# SAFEGUARDING CHILDREN ANNUAL REPORT 2016-2017

## 1.0 Executive Introduction

The purpose of this report is to update and inform the Board of Directors with regards to the corporate safeguarding children processes and activity within this organisation during the past year.

For clarification a "child" is defined as anyone who has not yet reached their 18th birthday and safeguarding responsibilities also extend to unborn children.

Safeguarding children is the action we take to promote the welfare of children and to protect them from harm and is the responsibility of everyone who comes into contact with children and their families. Children's needs are paramount and safeguarding children is defined as:

- Protecting children from maltreatment (Child Protection)
- Preventing the impairment of children's health or development
- Ensuring that children grow up in circumstances consistent with the provision of safe and effective care
- Taking action to enable all children to have the best outcome (Working Together to Safeguard Children HM Government 2015)

## 2.0 Cheshire West and Chester Local Safeguarding Children Board (LSCB)

Currently the LSCB is the key statutory mechanism (CA 2004, S13) for agreeing how the relevant organisations in each local area will cooperate (CA 2004, S11) to safeguard and promote the welfare of children and for ensuring the effectiveness of agency responses. The aim of the LSCB is to work together with all local organisations so that children can be safe from abuse or harm at home and within the community. The LSCB strategic priorities are reflected in the work of all CoCH safeguarding children processes.

### Section 11 audit

Is an electronic LSCB audit tool to monitor CoCH compliance with our statutory S11 duty to discharge all of our functions with regard to also safeguarding and promoting the welfare of children. The S11 audit tool also incorporates the CCG's commissioning standards for safeguarding children and lists numerous standards re core child protection functions and wider safeguarding children issues including for example HR process's re recruitment. The S11 is a 3 yearly undertaking for the LSCB but an annual undertaking for the CCG. We have to self – assess from grade 1-4, we then have to provide evidence to back up the self - assessment and attend moderation panel. We undertook this process for both the LSCB and the CCG in 2016 and I am pleased to report we are at level 4 for almost all standards and where we are not at level 4 we are at level 3 and regularly reviewing where possible lifting to 4. Action plans are only required for level 2 or below. At present we are undertaking our annual S11 audit for the CCG.

Currently the LSCB has CoCH representation as follows:

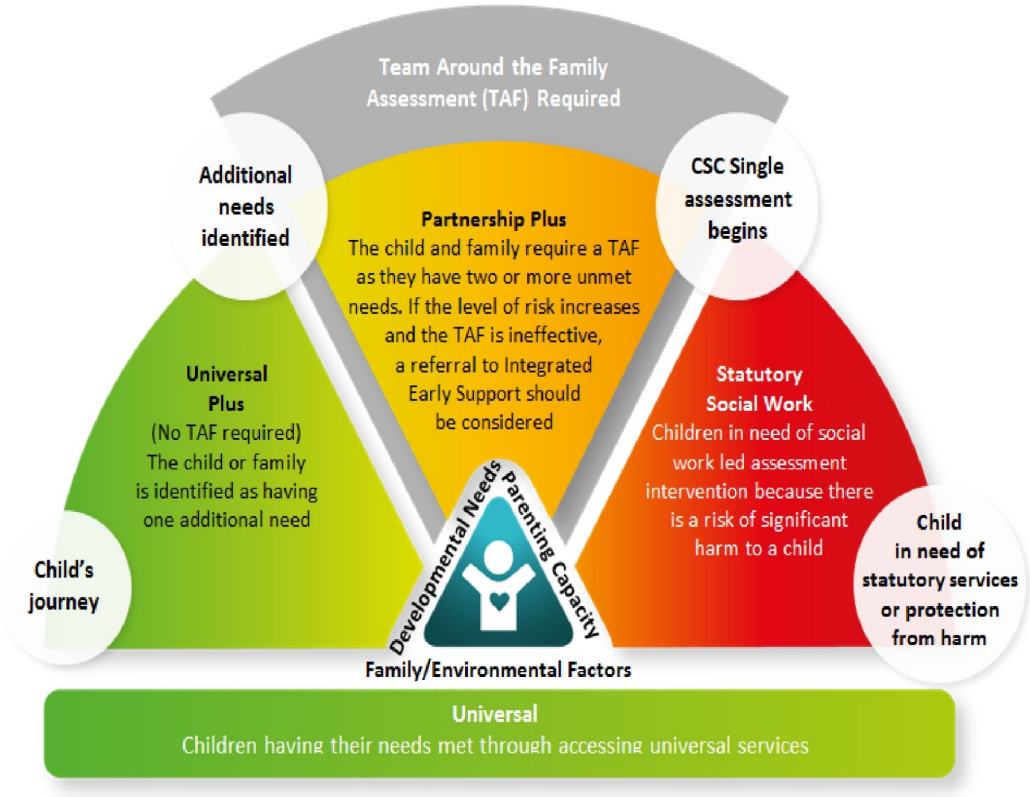
**LSCB Board**: Director of Nursing

**LSCB Subgroups:**

Child Death Overview Panel: Designated Dr
Performance Management and Quality Assurance: Named Midwife/Professional
Audit & Case Review: Designated Dr
Learning and Development: Specialist Safeguarding Children Practitioner
Child Sexual Exploitation Operational Managers Group: Named Midwife/Professional

