safeguarding Children provided assurance/ compliance reports to NHS Yorkshire and Humber on minimum standards in respect to safeguarding children assurance in commissioning and provider health organisations. Whilst NHS England North Yorkshire and Humber Area Team have not required similar assurance reports, the Designated Nurse has continued to use the framework to gather assurance on commissioner and provider arrangements. The position at March 2014 is included at Appendix 2.

5. North Lincolnshire Safeguarding Children Board

Role and Functions

5.1. The Children Act 2004 (section 13) requires each local authority to establish a Local Safeguarding Children Board (LSCB) for their area and specifies the organisations and individuals (other than the local authority) that should be represented on LSCBs.

5.2. Section 14 of the Act sets out the objectives of LSCBs, as:

(a) to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and

(b) to ensure the effectiveness of what is done by each such person or body for those purposes.

5.3. The core functions of an LSCB are set out in regulations[4] and are:

- developing policies and procedures including those on:
  - action taken where there are concerns about the safety and welfare of a child, including thresholds for intervention;
  - training of people who work with children or in services affecting the safety and welfare of children;
  - recruitment and supervision of people who work with children; investigation of allegations concerning people who work with children;
  - safety and welfare of children who are privately fostered; and
  - co-operation with neighbouring children's services authorities (i.e. local authorities) and their LSCB partners.
- communicating and raising awareness;
- monitoring and evaluating the effectiveness of what is done by partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve;
- participating in the planning of services for children in the area of the authority; and
- undertaking reviews of serious cases and advising partners on lessons to be learned.

5.4. In order to fulfil its statutory function under regulation 5 an LSCB should use data and, as a minimum, should:

- assess the effectiveness of the help being provided to children and families, including early help;
- assess whether LSCB partners are fulfilling their statutory obligations;
- quality assure practice, including through joint audits of case files involving practitioners and identifying lessons to be learned; and
- monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children.

NLSCB Priorities 2012-2015

5.5. NLSCB has identified 3 key priorities

- Reduce the harm from exploitation of children and young people
- Provide early help to children and young people
- Support effective parenting capacity

Membership

5.6. The Children Act 2004 (section 13) identifies the Board partners who must be included in the LSCB. At least one representative of the local authority and each of the other Board partners set out below (although two or more Board partners may be represented by the same person), The statutory membership includes

- NHS England and Clinical Commissioning Groups;

[4] Regulation 5 of the Local Safeguarding Children Board Regulations 2006

- NHS Trusts and NHS Foundation Trusts all or most of whose hospitals, establishments and facilities are situated in the local authority area;

5.7. Members of an LSCB should be people with a strategic role in relation to safeguarding and promoting the welfare of children within their organisation. They should be able to:

- speak for their organisation with authority;
- commit their organisation on policy and practice matters; and
- hold their own organisation to account and hold others to account.

5.8. The LSCB should either include on its Board, or be able to draw on appropriate expertise and advice from, frontline professionals from all the relevant sectors. This includes the Designated Nurse and Doctor for Safeguarding Children.

5.9. NLCCG has been represented on North Lincolnshire Safeguarding Children Board (NLSCB) by the Senior Officer for Quality and Assurance, then Director of Risk and Quality Assurance throughout the 2013-4 year. The Designated Nurse and Doctor attended each LSCB meeting as professional advisors to the Board during the year. In addition, the Designated Nurse is the Chair of NLSCB Serious Case Review Subcommittee, and as such is an ex-officio member of the Board.

5.10. In addition to the representation from NLCCG, NLSCB has representation from Northern Lincolnshire and Goole NHS Foundation Trust and Rotherham, Doncaster and South Humber NHS Foundation Trust. NHS England North Yorkshire and Humber Area Team have not attended any meetings of NLSCB in 2013/14 year and were represented by the NLCCG representative in accordance with a Memorandum of Understanding.

5.11. The work of the NLSCB Board has been supported through a number of key function/action groups

- Performance Action Group
- Child Death Overview Panel
- Serious Case Review Committee
- Quality Assurance Group
- Safe Practice Group
- Communications Group

The Designated Nurse ensures appropriate health commissioning and provision membership.

LSCB Monitoring and Evaluation Function

5.12. In fulfilment of its function to monitor and evaluate the effectiveness of what is done by partners individually and collectively to safeguard and promote the welfare of children, NLSCB requested each partner organisation to submit a report on their arrangements in 2013-2014, to form part of the overarching Annual Review Report. Each organisation was required to provide an account of:

- how effectively they had fulfilled its statutory responsibilities.
- the effectiveness of help (including early help) in the local area.
- their contribution to the effective functioning of the LSCB
- the progress made on key LSCB priorities
- Challenges and priorities for 2014-2015

NLCCG's submission is replicated at Appendix 3.

6. Review Processes

Child Death Overview Process

6.1. One of the LSCB functions is to review the deaths of all children who are normally resident in their area by:

a) collecting and analysing information about each death with a view to identifying—

(i) any case giving rise to the need for a review mentioned in regulation 5(1)(e);
(ii) any matters of concern affecting the safety and welfare of children in the area of the authority;
(iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and

(b) putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

6.2. In order to assist in the completion of this function, CCGs are required to employ , or have arrangements in place to secure the expertise of, consultant paediatricians whose designated responsibilities are to provide advice on:

- commissioning paediatric services from paediatricians with expertise in undertaking enquiries into unexpected deaths in childhood, and from medical investigative services; and
- the organisation of such services.

