NHS DORSET CLINICAL COMMISSIONING GROUP

GOVERNING BODY MEETING

SAFEGUARDING CHILDREN UPDATE

Date of the meeting	19/11/2014
Author	W Thorogood, Designated Nurse Consultant for Safeguarding Children
Sponsoring Clinician	S Shead, Director of Quality
Purpose of Report	Annual summary of safeguarding activity. Identifying key risks and responsibility including data.
Recommendation	The Governing Body is asked to **Note** the report.
Stakeholder Engagement	No engagement with patients & public specifically for this report. Children, young people and families are involved in the safeguarding process. GP leads for safeguarding involved in work plan.
Previous GB / Committee/s, Dates	19 March 2014

Monitoring and Assurance Summary

This report links to the following Strategic Principles	• Services designed around people • Preventing ill health and reducing inequalities within safeguarding children • Sustainable healthcare services • Care closer to home

	Yes [e.g. ✓]	**Any action required?**	
		Yes Detail in report	**No**
All three Domains of Quality (Safety, Quality, Patient Experience)	✓		✓
Board Assurance Framework Risk Register	✓		✓
Budgetary Impact	✓		✓
Legal/Regulatory	✓		✓
People/Staff	✓		✓
Financial/Value for Money/Sustainability	✓		✓
Information Management &Technology	✓		✓
Equality Impact Assessment	✓		✓
Freedom of Information	✓		✓
I confirm that I have considered the implications of this report on each of the matters above, as indicated	✓		

Initials : WCT

1. Introduction

1.1 This report covers the period from 1 March to 30 September 2014.The purpose of this half year report is to ensure that the Dorset Clinical Commissioning Group (CCG) Governing Body is informed of the progress and developments both locally and nationally on issues related to the safeguarding children's agenda.

1.2 There is a requirement for the CCG to receive as a minimum an annual report on the safeguarding arrangements for all the health services we commission in line with CQC compliance. Dorset CCG's Governing Body receive two reports a year, which supports them by ensuring there is a clear line of accountability from front line practitioners in provider organisations to the Chief Officer of the CCG. Detailed quarterly safeguarding reports are also submitted to the CCG Quality Group.

1.3 Key legislation for children and young people includes the Children Act 1989 and 2004. Sections 11 and 13 of the 2004 Act have been amended through the Health and Social Care Act 2012 so that NHS England and CCGs have identical duties to those previously applying to Primary Care Trusts and Strategic Health Authorities. The revised edition of Working Together to Safeguard Children (2013) sets out expectations as to how these duties should be fulfilled. Safeguarding Vulnerable People in the Reformed NHS Accountability & Assurance Framework (2013) provides further guidance on accountabilities for safeguarding children in the NHS.

2. Background

2.1 Child safeguarding is important to the child's safety and wellbeing but it is also important for the long-term health of the adult population as children who experience abuse will be the adult patients and parents in the future. The Adverse Childhood Experience (ACE) Study recognises that children who experience abuse can have health implications when they become adults.

2.2 Their longitudinal study states: *'strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults.'* American Journal of Preventative Medicine 1998;14:245–258.

2.3 These include poor outcomes for mental health, heart disease, strokes and diabetes. In an NSPCC study in 2011; 1:4 adults reported having experienced severe maltreatment in childhood and 1:8 of children aged 11-17 years had experienced this abuse from their main carer. If these figures were transferred to Dorset's teenagers we could, across the County, have a large number of children who have experienced abuse and the associated risks and health needs that stem from it.

2.4 The safeguarding issues and risks associated with young children are well known and reported especially around physical abuse and neglect. The experience of teenagers who have been abused is often neglected or not recognised, yet 23% of serious case reviews in England involve teenagers

(Brandon et al 2009, Rees et al 2011, NSPCC 2014). In Dorset, a Serious Case Review (SC11) and a Domestic Homicide Review concerned adolescent males who both had histories of neglect which impacted significantly on their wellbeing. The CCG as a joint commissioner of children's services or the adult services who treat parents must recognise and consider the impact of how we work together to safeguard children and improve their health outcomes.