The LSCB is responsible for publishing a "Thresholds Document" setting out the levels of needs for children and access to Early Intervention services and to Children's Social Care. The Cheshire West and Chester Continuum of need (see **2.1** below) thresholds document was revised and re-launched in October 2016 and sets out how to access early support, the thresholds for single and multiagency interventions at all levels and when to consider a referral for a statutory children's social care single or pre-birth risk assessment. The model requires CoCH staff to assess where the level of need is for children (including unborn children) and to ensure that if required, the correct level of support is appropriately initiated in a timely way. On-going CoCH staff involvement with the processes/support in place to support the child/family will continue until the child/family no longer need a service from the CoCH.

## 2.1 Cheshire West & Chester (CWAC) Continuum of Need




**Important Note re the abolition of LSCB's as we know them:**

- Following the "Wood Review" of LSCB's (2016) the Children & Social Care Act 2017 is now in place and the abolition of LSCB's as we know them will take place. The 3 key partners in CWAC (Local Authority, the Police and the Health Service) will be required to make and publish plans showing how they will work together to safeguard and promote the welfare of children in this local area. These should include: the area or region which is covered by the plan, how other local agencies with a key role in protecting children will be involved, how the arrangements will be resourced and how independent scrutiny will be ensured. All local organizations involved in the protection of children will be expected to cooperate with the multi-agency arrangements. They must help the key partners to understand how agencies are performing across the local area, and make evidence-based decisions so that the key partners have the flexibility to respond to existing and emerging needs, the requirement for LSCBs to have set memberships will be removed. However if a Local Area see's the current arrangements as the most effective form of joint working they will be able to continue with those arrangements which must reflect the 2017 Act as the underpinning legislative framework. There will also be changes to the Serious Case Review (SCR) process and the Child Death Overview Panel (CDOP) process. Arrangements for inspection and review will be established. In the event that the 3 key agencies cannot reach an agreement on how they will work together, or where arrangements

are seriously inadequate, the Secretary of State will have the power to intervene.

*"The Safeguarding Children Team Countess of Chester Hospital have made a significant contribution to work of the Local Safeguarding Children Board, through active participation in Task and Finish groups such as Care Planning and Neglect; and Operational groups such as the Child Sexual Exploitation Operational Group. Members of the CoCH safeguarding team are facilitators at the LSCB Quarterly Audits and also form part of our Training Pool delivering specialist courses such as Pre-Birth Assessment and Managing Neglect to the wider partnership. This year the LSCB Audit and Case Review sub-group received the CoCH Safeguarding Audit on Safeguarding Children and Domestic Abuse practices which provided assurance of the robust safeguarding practices in this area within the hospital"*

*Sian Jones*

*Cheshire West and Chester Local Safeguarding Children Board Business Manager June 2017*

### 3.0 CoCH Safeguarding Children Policies and Processes

The Trust has a statutory responsibility to have safeguarding children policy and practice as a key area of priority led by the Executive Nurse. The Trust is also required to have a Named Midwife/Nurse and a Named Doctor for Safeguarding Children. In addition there must also be Trust engagement in the local multi-agency early intervention and prevention processes. The Trust must also have a robust policy and response that helps to reduce risk to adult victims and also addresses the safeguarding children issues for adults, children and young people living with domestic abuse. All of the above are in place.

The Trust safeguarding children processes are scrutinized and closely monitored by:

Care Quality Commission 3 yearly Inspection
NHS Northwest
NHS West Cheshire Clinical Commissioning Group
The CWAC Local Safeguarding Children Board.