6.3. NLSCB have had access to consultant paediatrician capacity as outlined above, but via a collaborative approach., The consultant paediatrician on call at the time of an unexpected death acts as the lead clinician for the rapid response and case review process for each individual case; with the Designated Doctor taking a lead role in terms of acting as medical advisor to the Child Death Overview Panel, and assisting in trend analysis.

6.4. During the year the Paediatricians have picked up a more significant role in supporting the rapid response and Child Death processes, starting to chair/lead meetings within 3 working days of a child's death, and following the results of final post mortem.

Serious Case and Learning Lessons Reviews

6.5. No multi-agency Serious Case Reviews have been completed by NLSCB in 2013/4. However, in the year, NLSCB Serious Case Review Committee has received a number of referrals for consideration, but has made the decision that none met the criteria for a SCR.

6.6. In the 2012/13 year, the SCR subcommittee decided that a Learning Lessons Review be completed on a case. The final report from this review was presented to NLSCB in June 2013.

Safeguarding Children Serious Incidents

6.7. An outstanding Safeguarding Children Serious Incident report was completed in June 2013.

7. Care Quality Commission Child safeguarding and looked after children inspection programme

7.1. In September 2013, The Care Quality Commission (CQC) announced a programme of reviews into how health services keep children safe and contribute to promoting the health and wellbeing of looked after children and care leavers.

7.2. The programme began on 30th September 2013, and will run to April 2015. From April 2015, it is anticipated that the CQC will join with

- Ofsted

- Her Majesty's Inspectorate of Probation
- Her Majesty's Inspectorate of Constabulary
- Her Majesty's Inspectorate of Prisons

to undertake multi-agency inspections.

7.3. The review will use powers under Section 48 of the Health and Social Care Act 2008 to conduct this review, and will focus on:

- Evaluating the quality and impact of local health arrangements for safeguarding children.
- Improving healthcare for children who are looked after.

and will look at the quality and effectiveness of the arrangements that health care services have made to ensure children are safeguarded and how health services promote the health and wellbeing of looked after children and care leavers, with a local authority area. The reviewers will case track individual children in each area.

7.4. North Lincolnshire health services were not subject to a review by the Care Quality Commission in the 2013/2014 year. However, key themes have been drawn from the reviews completed to date in other localities in England, and the CCG will look to incorporate relevant themes into the work plan for the 2014/2015 year.

7.5. NHS England have completed an exercise to identify the key themes in the first 8 published reports, which was published in early April 2014. The text of this review is replicated at Appendix 4.

7.6. Key issues (in relation to safeguarding arrangements) which arise include:

- Clarity in respect to GPs role and responsibility to safeguard children
- Where GPs and other health providers share the same information system, information sharing in relation to vulnerable families is more effective
- Gaps in proactive information sharing between health services
- Lack of curiosity in some services to establish and assess risks.
- Some ‘adult’ services do not always effectively share information or concerns in a timely fashion
- Risks that support needs of adult override those of child, and the ‘Think Family’ approach is not routinely embedded in practice.
- Safeguarding children supervision not routine in some ‘adult’ services.
- Lack of ability by some health services to articulate risk when referring into children’s social care
- Under-use of assessment for early identification of vulnerable children, leading to late recognition and often the need for more resource intensive interventions.
- Gaps in identification/recording of all significant adults in ‘child’s world’, particularly men.
- Alert/flagging systems in relation to vulnerable children and parents are not routinely robust.
- Insufficient capacity in Tier 4 CAMHS and, where available, often distant from child/ young person’s home.
- Arrangements in some services for safeguarding and promoting the welfare of young people aged 16 and 17 are not as robust as for under 16s.
- Capacity of Named and Designated Professionals

There are also a number of issues which have been identified in respect to arrangements for Looked After Children which are included in Appendix 4, but not listed above.

7.7. The Designated Nurse along with colleagues in NLCCG and health providers will utilise the learning from these and subsequently published reviews to benchmark North Lincolnshire health services.

8. Safeguarding Children issues highlighted within the North Lincolnshire health economy: 2013-2014

Challenges in Safeguarding Children Assurance/Compliance

8.1. At 31st March 2013, NLaG were reporting 52% uptake on Level 1 Safeguarding Children Training. Through the 2013/14 year, NLaG have addressed this with a robust recovery plan, and by March 2014, more than 80% of staff had received training at Level 1, 2 or 3, commensurate with their role and responsibilities.

Provision of Forensic Paediatric Service for children who have experienced sexual harm.

8.2. Children who have experienced sexual harm require specialist paediatric forensic examinations, by a clinician who has the skills/ competencies identified The Royal College of Paediatrics and Child Health Faculty of Forensic and Legal Medicine Guidelines on Paediatric Forensic Examinations in Relation to Possible Child Sexual Abuse. These skills/competencies once acquired need to be maintained by the completion of paediatric forensic examinations on a regular basis.

8.3. There are insufficient numbers of examinations required to maintain the competence of paediatricians working in Northern Lincolnshire. Therefore, children resident in North Lincolnshire require examinations completed outside the locality, but as near as possible to Northern Lincolnshire.

8.4. The responsibility to secure sufficient capacity to undertake these assessments is the responsibility of NHS England. With effect from December 2013, all North Lincolnshire children who have required paediatric forensic examinations following possible child sexual abuse, have been seen by appropriately competent clinicians in Hull and East Yorkshire Hospitals' Trust.