2.5 The two Local Safeguarding Children's Boards (LSCB) supports this joint working and have developed key strategic work plans for the coming year. These will include bringing agencies together to consider the impact of the 'toxic trio'- parental mental health, substance misuse and domestic abuse on the outcomes for children.

3. Safeguarding Leads

3.1 Dorset CCG is compliant with its statutory requirement for Safeguarding Lead Executives, Nurses and Doctors. Further information regarding roles and responsibilities can be accessed on the CCG website.

4. General Safeguarding Activity

4.1 The CCG developed Safeguarding standards and reporting schedules which have been included in all health contracts commissioned by Dorset CCG. This includes development and supervision of the named nurse for each provider, including the Ambulance Trust.

4.2 The Bournemouth and Poole Local Safeguarding Children Board's Business Plan for 2013/14 identified as one of their objectives the need to create a Multi-Agency Safeguarding Hub (MASH). This was identified within the recent Ofsted inspection as a current gap in service. A Task and Finish Group was established involving the three Local Authorities. The Designated Nurse Consultant and Dorset Police are part of this group. Health are currently fulfilling the role as part of the MASH at arm's length and this has involved a change in working arrangements/practice. However, an agreement for staff to relocate has not been met due to lack of capacity which requires financial support. A business plan is being prepared for consideration at the next Maternity, Reproductive and Family Health Clinical Commissioning Programme (CCP).

4.3 As part of the CCG's Named GP's induction they each undertook training provided by the Red Cross to ensure they understood the work which would be required with regard to asylum seekers, Prevent and forced marriage. This role was put to the test recently when over 100 asylum seekers were placed in hotels in Bournemouth. Dr Blick worked alongside the Red Cross Refugee Services Co-ordinator, to ensure medical oversight of this group of people.

4.4 This area of work had been an unexpected test to the safeguarding role. The CCG will be hosting a review regarding the placement of the asylum seekers to ensure that health services are prepared for any similar situation which may arise in future.

5. Serious Case Reviews

5.1 A new Serious Case Review (SCR) was commissioned on 5 August 2014. The criteria were met in that the female young person in this case suffered significant harm via the contact she had with a known male perpetrator who was living in the family home. The full detail of the areas where agencies failed to respond as expected is set out in the minutes of the SCR Group and in the draft Terms of Reference for the recommended SCR. The SCR should be completed within six months; February 2015.

5.2 The case regarding a 15-year old male who died in the care of his father from a drug overdose has been published. It identifies neglect and missing from school with a history of depression. The full report can be found on link below:

http://www.dorsetlscb.co.uk/site/advice-for-people-working-with-children/serious-case-reviews/

5.3 Bournemouth published a SCR after the death of a baby whose mother had been excessively drinking. Dorset held a case audit on three babies with a similar theme during 2013/14. Making learning count is a recommendation and part of a current national campaign which was supported by Dorset CCG "Drink Heads" campaign, which aimed to raise awareness of the dangers of alcohol whilst looking after young children.

5.4 The campaign was shortlisted in the new Health Services Journal (HSJ) Value in Healthcare Awards which seek to recognise and reward outstanding efficiency and improvement by the NHS. This was considered as an example of perceptible improvement in outcomes, both within back office functions and clinical initiatives. This was the first time learning from a SCR had been presented to HSJ.

5.5 Dorset still aim to raise awareness from the dangers of excessive use of alcohol while parenting, so the CCG continues to work closely with the police and Public Health in the run up to Christmas ensuring awareness of the signs and risks.

6. Examples of Complex Cases

6.1 The Designated leads are currently investigating six cases of potential fabricated or induced illnesses.

6.2 The sister of a SCR S11 is considered to be at risk of harm. She is currently within foster care for her own protection. At the time of the review she was living out of area with her mother and she was placed in foster care once it was identified she was living in an unsafe environment,.She is now back in the education system and responding positively to agencies involved.

6.3 The CCG is currently leading a Root Cause Analysis, which was the result of a serious injury to a baby, that only health services had involvement with. This is seen as a vehicle to promote learning from incidents, not to apportion blame to improve the quality of health intervention.