The following professionals undertake the Trust responsibilities
Executive Lead: Director of Nursing:
**Alison Kelly**

Named Midwife/Professional & Lead for Domestic Abuse/ Lead / Child Sexual Exploitation:
**Karen Milne**

Named Dr:
**Howie Isaac**

Specialist Safeguarding Children Practitioner/ Early Intervention & Prevention:
**Paula Lewis**

AED Nurse Safeguarding Children / Domestic Abuse Link
**Vivien Beswick**

CoCH Independent Domestic Violence Advisor (IDVA):
**Rachel Pickering & Sam Brookfield** (LA 2016-2017 secondment)

**Policies in place:**
Safeguarding & Promoting the Welfare of Children Policy
Domestic Abuse Policy (services users and staff)
Safeguarding Children Clinical Supervision Policy

**Linked Policies**

Paediatric Discharge Policy
Paediatric DNA Policy
Safeguarding Adult Policy

HR Policies:
Safe Recruitment
Speak Out Safely
Managing Allegations

## 4.0 Reporting Mechanisms

Assurance is provided through the following processes/forums:

**Monthly:** Safeguarding Assurance Framework report to the CCG.
**Monthly:** CoCH HR: Safeguarding Children training compliance report
**Quarterly:** Updates to the CoCH Safeguarding Strategy Board
**Annual:** CoCH Safeguarding Children Report Board Report
**Annual**: CWAC/ CoCH Independent Domestic Violence Advisor Report

## 5.0 CWAC Integrated Access and Referral Team (iART)

The iART team is the initial single point of contact for all agencies wishing to see if a child is already open to early Intervention services or to Children's Social Care. An initial contact with the iART will result in a decision being made regarding next steps. In the first instance CoCH staff will discuss a case with the CoCH Safeguarding Children Team before a decision is made to contact the iART. if it is out of hours CoCH staff will discuss a potential child safeguarding issue with the Emergency Out of Hours Duty Team Social Worker and the CoCH Safeguarding Children Team will follow up the case in-hours.

*24/5/16*
*"Dear Karen*
*There has been a long standing health partner relationship between CART ( now i-ART) and CoCH SGCT. This has been built on professional respect and understanding of respective roles and expertise. There is a healthy culture of professional challenge between the two teams. There is extremely frequent exchange of information between the two teams which is completed in a professional and efficient manner." May 2016*
*Dave Spender*
*CWAC*
*Integrated Access and Referral Team Manager*

### 6.0 Domestic Abuse - Domestic Abuse UK Government Definition

*Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:*

*Psychological*

*Physical*

*Sexual*

*Financial*

*Emotional*

*Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.*

*Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim*
*This definition includes so called "honour" based violence, female genital mutilation and forced marriage, and is clear that victims are not confined to one gender or ethnic group*

### 6.1 Domestic Abuse work at CoCH

Our first policy was the result of the CoCH setting up a multi-agency working party who worked together to write and agree the policy with a launch event in November 2004. The CoCH Executive Lead for Safeguarding (Director of Nursing & Quality) currently chairs the West Cheshire Domestic Abuse Strategic Partnership Group (a subgroup of the Local Safeguarding Children's Board).

### 6.2 Independent Domestic Violence Advisor (IDVA)

The CoCH DA Lead worked with CWAC to secure an IDVA 12 month secondment to the CoCH. The secondment commenced in February 2014 and is proving extremely beneficial to CoCH services users and staff alike who are experiencing domestic abuse. This secondment has been extended and is secure until April 2018. We now have 2 IDVA's (1WTE) In this reporting period this team has dealt with **141** DA cases in the main from the AED and **55** cases in maternity services. Out team also support staff members who are victims.

*20/5/16*
*"Dear Karen*
*Although I was 'scarred' after attending your meeting, I could not believe the amount of work you and your team do! From a staff perspective, in relation to domestic abuse support, you and your team are fantastic. One of the nurses I am responsible for has required such support and cannot believe what a difference this support has made to her life". May 2016*
*A big thank you from me.*
*Kind Regards*
*Karen Rees*
*Head of Nursing Urgent Care*

### 6.3 Local Area Designated Officer (LADO)

The role of the LADO is set out in Working Together to Safeguard Children (2015) and is governed by the Authorities duties under section 11 of the Children Act 2004 The LADO must be contacted within one working day in respect of all cases in which it is alleged that a person who works with children has: behaved in a way that has harmed, or could 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.

There will be three strands in the consideration of an allegation: a police investigation of a possible criminal offence; enquiries and assessment by children's social care about whether a child is in need of protection or in need of services; consideration by the employer of disciplinary action in respect of the individual. In the event of no criminal proceedings, the end task may be for the organisation to make a decision regarding "the suitability" of an employee to continue to work with children. The CoCH should have a Senior Designated Officer to lead on LADO cases and this person will work closely with the LADO, the staff member's management line and HR until the conclusion of the case.

### 6.4 Multi Agency Risk Assessment Conference (MARAC)

The CoCH is represented at both CWAC and Flintshire MARAC each month, MARAC is a home office initiative led by the Police where all victims of Domestic Abuse assessed as at "High Risk" (at risk of serious or fatal injury) are reviewed in multiagency meeting chaired by the Police. The outcome from MARAC is the risk should be reduced by multiagency action planning. All high risk victims of DA who have an account at the CoCH who are reviewed at MARAC will have a MARAC alert placed on their records. This remains in situ for twelve months post last MARAC.