9. Programme of Work for NLCCG in 2014-2015

9.1. The work plan for the 2014-2015 is based on:

- Embedding safeguarding children arrangements for the CCG are in line with the NHS England Safeguarding Accountability and Assurance Framework
- Learning from the CQC review programme on a national basis

9.2. Key priorities for 2014-15 include:

- Supporting the quality arrangements required in primary care and other independent contractor services.
- Development and roll out of safeguarding supervision strategy for Northern Lincolnshire health economy (in collaboration with North East Lincolnshire CCG)
- Development of safeguarding children training strategy for Northern Lincolnshire health economy (in collaboration with North East Lincolnshire CCG)
- Embedding the monitoring of safeguarding children arrangements for all provider health services.

Sarah Glossop

17th July 2014.

Appendix 1. Safeguarding Professional Leadership in North Lincolnshire for the period April 2013 – March 2014

North Lincolnshire Clinical Commissioning Group

Designated Doctor	Dr Suresh Nelapatla
Designated Nurse	Sarah Glossop
Named GP	Dr Robert Jaggs-Fowler

Northern Lincolnshire & Goole NHS Foundation Trust

Named Doctor	Dr Onajite Etuwewe
Named Nurse (Acute)	Sue Kidger
Named Nurse (Community)	Jane Westoby/Lisa Robinson
Named Midwife	Sharon Humberstone
Head of Safeguarding	Craig Ferris

Rotherham, Doncaster & South Humber Mental Health NHS Foundation Trust

Named Nurse (North Lincs)	Sam Davies
Named Doctor (trustwide)	Dr Navjot Ahluwalia

East Midlands Ambulance Service

Safeguarding Lead	Danielle Burdett
Named Professional (North/North East & County of Lincolnshire)	Paul Benton

Appendix 2 – Safeguarding Children Assurance – March 2014.

Until March 2013, Primary Care Trusts were required to ensure the compliance with Minimum Standards in respect to their own Safeguarding Children Arrangements, and that of providers for whom they were lead commissioners. PCTs were then required, through their Designated Nurse, to provide exception reports to NHS Yorkshire and Humber (NHS North of England) on a quarterly basis in respect to gaps in this compliance.

Such reporting arrangements were not required of CCGs by NHS England in the 2013/14. However, the Designated Nurse has continued to use the framework to identify gaps in assurance in order to report to Quality Group.

The Minimum Standards are:

1. The Trust meets the statutory requirement of carrying out Disclosure and Barring Service checks on relevant employees.
2. Child protection policies and systems are up to date and robust.
3. A process is in place for following up children who miss outpatient appointments.
4. An alert system is in place to flag up children whose safeguarding is of concern.
5. All staff working in health care settings (clinical and non-clinical) have undertaken level 1 safeguarding training.
6. A training plan has been developed for staff that will require more in depth training e.g. levels 2 or 3.
7. A named doctor is in place with a clear job description and sufficient capacity
8. Named nurse is in post with a clear job description and sufficient capacity
9. Where the organisation provides maternity services named midwifery is in place with sufficient capacity
10. Board level Executive Director Lead for safeguarding has been identified.
11. The Board reviews safeguarding arrangements on an annual basis at minimum.
12. Robust audits are in place to ensure safeguarding systems and processes are functioning effectively.
13. Where children's services are provided, a designated paediatrician for SUDI is in post with clear JD

For Commissioners, there are 5 further standards:

14. PCTs have robust performance monitoring systems in place for all providers, including the independent sector, in relation to safeguarding.
15. PCTs ensure that GP practices and staff have robust systems and practices in place to ensure they can fulfil their role in safeguarding children.
16. Designated nurse is in post with clear JD
17. Designated doctor is in post with clear JD and SLA with the commissioner
18. Designated doctor and nurse for LAC in post with clear JDs and SLAs with the commissioner

The following document provides an overview of how NLCCG/ NLaG and RDaSH were performing as of 31st March 2014.

Organisation	Requirement No.	Assurance Requirements	Compliance Status*	Compliance Comments & Remedial Action
NLCCG	1	The Trust meets the statutory requirement of carrying out Disclosure & Barring Service checks on relevant employees.	**G**	All relevant staff have been subject to standard or enhanced DBS checks on appointment or on change of role within the organisation.
NLCCG	2	Child protection policies and systems are up to date and robust.	**G**	NLCCG has a current safeguarding children policy, which incorporates Safeguarding Children through Commissioning of Services policy. The policy is compliant with national and local multi-agency guidance and is reviewed in line with national guidance as available.
NLCCG	3	A process is in place for following up children who miss outpatient appointments.	**G**	The Safeguarding Children through Commissioning of Services Policy sets a standard for all providers to ensure they have a process for following up children who miss outpatient appointments.
NLCCG	4	An alert system is in place to flag up children whose safeguarding is of concern.	**G**	Flags/Icons are available on SystmOne and other electronic record systems to alert users to children who may be vulnerable.
NLCCG	5	All staff working in health care settings (clinical and non-clinical) have undertaken level 1 safeguarding training.	**G**	All staff have completed training to level 1.
NLCCG	6	A training plan has been developed for staff that will require more in depth training e.g. levels 2 or 3.	**G**	A Governing Body development session was delivered in June 2013. The Designated Nurse has accessed training/development through regional/ national networks.
NLCCG	7	A named doctor is in place with a clear job description and sufficient capacity	**G**	A Named GP is in place.
NLCCG	8	Named nurse is in post with a clear job description and sufficient capacity	**N/A**	