7. Wessex Area Safeguarding Forum Professional Support and Development

7.1 NHS England Wessex Area Team Director of Nursing has established a local Safeguarding Forum. The Forum provides appropriate support and advice to the Designated and Specialist professionals using the widest possible expertise to improve safeguarding practice. The Forum has no executive powers other than those specifically delegated by NHS England as set out in itsTerms of Reference. The Forum shares intelligence on safeguarding concerns across Wessex and keeps the Quality Surveillance Group informed of recurring concerns and issues.

8. The Local forum links with National forum

8.1 A National Designated Forum, supported by National Safeguarding Lead Nurse, Moya Sutton, met in June 2014 for its first Annual Conference. This event ensured Designated Leads received the advance Level 6 training which is mandatory. The leadership course has been developed in line with the Laming Report to ensure all designated staff have the right leadership training.

9. CCG Key Developments over the report period

9.1 As a commissioning and employing organisation, Dorset CCG has developed a training framework to ensure that employees and staff working in commissioned services understand the level of training they are required to undertake to fulfil their safeguarding children responsibilities. The framework also provides guidance on how to access training and aims to engender a culture of corporate responsibility towards safeguarding which includes safer recruitment measures. Training briefing was delivered to the Board members in August 2014.

9.2 The Workforce Development Team report 94% of staff within the CCG are trained to Level 1, staff requiring additional training levels are recorded within personal appraisals, the safeguarding leads are establishing a process for recording and monitoring this.

9.3 In partnership with the Local Medical Committee six workshops were held across Dorset to consider the findings and learning from the Weymouth Domestic Homicide Review. The theme of Adolescent neglect was highlighted which had been a feature of this review and also of the Dorset SCR S11 where a 16-year old male died following an overdose of medication not prescribed to him. Over 150 GPs attended these events which were well received and evaluated. The ‘lunch and learn’ format of these events was popular and will therefore be repeated later in the year with another topic requested by GPs.

9.4 Dorset Safeguarding Children Board synopsis of learning from a serious case audit and multi-agency case audits are monitored via the LSCB training department and shared widely throughout the CCG.

9.5 Following an increase in the number of cases being identified in practice and escalated under the Fabricated Illness protocol, the Designated Nurse in partnership with the LSCBs has been providing specialist training session on managing the complexities of this area, a request for additional training session has been granted for two further sessions as the course has been very oversubscribed.

10. Key issues from the quality assurance framework reported to the LSCB

- reporting a rising number of Looked after Children across Dorset;
- need for improvement in placement stability;
- need improvement to safeguard children who go missing;
- need for inter-agency service developments to support the emotional health and sexual health of young people in care.

11. LSCB Section 11 Audit

11.1 In June the Dorset CCG submitted for the first time, a response to the Safeguarding Boards Section 11 of the 2004 Children Act request. The CCG was found to be fully compliant with its statutory duties. We have one area requiring improvement which is the evidence of effective practice. This will need to be considered how we can meet this requirement; the internal audit will assist this process.

12. Safeguarding Assurance from Provider Organisations

12.1 The Designated Nurse is a member of Safeguarding meetings at Dorset HealthCare University NHS Foundation Trust and Dorset County Hospital NHS Foundation Trust.

12.2 The Designated Nurse supported a Safeguarding peer review over the Summer 2014 of South West Ambulance Services NHS Foundation Trust (SWASFT). The peer review highlighted some gaps in service. These are being addressed in an independent action plan owned by SWASFT. One-to-one supervision with the named lead for safeguarding is being provided. Specific evidence required and developments of work stream include:

- ensuring supervision for all safeguarding champions;
- review all policies currently awaiting approval;

- the safeguarding team has moved from within the medical directorate to nursing as outcome of the review;
- to ensure the needs of the children are captured by from line staff;
- training at the right level including volunteers;
- strengthen links with all LSCB's within their area.

12.3 Development work with Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust is progressed via meetings with the Named leads.

12.4 Supervision arrangements are in place for all named nurses and midwives for each provider. Independent supervision is offered to designated professionals by an independent provider.