Full engagement in DA processes is essential if the CoCH is to work on a multi-agency level to reduce the risk of Domestic Abuse Homicides.(Domestic Violence, Crime and Victims Act 2004)

### 7.0 Child Sexual Exploitation (CSE)

CSE is an increasingly worrying issue on both a national and local level. The CoCH is in contact with victims of Child Sexual Exploitation and we have dealt with some particularly harrowing cases in our maternity services. The CoCH is represented on the CSE operational group that meets monthly at Winsford Police HQ. We have a CSE alert process and any child or young person who has an account at the CoCH who is identified as at risk from CSE will have an alert placed on their records until they are no longer at risk.

### 7.1 Sex Offenders

We have seen an increase in those who are registered as posing a risk of sexual harm to children needing access to the hospital for example the father of an unborn baby. In all case's robust working with Children's Social Care will be a fundamental part of our practice. With regard to people with this status being permitted access to the CoCH each case is dealt with on an individual basis in conjunction with the

allocated Social Worker, the Police and our own legal team led by our Director of Corporate & Legal Service.

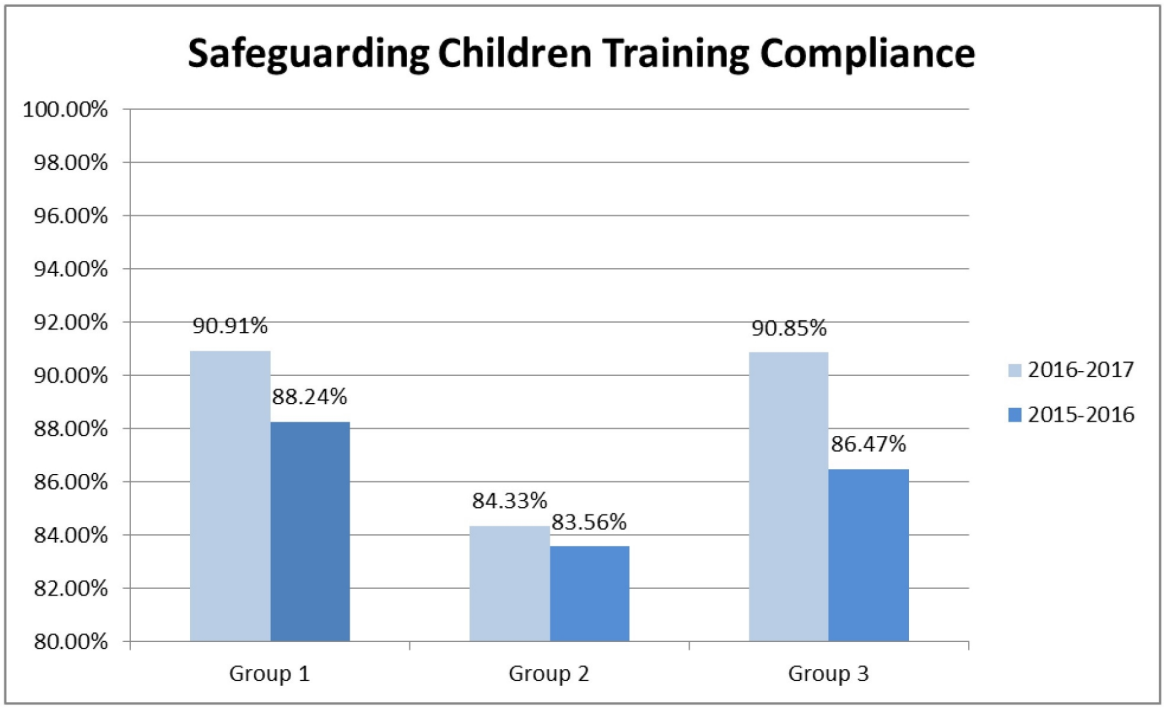
**7.2 Independent Inquiry into Child Sexual Abuse** (IICSA) and the Truth Project

Previously known as the Goddard Inquiry the IICSA was established as a statutory inquiry in 2015 to consider the extent to which institutions failed to protect children from child sexual abuse, and to make recommendations to ensure the best possible protections for children in the future. The Truth Project was set up to enable victims and survivors of child sexual abuse to share their experience with the IICSA. This will help those leading the inquiry to better understand issues surrounding child abuse and will help them make recommendations to protect children now and in the future. Accounts shared with the inquiry will not be tested, challenged or contradicted and all information shared will be anonymised. The information shared will then be considered by the inquiry panel and chairperson and will help in making recommendations for the future. A number of communications have been shared with staff regarding this and more information is available on the CoCH safeguarding children web pages.