Organisation	Requirement No.	Assurance Requirements	Compliance Status*	Compliance Comments & Remedial Action
NLCCG	9	Where the organisation provides maternity services named midwifery is in place with sufficient capacity	**N/A**	
NLCCG	10	Board level Executive Director Lead for safeguarding has been identified.	**G**	The role of Board Executive Director Lead is fulfilled by the Director of Risk & Quality Assurance
NLCCG	11	The Board reviews safeguarding arrangements on an annual basis at minimum.	**G**	NLCCG Governing Body received 2012/2013 Annual Report in August 2013
NLCCG	12	Robust audits are in place to ensure safeguarding systems and processes are functioning effectively.	**G**	NLCCG work collaboratively with NLSCB and provider health services to ensure appropriate audits are supported and completed. NLCCG actively participates in multi-agency scrutiny via s11 audits.
NLCCG	13	Where children's services are provided, a designated paediatrician for SUDI is in post with clear JD	**G**	The paediatric input into Child Death processes is secured from NLaG.
NLCCG	14	CCGs have robust performance monitoring systems in place for all providers, including the independent sector, in relation to safeguarding.	**G**	NLCCG has a Safeguarding Children through Commissioning of Services Policy which outlines expected standards along with performance measures of all providers.
NLCCG	15	CCGs ensure that GP practices and staff have robust systems and practices in place to ensure they can fulfil their role in safeguarding children.	**G**	The Named GP and Designated Nurse work together to support GP practices in fulfilling their role in safeguarding children.
NLCCG	16	Designated nurse is in post with clear JD	**G**	Full time (shared with NELCCG) Designated Nurse in post. Job Description of postholder is in keeping with RCPCH led Intercollegiate Competency Framework.
NLCCG	17	Designated doctor is in post with clear JD and SLA with the commissioner	**G**	Designated Doctor in post with RCPCH consistent Job Description. Employed by NLaG but with SLA for 1.5 sessions per week.

Organisation	Requirement No.	Assurance Requirements	Compliance Status*	Compliance Comments & Remedial Action
NLCCG	18	Designated doctor and nurse for LAC in post with clear JDs and SLAs with the commissioner	G	Designated Doctor and Nurse for LAC in post – both employed by NLaG
NLaG	1	The Trust meets the statutory requirement of carrying out Disclosure & Barring Service checks on relevant employees.	G	All staff employed have been subject to Disclosure & Barring Service checks on appointment, or change of role within the organisation.
NLaG	2	Child protection policies and systems are up to date and robust.	G	The organisation has a current safeguarding children policy which is consistent with both national and local guidance.
NLaG	3	A process is in place for following up children who miss outpatient appointments.	G	The organisation has reviewed and refreshed its policy for the management patients who miss both hospital and community outpatient appointments, to ensure that vulnerable children are identified and there is a proactive process for follow up.
NLaG	4	An alert system is in place to flag up children whose safeguarding is of concern.	G	All acute and community electronic recording systems have available flags for children for whom there are safeguarding concerns. Paper records used within the acute setting are also flagged to alert staff to children who are known to be vulnerable.
NLaG	5	All staff working in health care settings (clinical and non-clinical) have undertaken level 1 safeguarding training.	G	84% of staff requiring training to Level 1 are up to date. 80% of staff requiring training to Level 3 are up to date.
NLaG	6	A training plan has been developed for staff that will require more in depth training e.g. levels 2 or 3.	G	A current training plan is in place for all Safeguarding Children training.
NLaG	7	A named doctor is in place with a clear job description and sufficient capacity	G	NLaG have separate Consultant Paediatrician/Named Dr for the North Lincolnshire & Goole area, and North East Lincolnshire area.
NLaG	8	Named nurse is in post with a clear job description and sufficient capacity	G	3 wte. Named Nurses are in post within NLaG: 1wte for North East Lincolnshire Acute services, 1wte for North Lincolnshire Acute services, 1 wte for North Lincolnshire Community services.

Organisation	Requirement No.	Assurance Requirements	Compliance Status*	Compliance Comments & Remedial Action
NLaG	9	Where the organisation provides maternity services named midwifery is in place with sufficient capacity	G	1.0 wte Named Midwife is in post for the organisation covering maternity services in North Lincolnshire, North East Lincolnshire and Goole.
NLaG	10	Board level Executive Director Lead for safeguarding has been identified.	G	The Chief Nurse is the Executive Director Lead for safeguarding children.
NLaG	11	The Board reviews safeguarding arrangements on an annual basis at minimum.	G	An annual report is presented to the Trust Board.
NLaG	12	Robust audits are in place to ensure safeguarding systems and processes are functioning effectively.	G	A programme of audits is in place. The programme includes regular audit of recording systems, training and supervision arrangements, along with audits identified as a result of internal and multi-agency learning lessons reviews.
NLaG	13	Where children's services are provided, a designated paediatrician for SUDI is in post with clear JD	G	A team approach is taken to sudden unexpected deaths, where the Consultant of the Week acts as SUDIC for Rapid response purposes. The Designated Doctor takes the co-ordinating role and sits on the LSCB CDOP
RDaSH	1	The Trust meets the statutory requirement of carrying out Disclosure & Barring Service checks on relevant employees.	G	All staff employed have been subject to Disclosure & Barring Service checks on appointment, or change of role within the organisation.
RDaSH	2	Child protection policies and systems are up to date and robust.	G	The organisation has a current safeguarding children policy which is consistent with both national and local guidance.
RDaSH	3	A process is in place for following up children who miss outpatient appointments.	G	The organisation has a robust process for following up children who fail to attend CAMHS appointments in North Lincolnshire.
RDaSH	4	An alert system is in place to flag up children whose safeguarding is of concern.	G	Alert/flagging systems are in place to identify children for whom safeguarding is a concern, as well as appropriate systems for identifying where there are vulnerable children in the acre of service users.