13. Work of the Local Safeguarding Children Boards

13.1 The Dorset CCG area is covered by two LSCBs one which covers the conurbations of Bournemouth and Poole and the other which covers Dorset County. Both Boards are chaired by the same Independent Chair who was appointed early in the year.

13.2 On 1 August the new electronic safeguarding children procedures went live. It is expected that the new procedures now managed by TriX will be more accessible for practitioners.

13.3 In order to meet the requirements set out in statute both Safeguarding Boards have agreed a core data set which the executive consider to understand the local picture, trends and areas for further scrutiny.

13.4 Information in relation Female Genital Mutilation is now being mandatorily collected by Acute Trusts as of 1 September 2014 and this will be added to the data set and reported alongside the other indicators.

13.5 Dorset HealthCare University NHS Foundation Trust report they have problems producing the data required due to systems in place. This has been challenged by the LSCB. The Trust is working to develop their reporting capability.

13.6 Data is provided by the police which allows for some analysis of the main risks and will feed in to a joint work plan looking in depth at teenage neglect , which links to criminal activity among young people and risk taken behaviours.

14. Child Protection Activity

14.1 The total number of children on a plan for child protection, for Dorset, Bournemouth and Poole for the month of September is 867 with a percentage 8.7 per 10,000, which is slightly lower than the national average of 10.7.

14.2 Trends identified by the Local Authorities are teenage neglect and self-harm, neglect and children missing from education. This includes the effects from domestic violence and emotional abuse. The ages that appear to be most at risk are zero to four years and 14-17 years old with no real difference in gender.

15. Child Death Overview Panel

15.1 During 2012-2014 CDOP reviewed a total of nine cases, none of which were deemed to be 'preventable'. A full report is available from "Dorset for You" Child Death Annual Report . From the data available, analysis undertaken and cases reviewed by the Child Death Overview Panel, there were no significant matters of concern affecting the safety and welfare of children in Dorset or other wider public health and safety concerns which needed to be reported to either LSCB during 2012/13. However, the most common causes of potentially preventable deaths related to children who died whilst co-sleeping with one or both parents. In order to address this, during 2013 /14 the Panel will collate additional local data which focuses specifically on the following:

- alcohol misuse;
- substance misuse;
- mental health issues;
- domestic violence;
- socio-economic factors;
- ante-natal service provision and advice/guidance about co-sleeping;
- ante-natal - booking time and level of engagement by expectant parent(s).

15.2 An audit has been completed to support a work flow from the child death group to explore what messages have been learnt by mothers in relation to safe sleeping advice, with over a 1,000 responses, the report is currently in draft form and awaiting sign-off. The key message fed back was consistent with our Safe Sleeping campaign and most mothers reported the safest place to sleep baby is in a cot.

16. Current Work Streams

16.1 Female genital mutilation (FGM) is part of a new work stream. Key professionals from Dorset attended a national conference; the police are leading this area of work. FGM became a mandatory reportable condition from September 2014. Across Dorset there have been three reported cases within the last six months. The aim is to have a short working group to ensure we have the right systems in place and this should be completed within six months.

16.2 Child Sexual Exploitation (CSE) is another work stream being led by police. Pan-Dorset there are low numbers of children subject to plans for sexual abuse, less than 25 for the whole of pan-Dorset. Current numbers of children with a plan for being at risk from sexual abuse:

- six children in Dorset;
- zero in Poole;
- four in Bournemouth.

16.3 Training from Drama Company was delivered last year and has been re-commissioned due to the positive feedback.

16.4 The shame of sexual abuse makes it very difficult for children to come forward and this needs to be understood by professionals. Therefore training and awareness is being improved.

17. Conclusion

17.1 The CCG continues to meet its statutory requirements for safeguarding children.

17.2 Key areas for development over the coming year are the Multi-Agency Safeguarding Hub, improved evaluation of training and continued monitoring of Provider's safeguarding children arrangements and standards to gain assurance that vulnerable children and their families receive services which meet their needs and effectively safeguard children.

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