## 8.0 Safeguarding Children Training

The CoCH has a safeguarding children training programme in place. This reflects the Intercollegiate document "Safeguarding Children & Young people: Roles and Competencies for Health Care Staff" (2014). In the main CoCH staff are defined into groups 1, 2, & 3 in accordance with their role within the organization. The CoCH must maintain at least 80% compliance with SGC training. Safeguarding children training compliance is reported to the CCG on a quarterly basis.

**8.1**
The table below depicts the training data for groups 1, 2 and 3 at March report 2016 and March report 2017.




As can be seen by the table, compliance with group 2 training is now over 80% this has been a significant achievement by the safeguarding children team and CoCH managers and in ensuring that an action planning moved the Trust back into compliance.

*Training must also be completed by "Board Level Executive Officers, Trust and Health Board Executive and Non - Executive Directors/ Members. This training was completed in 2014 and recorded with HR. update due 2017.*

**8.2 Domestic Abuse Training**

All current safeguarding children training includes domestic abuse training.

**8.3 Multi agency Safeguarding Children/Domestic abuse training:**

Some members of staff from group 3 should also attend external multi agency training provided by the LSCB, The Local Authority Children's Social Care and the Domestic Abuse Partnership (this is an LSCB and CQC requirement).
We are currently focusing on this to ensuring we try to get as many group 3 staff as possible to complete multi agency training which will enhance their annual CoCH single agency training

**8.4 Regular LSCB Bulletins** are sent out to all CoCH staff. This helps to increase staff awareness of the role of the LSCB and of the responsibilities we all have to safeguard children. These bulletins are placed on staff notice boards along with a copy of the 'What to do if you're worried a child is being abused' flowchart with photographs and contact details of the CoCH safeguarding children team.

### 8.5 Safeguarding Children Training Needs Analysis and Domestic Abuse Training Needs Analysis

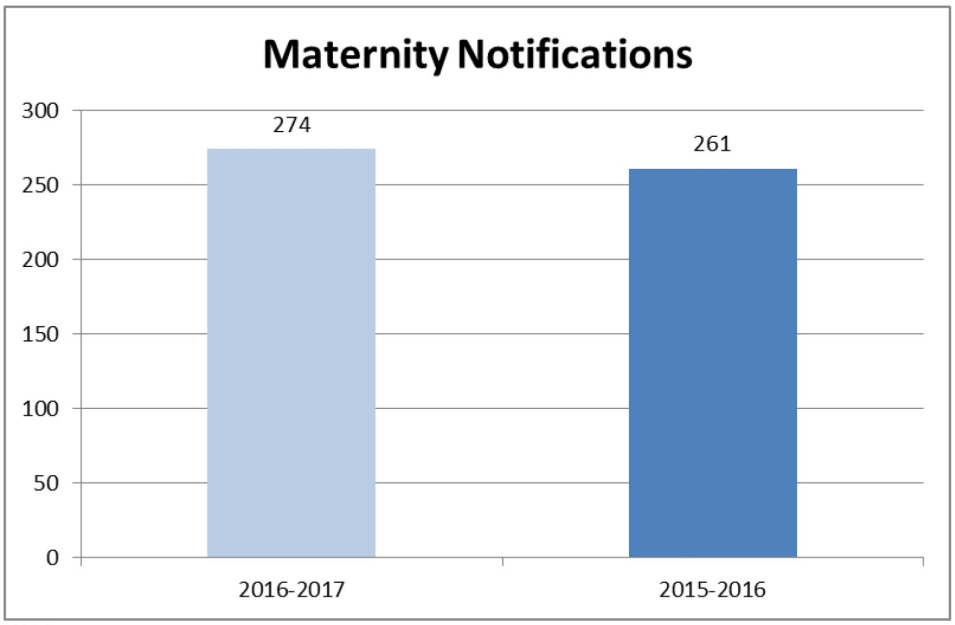
A Training Needs Analysis has been developed to incorporate all of the related training already in place and additional training that is required in relation to NICE PH50 which highlights additional Domestic Abuse training requirements for a wider group of CoCH staff and in relation to additional training needed about Female Genital Mutilation (FGM) and Child Sexual Exploitation (CSE).