Organisation	Requirement No.	Assurance Requirements	Compliance Status*	Compliance Comments & Remedial Action
RDaSH	5	All staff working in health care settings (clinical and non-clinical) have undertaken level 1 safeguarding training.	G	The organisation's Level 1 training figures are consistently above 95%, with staff turnover, and periods of staff absence accounting for the gap from full compliance.
RDaSH	6	A training plan has been developed for staff that will require more in depth training e.g. levels 2 or 3.	G	A training plan is in place to provide more in depth training where required, with uptake at Level 2 and Level 3 being consistently in excess of 85%
RDaSH	7	A named doctor is in place with a clear job description and sufficient capacity	G	A Named Doctor is in place supporting all RDaSH services.
RDaSH	8	Named nurse is in post with a clear job description and sufficient capacity	G	RDaSH has a team comprising 5.2 wte Named Nurses who provide support to their services in 5 localities. 1.8wte of this team are based in North Lincolnshire, and provide support to their North and North East Lincolnshire services, as well as part of Doncaster.
RDaSH	9	Where the organisation provides maternity services named midwifery is in place with sufficient capacity	N/A	
RDaSH	10	Board level Executive Director Lead for safeguarding has been identified.	G	The Director of Nursing/Deputy Chief Executive is the Trust Board Lead for Safeguarding, supported by the Deputy Director of Nursing.
RDaSH	11	The Board reviews safeguarding arrangements on an annual basis at minimum.	G	The Trust Board receives an Annual Report into Safeguarding Arrangements, along with quarterly updates.
RDaSH	12	Robust audits are in place to ensure safeguarding systems and processes are functioning effectively.	G	A programme of audits is in place. The programme includes regular audit of recording systems, training and supervision arrangements, along with audits identified as a result of internal and multi-agency learning lessons reviews.
RDaSH	13	Where children's services are provided, a designated paediatrician for SUDI is in post with clear JD	N/A	

Appendix 3. North Lincolnshire Safeguarding Children Board Annual Review Report 2013-2014

North Lincolnshire Clinical Commissioning Group

Effectiveness of NLCCG in meeting statutory responsibilities

Under the provisions of the Health and Social Care Act 2012, from April 2013, North Lincolnshire Clinical Commissioning Groups (NLCCG) became responsible for commissioning most healthcare services for North Lincolnshire residents. The commissioning responsibility for some services which the predecessor Primary Care Trust – NHS North Lincolnshire – had been accountable transferred to other organisations:

- For most local public health services responsibility transferred to North Lincolnshire Council, supported by Public Health England.
- Health visiting services transferred to NHS England until April 2015
- Primary medical care (GP services) and other primary care services i.e. NHS dentistry, pharmacy and optometry services transferred to NHS England, though CCGs have a duty to support improvements in the quality of primary medical care.

There are also a range of other services which are directly commissioned by NHS England:

- specialised services,
    - i.e. those provided in relatively few settings, accessed by comparatively small numbers of patients but with catchment populations of usually more than one million. These services are located in specialised centres that can recruit a team of staff with the appropriate expertise and enable them to develop their skills, and maintain their competences
- offender healthcare and
- services for members of the armed forces.

As well as ensuring that they as an organisation meet the statutory duties under s11 Children Act 2004, as a commissioner of services, NLCCG is responsible for ensuring that the organisations from which they commission services provide a safe system that safeguard children at risk of abuse or neglect.

To ensure statutory responsibilities remained clear through the transitions in NHS structures from April 2013, the NHS Commissioning Board (now NHS England) published Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework in March 2013. NLCCG has worked within this framework which is consistent with s11 duties, and Working Together 2013 to maintain their focus on robust safeguarding arrangements.

As with all organisations the final accountability for safeguarding children arrangements within NLCCG laid with the Chief Officer. However, as with the majority of health organisations, a Governing Body level Executive Lead for Safeguarding,

- Senior Officer for Quality and Assurance (April – August 2013)
- Director of Risk and Quality Assurance (September 2013 – March 2014)

was identified by NLCCG and provided strategic safeguarding children advice to the Governing Body.

CCGs are required to secure the strategic professional expertise through the availability of Designated Nurse and Doctor for Safeguarding Children. Whilst these professionals should be employed by the CCG (or secured via specific Service Level Agreements from a provider), they have the authority to work across the entire local health economy to influence local thinking and practice. They will be expected to give clinical advice, for example in complex cases or where there is dispute between practitioners. As clinical experts and strategic leaders, they are a vital source of advice to their CCG, NHS England, Local Authorities, the LSCB and the health and wellbeing board, and of advice and support for other health professionals in provider organisations.