## 9.0 CoCH Safeguarding Children Activity

### 9.1 Maternity Services

Newborn children are the most vulnerable children there are and are most at risk because they depend totally on their carers for safe and effective care. Serious Case Reviews repeatedly evidence that it is babies and young children who are most at risk of serious and fatal injury from abuse and neglect. The need to ensure all is done to reduce risk to a new born child must not be underestimated and this aspect of our work is one of the most important areas of our practice not least for the child and family but also on behalf of the CoCH maternity services.
CoCH Midwives will contact the CoCH safeguarding children team at the earliest opportunity when they have concerns that a family may have additional needs or that an unborn baby could be placed at risk of significant harm when born.

Notifications to the CoCH Safeguarding Children team by CoCH Midwives: 2016-2017: Cheshire West and Chester **177**, out of area **97** total **274**
The comparisons between the data from 2015-2016 and 2016-2017 can be seen in the table below and shows an increase in the number of maternity safeguarding children cases in this reporting period.




20/5/16
“Hi Karen

*Midwifery Services would not be able to deliver the high quality service it provides without its seamless interaction with the Safeguarding Children's Team. Year on year the maternity services is experiencing both an increase in safeguarding numbers and the spectrum of issues that the service requires from the ongoing support and advice from the SGCT. All health professional are aware of their responsibility thanks to the excellent face to face training provided. The annual compliance of safeguarding children strategy audit released in February 2016, which involved the need to have a good understanding of wider safeguarding children practice and the standards set out in the Trust policy concluded that a high standard of safeguarding practice was taking place within midwifery services. The audit evidences that the learning from mandatory SGC training knowledge was embedded in practice. The team have a visible presence within Midwifery and the addition of Sarah Taylor IDVA has only added to the quality of the service provided and level of support available to both staff and women alike. Midwives who are receiving clinical supervision always provide positive feedback as to the quality of that provision."*
*Julie Fogarty*
*Head of Midwifery May 2016*

### 9.2 Safeguarding Children Clinical Supervision

Safeguarding Children Clinical Supervision is an essential component of effective safeguarding children practice this is widely written in research and practice literature. **The CQC, LSCB and the CCG have a fundamental focus on our processes around this aspect of our work**. This is because the support provided by Safeguarding Children experts to individual staff members which enables a focus on each individual child in each case is proven to reduce the risk of significant harm to children and young people. Supervision is evidenced to reduce drift, ensure the appropriate level of a multi- agency response as well as adherence to national and local legislative procedures.

**The supervision processes at the CoCH are listed below:**

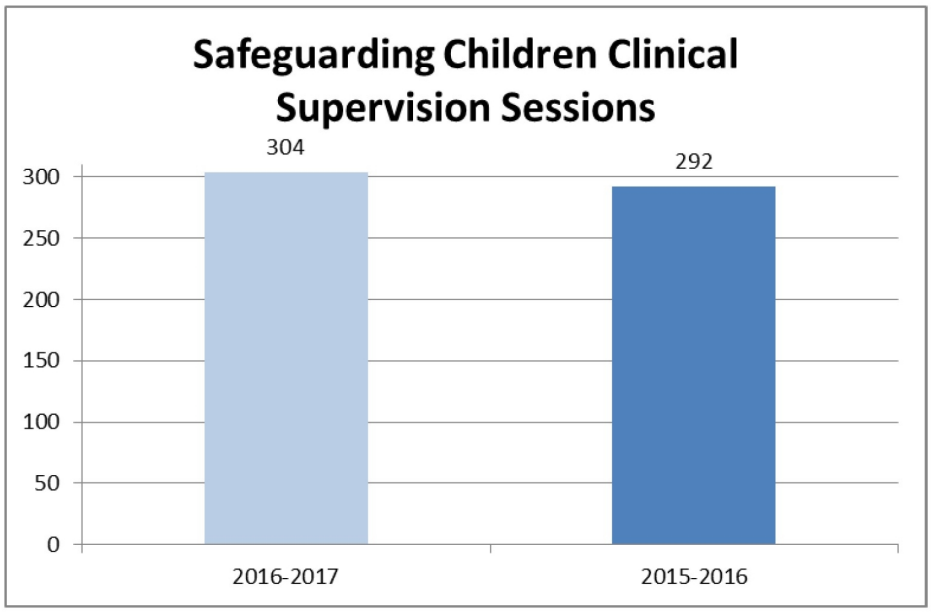
Named Midwife/Professional SGC supervised by the Designated Nurse CCG
Named Doctor SGC supervised by the Designated Doctor CCG
Specialist Safeguarding Practitioner supervised by the Named Midwife/Professional
CoCH IDVA Supervised by the Named Midwife Professional
The Named Doctor leads on ensuring 4 annual Paediatric Safeguarding Children Peer Review sessions for Pediatricians, Paediatric Nursing staff, and AED staff.

**Formal Safeguarding Children Clinical Supervision** (face to face sessions to review individual cases)

All Community staff who are or are likely to carry a case load where a child may be subject to safeguarding procedures sign a supervision agreement that is reviewed every 3 years. Staff are allocated to an NSPCC accredited trained supervisor from the CoCH safeguarding children team. Staff will include Community Paediatric nursing and therapy staff and community midwives. Once a case has been added to the safeguarding children team case load, the staff member will meet with their allocated supervisor regularly in accordance with the case until the service user is discharged from CoCH services care. This ensures that the concerns are being managed appropriately and that the CoCH staff involved are engaging appropriately and working together with other agencies to address the needs and reduce any risk to the child/ unborn baby/baby when born and to any other children in the family.

**All safeguarding children supervision is recorded** for future reference if required. When an unborn baby is born that has been on the CoCH safeguarding children case load a multi-agency discharge planning meeting will take place before the baby is transferred from hospital to community care to ensure there is a clear focus on the case until discharge from CoCH services completely.

Total number of **formal (sit down face to face meeting to review an individual case load)** Safeguarding children clinical supervision sessions provided to CoCH staff by the CoCH safeguarding children team **304.** This is slightly more than the previous year and equates to at least **608** hours spent with individual staff members to review individual cases. In addition safeguarding children clinical supervision is given to CoCH staff whenever they telephone the team to discuss a concern and each and every call is given the utmost attention. There has been an increase in the formal supervision sessions when compared to the last reporting period.



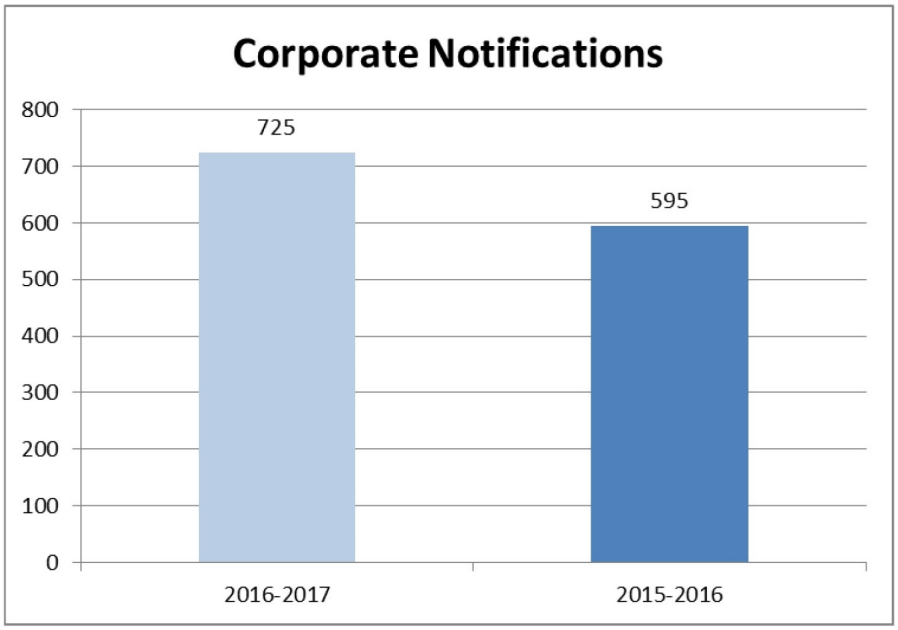

In some cases in Maternity services the concerns of risk of significant harm to the baby is so serious that Children's Social Care will apply to the family courts once the baby is born for an Interim Care Order (ICO) to remove the baby from the mothers care. If an ICO is granted the Local Authority gain Parental Responsibility over the child and share this with the birth mother. The baby is then discharged to foster care (often with the birth mother/father having supervised contact with their baby). These cases are sensitive, traumatic and widely in the public interest and the CoCH safeguarding children team works closely with the relevant Local Authority Children's Social Care and their legal team, as well as the CoCH legal team where appropriate to ensure that these cases are handled appropriately primarily in the interests of the child's safety and protection, but also to ensure that the Trust has acted completely appropriately and can-not be brought into disrepute or face legal challenge and to ensure that the mother/father/ family and CoCH staff are appropriately supported at what is a very difficult time.

### 9.3 Accident & Emergency Department (AED) and corporate notifications

A member of the CoCH Safeguarding Children team attends the AED daily to collect the safeguarding notifications from the previous 24 hours. This process ensures all AED notifications are reviewed and followed up to ensure the appropriate actions and onward referrals have taken place. In the case of a referral having been made by AED staff to Children's Social Care (CSC), the Safeguarding Children's Team will contact CSC to ensure the referral has been received and is being managed appropriately from the CoCH safeguarding children team perspective. On a Daily basis AED staff and staff across the hospital may contact the team for advice /support regarding an individual situation.