In 2013-14, NLCCG had a full time Designated Nurse shared with neighbouring North East Lincolnshire Clinical Commissioning Group (NELCCG). The Designated Doctor was employed by Northern Lincolnshire and Goole Hospitals' NHS Foundation Trust with a Service Level Agreement in place to NLCCG to provide the Designated function for 1.5 Programmed Activity[5] per week for NLCCG. During the 2013-14 year it was recognised that additional nursing capacity was required to work across the 2 localities. At 31st March 2014, NLCCG, in collaboration with NELCCG, had begun the process for the recruitment of a full-time experienced nurse to work with the Designated Nurse across the two health economies.

The organisational structure of NLCCG includes a Quality Group (QG). This group had the lead responsibility for monitoring commissioning safeguarding children arrangements and met monthly throughout the year. The Quality Group received monthly reports from the Designated Nurse which included evidence of/issues in respect of commissioning and provider compliance with statutory and regulatory safeguarding children standards. Exceptional events were reported via the Quality Group and where appropriate included on the locality Risk Register, and, if had been necessary, would have been added to the Board Assurance Framework.

NLCCG has not been required to provide compliance reports to NHS England on minimum standards in commissioning and provider health organisations, as had been the case in previous years to NHS Yorkshire and Humber (as Strategic Health Authority). However, the Designated Nurse for Safeguarding Children has utilised the previous framework to ensure continuing robust arrangements. It should be noted that NHS England will require compliance reports on local health safeguarding arrangements starting in the 2014-15 year.

NLCCG has identified 10 safeguarding children standards to be included in all contracts for services commissioned by, or on behalf of, NLCCG. These standards reflect provider requirements arising from s11 Children Act 2004, and Care Quality Commission Outcome 7. Assurance has been sought from each provider to ensure compliance with the standards. These standards cover the areas of organisational and professional leadership, compliance with LSCB and national policy, compliance with LSCB priorities, training requirements, safe recruitment and management of allegations, compliance with local and national safeguarding supervision processes, management of significant safeguarding incidents, serious case reviews and child death process.

Whilst North Lincolnshire CCG, as a commissioner of health services, did not provide direct services to children and families, as part of their role as strategic professional leads the Designated Professionals were involved in supporting clinicians in health

[5] One Programmed Activity/session is equivalent to four hours)

providers, in particular named professionals, and practitioners in partner agencies on the appropriate management of cases in particular those with complexity.

Effectiveness of help (including early help) in the local area.

Whilst North Lincolnshire CCG does not directly deliver services to children and families, their responsibility to ensure commissioned services provide safe and responsive system means that the CCG through their professional leadership have contributed to the development of the North Lincolnshire approach to Early Help and embedding it across all agencies.

The CCG duty to support the improvement in quality of primary care services meant that the Designated Nurse, in collaboration with Named GP for Safeguarding, has worked with GPs to promote opportunities for practices to identify children/ families in need of Early Help.

NLCCG Contribution to Effective Functioning of the LSCB

North Lincolnshire CCG has been represented on North Lincolnshire Safeguarding Children Board (NLSCB) by the Senior Officer for Quality and Assurance (April 2013-August 2013), then Director of Risk and Quality Assurance (September 2013-March 2014). The Designated Nurse and Doctor also attended the LSCB as professional advisor to the Board.

The Designated Nurse was the Chair of NLSCB Serious Case Review Subcommittee, as well as a member of all other subgroups of the LSCB. However, the Designated Nurse's capacity to ensure attendance at the subgroups was limited, and was one of the factors in NLCCG (along with NELCCG) taking the decision to increase nursing capacity.

The Designated Doctor is a member of the Child Death Overview and Serious Case Review groups. The Designated Nurse has worked with all health providers to ensure appropriate health representation on all LSCB groups. Through the Designated Professionals, NLCCG has overseen the health service learning from Learning Lessons and Child Death Overview reviews and worked with providers to explore and action changes where appropriate.

A requirement for commissioned providers to incorporate LSCB priorities into their services is included in the local safeguarding children standards set by NLCCG.

Progress made on key LSCB priorities

All commissioned providers are required to incorporate and address LSCB Priorities in the services they deliver.

During the final quarter of 2013/14, the Director of Risk and Quality Assurance attended and contributed to the development of the North Lincolnshire CSE strategy through the CSE Strategic Group.

Whilst the standards included in contracts for services commissioned by, or on behalf of, NLCCG, set out an expectation that providers will "work with NLSCB and partner organisations to respond to agreed LSCB priorities", NLCCG plans to more proactively monitor provider compliance with LSCB priorities within the 2014/15 year.

Challenges and priorities for 2014-2015

As reported above, NLCCG has recognised the need for additional professional capacity to support the organisation in delivering on their statutory safeguarding responsibilities. Once this post is filled NLCCG will have sufficient capacity to take on a more proactive approach to

- ensuring those organisations from which they commission services provide a safe system that safeguards children
- supporting improvements in the quality of safeguarding arrangements in primary medical care.

To this end, NLCCG has developed a work plan for 2014/15. It is anticipated that the work plan will be dynamic and responsive to issues arising from local and national learning, reviews and inspections. Initial Key priorities for 2014-15 include:

- Supporting the quality arrangements required in primary care and other independent contractor services.
- Development and roll out of safeguarding supervision strategy for Northern Lincolnshire health economy (in collaboration with North East Lincolnshire CCG)
- Development of safeguarding children training strategy for Northern Lincolnshire health economy (in collaboration with North East Lincolnshire CCG)
- Embedding the monitoring of safeguarding children arrangements for all provider health services.

Appendix 4: Key Issues from the Published Care Quality Commission Reviews of Health Services for Children Looked After and Safeguarding

1.0 Introduction

1.1 This report contains the key learning and areas for improvement from the eight reviews undertaken by the CQC using the new framework for inspection launched in September 2013

2.0 About the Reviews:

2.1 The reviews were conducted under Section 48 of the Health and Social Care Act 2008 which permits the CQC to review the provision of health care and the exercise of functions of the NHS England and Clinical Commissioning Groups (CCGs).

2.2 The reviews explored the effectiveness of health services for Looked After Children (LAC), their focus was around the experiences of LAC and children and their families who received Safeguarding services.

3.0 Methodology:

3.1 A range of methods were used to gather information including documented reviews, interviews, focus groups and visits. Wherever possible children and young people were consulted, this approach provided the CQC with evidence that could be verified in several ways.

3.2 A number of individual cases were tracked where there had been Safeguarding children concerns. This included cases which had been referred to Children's Social care and some which had not.

3.3 The tracking and sampling also followed the experiences of LAC to explore the effectiveness of health services in promoting their well-being. In essence this was around the child's journey.

4.0 Key findings from the 8 published reports:

4.1 This report provides an overview of health services delivered to LAC and children and families who were provided with Safeguarding services and focuses on areas for improvement. The information provided within this report does not necessarily apply to every inspected area but was considered to be significant to learning and subsequent improvement in the delivery of safe services to children and young people.

5.0 General Practice:

5.1 The inspection reports which have been reviewed identify that across a number of areas, GP's remain unclear about their role and responsibility to Safeguard children. In some cases they are not fully equipped and competent to carry out their role in child protection or to meet the needs of LAC.

5.2 In most areas there are concerns that GP's are not routinely participating in Child Protection Conference either by attending or submitting a comprehensive report. The reports which are submitted tend to only contain basic information about the child.

5.3 In most areas, GP's do not routinely participate in the Health Assessments or Review of LAC and Care Leavers, neither are they routinely asked to do so and there is a lack of understanding about their responsibility to this client group

5.4 The Named GP role is not effectively discharged and the leadership of Named GP's requires development to support the delivery of effective Safeguarding across services.

5.5 There are still some concerns about information sharing across other health services where practitioners are requesting health information about children. However, there is evidence of a lack of response to correspondence, or acknowledgement of correspondence, from Social Workers.

5.6 In areas where GP's are using the same information system as other health providers such as Health Visitors and School Nurses, information sharing in relation to vulnerable families is more effective

6.0 Child and Adolescent Sexual Health services (CASH):

6.1 CASH services are not sufficiently robust in terms of Safeguarding children. Records contain little detail of actions taken following the identification of risk, or of engagement with other professionals. There is also little evidence of communication with the young person in respect of other professionals involved in their care.

6.2 CASH services do not routinely follow up referrals to Children's Social Care and do not actively attend core group meetings or strategy meetings.

6.3 There is a need to implement clear strategies for the identification and reporting of sexually harmful behaviour and Child Sexual Exploitation (CSE) which ensures a robust shared response.

6.4 There is insufficient curiosity and questions about sexual partners where CSE is suspected.

6.5 In one area within an 18 month period since the service inception, there were no referrals into Children's Social Care which is a cause for concern.

6.6 LAC and Care Leavers are not routinely identified.

7.0 Drug and Alcohol Services:

7.1 There is evidence that services do not always effectively share information or concerns with other agencies in a timely manner.

7.2 The referral pathways from other health services into young people's drug and alcohol services sometimes lacks clarity.

7.3 In one area there was some noted good practice in relation to services who actively try to engage young people until they are nineteen and within another where good systems were in place to ensure effective communication and monitoring of pregnant women.

8.0 Adult Mental Health Services:

8.1 Adult Mental Health Professionals do not routinely attend Child Protection Conference and there is a lack of consistency in respect of the reports which are submitted. This may result in some key issues being unidentified.

8.2 There is a risk that the support needs of the adult override those of the child and the 'Think Family' approach is not routinely embedded within practice. Specific Safeguarding children supervision is not routinely provided.

8.3 There remains a lack of communication and consultation with other health professionals and a lack of ability to articulate risks when referring into Children's Social Care.

8.4 However within one area there was noted good practice in relation to joint clinics for pregnant women and complex cases in line with NICE guidance.

9.0 Maternity Services, Health Visiting Services and Family Nurse Partnership:

9.1 The CAF may be under utilised in some areas for teenage parent, which could lead to delay or lack of timely support for this potentially vulnerable group.

9.2 Although there is improvement, not all Midwifes routinely focus on domestic violence

9.3 There are reported delays in the convening of Child Protection Conferences for unborn babies which can result in the baby being born without a plan in place. This is an issue for Children's Social Care.

9.4 An increased awareness is needed in respect of Female Genital Mutilation (FGM) and practitioners need to be fully trained and vigilant.

9.5 Whilst there have been noted improvements in some areas, in others Health Visitors are not always vigilant when recording men within the home.

9.6 In some areas Health Visitors are not always engaged with families early and do not routinely attend pre-birth conference. This can lead to babies being discharged home before the Health Visitor has had any involvement. As such, early plans to reduce risks may be lost.

9.7 In the areas where the Family Nurse Partnership is established, this service is reportedly good and effective.

10.0 A & E and Minor Injury Units (MIU):

10.1 The details of adults who accompany children are not routinely collated.

10.2 Alert systems for the flagging and management of alerts in relation to vulnerable children and parents are not routinely robust and not all discharge pathways are effective in ensuring the sharing of information about risks.

10.3 In some areas, joint systems for the identification and follow up of young people and those with parental responsibility who present at A&E or at Minor Injury Units under the influence of alcohol or substances requires strengthening.

10.4 There is inconsistent support for young people attending A&E with emotional, behavioural and mental health problems which can lead to inappropriate admittance onto adult wards for observation.

10.5 MIUs do not routinely consider Safeguarding Children when adults present with minor injuries and in both MIU's and A&E departments within some areas, staff are inappropriately trained in caring for children and young people who require urgent care.

10.6 There is a lack of focus on LAC and Care Leavers

11.0 Children and Mental Health Services (CAMHS):

11.1 There remains a lack of timely response to children in need within some areas. NHS England Local Area Teams, CCG's and provider organisations should work in partnership to ensure that commissioning and operational management enables children to have timely access to early help, specialist assessment and treatment. Management oversight needs improvement to ensure compliance with National guidance.

11.2 There is a lack of timely access for LAC

11.3 There is a lack of Attendance at Child Protection Conference and a variable quality of reports.

11.4 There is insufficient capacity in Tier 4 CAMHS which may lead to inappropriate placement of children within adult or paediatric wards. Tier 4 CAMHS in some

areas have poor discharge planning which fails to ensure that local services are in place.

11.5 There is a need to ensure that children and young people are placed as near to their home as possible.

12.0 Looked After Children and Care Leavers:

12.1 There are unacceptable delays in most areas in children and young people being seen for their Initial health assessment. This is sometimes as a result of the late notification from Children's Social Care of placements.

12.2 There are ongoing issues with the quality of Initial health assessments and reviews, in some areas these are poor and do not take into account the holistic needs of the child. There is a general consensus that these assessments should be quality assured.

12.3 The Strengths and Difficulties questionnaire is not being used to inform the assessment and children and young people are often not involved in a meaningful way or told how important it is that they contribute to the assessment. There is a need to strengthen young people's participation in their health assessment and care planning and use feedback to continuously improve services.

12.4 Issues identified within the health review are not always followed through.

12.5 There are concerns that children and young people who are placed out of area are not receiving a level or quality of support needed to ensure their safety and well being. This requires great scrutiny. The placement of children and young people out of area can lead to disadvantage and less than equitable service provision.

12.6 Accurate and up to date information is not maintained in relation to LAC and Care Leavers about their whereabouts.

12.7 In some areas there are inadequate IT systems and insufficient performance reporting around the holistic health needs of all LAC.

12.8 There is lack of health support for Care Leavers and their outcomes remain poor. They are not well supported in transitioning to adult health services.

12.9 Care Leavers are not routinely provided with their health summary, one young person commented that

13.0 "A lot of kids in care, we don't know our histories, we've got no one to ask about inherited things, we don't know anything" (CQC, 2013).

13.1 We cannot be fully assured that the health needs of LAC are being met.

13.2 CCG's should work with providers to embed a continuous programme of quality assurance to ensure that all LAC and Care Leavers have their health needs assessed and reviewed in a timely and meaningful way to include parental histories, GP contributions and health plans.

14.0 Other reoccurring themes across all Health Services:

14.1 A consistent theme across all health services is the inability of health professionals to articulate risk when making referrals into Children's Social Care. Professionals need to assess and describe risk when making referrals to ensure that Social Workers are making informed decisions.

14.2 Improvement is needed in communication between multi-disciplinary professionals outside of formal child protection procedures.

14.3 We need to ensure that all frontline staff receive appropriate training around Safeguarding in respect of those children and young people who may be at risk form sexual exploitation.

15.0 Leadership and Governance:

15.1 NHS England should work with GP's to ensure that they fulfil their responsibilities in Safeguarding Children and young people and LAC. There needs to be prompt and effective risk assessment and referral where areas of concern are identified in relation to Safeguarding Children and young people

15.2 The capacity of Named and Designated professionals requires consideration in order that they fulfil their statutory roles and responsibilities. In some areas the role of the Paediatric Liaison Nurse in some areas is also stretched to capacity.

15.3 Commissioning governance and assurance needs to provide effective scrutiny of the experiences and impact of local health services in delivering improved outcomes for children and young people who are looked after.

15.4 In some areas there is need for CCGs and providers to review the arrangements in emergency departments for 16 and 17 yr olds as systems and processes for Safeguarding and follow up are not robust enough and risks are missed.

15.5 There is a need to continue to monitor health information systems to ensure information sharing is effective in relation to child protection.

15.6 NHS England and local area teams are making good progress in effectively implementing the Accountability and Assurance Framework (2013).

16.0 Conclusions:

16.1 It would appear that the new inspection framework and lines of enquiry are effectively identifying areas for improvement in relation to the safety and quality of health services provided to LAC, Care Leavers and those children and families who require Safeguarding services. In doing so, they are actively raising the profile of this vulnerable client group.

16.2 On considering all the reviews it is strikingly obvious that LAC and Care Leavers do not routinely receive safe and effective services and that those placed out of area may be at risk of greater disadvantage. These issues require a timely and effective resolution

Julie Warren-Sykes

Associate Safeguarding Professional

09.04.14

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