**Corporate (mainly AED)**
**Notifications to the Safeguarding children team 725**

Comparisons between the data for 2015-2016 and this reporting period can be seen in the table below. There has been a notable increase in this reporting period.




*"Hi*
*It's good to know that we have a team behind us who have the agility to respond to and follow up our concerns with such vigour. It's also valuable that they feel enabled to challenge and advise when circumstances dictate".*

*Steve Moore*
*Consultant AED June 2017*

All corporate notifications to the safeguarding children team will lead to a safeguarding notification to the Liaison Health Visitor service in the safeguarding Children Team in Cheshire & Wirral Partnership Trust. This is an established safeguarding pathway that ensures the health visitor (pre-school children) and the school health advisor (school age children) is notified of any safeguarding children issues. The majority of corporate notifications received originate in the AED and a high percentage relate to adult attendances whereby the nature of the attendance raises concerns with regard to their ability to care safely and effectively for their

children. These processes were reflect our **"Think Family"** approach to our safeguarding children responsibilities.

### 9.4 Northwest Ambulance Service (NWAS) notifications & Cheshire Police Vulnerable Persons Assessment (VPA) notifications

Previous Serious Case Reviews have identified lack of multi-agency working between ambulance services and AEDs where there have been safeguarding children concerns. For this reason the formal communication NWAS to the CoCH Safeguarding Children Team has been put in place. NWAS notify the CoCH Safeguarding Children Team of any referrals by their staff to Children's Social Care when they have brought the Adult/child to CoCH AED. This is so the CoCH Safeguarding Children Team can ensure that the NWAS staff concerns have also been acted upon as appropriate by CoCH AED staff. **NWAS notifications to CoCH: 35 this compares to 41** in the previous reporting period. The decrease is due to an issue earlier this year when notifications were not being shared with the CoCH this was raised with NWAS and the notification pathway re-commenced.. Cheshire Police copy the CoCH safeguarding children team into all Vulnerable Persons Assessments (VPA) they submit to children's social care in relation to pregnant women. In this period we have had **44** cases referred to us by the police.

**9.5**

Safeguarding processes have led to an increase in contacts to the Integrated Access and referral team (iART) leading to **248** Multi Agency Referral forms (MARF) being submitted.

**Note**: where a contact / referral to CSC has not taken place in response to a CoCH notification to the CoCH Safeguarding Children Team, a range of safeguarding actions as appropriate have been implemented **in accordance with the Continuum of Need Model** seen in **2.1.**

**Note:** periodically the iART will complete and audit of contacts made to the team, a recent audit has identified some agency referrals may have not had to go into iART if that agencies staff had discussed the case with their own safeguarding children team first. We are confident that the CoCH has good processes in place that minimize the risk of unnecessary contacts being made to the iART.

### 9.6 Child Protection Medicals

If a child is thought to have been abused a child protection medical will be required. Medicals will be requested by Children's Social Care requested and are completed by CoCH Peadiatrician's. Number completed in this reporting period is **65 a slight increase** on the previous year. A written report from the Peadiatrician in each case has to be submitted within set timescales **as per LSCB Child Protection Standards.** CoCH Peadiatrician's do not complete sexual abuse medicals. This is a commissioned service from the Sexual Abuse Referral Centre (SARC) at St Mary's in Manchester.

## 9.7 Children made subject to a Child Protection Plan

When a single assessment or pre-birth risk assessment has identified a potential "risk of significant harm" the case will proceed to an Initial Child Protection Case Conference (ICPCC).This is an extremely serious situation for the child/family. If involved the CoCH staff member will have to submit a chronology of CoCH involvement and an analysis of their view of risk to the child. The report has to be shared by the CoCH staff member with the family before the conference and submitted to the Child Protection Case Conference Chair before conference **as per LSCB Child Protection Standards.** It is essential that staff access support in all of these processes via the safeguarding children clinical supervision processes highlighted in **8.2**

We have attended and supported staff to attend a number of Initial Child Protection Case Conferences (ICPCC) in this reporting period. This has included the writing and submission of a report for each conference as per CWAC Child Protection Standards. The majority of ICPCC's attended are for children in Cheshire West and Chester, but these figures do also include some ICPCC in Flintshire. An ICPCC is a statutory requirement where children have been assessed as at being at potential risk of significant harm. The need for a Child Protection Plan under the category of one of the 4 categories of abuse will be decided at case conference. The plan is reviewed in 3/12 (review Child Protection Case Conference and then at 6/12 intervals). This means that the child remains in the care of the parents but a "core group" of professionals will meet regularly with the family to ensure that the recommendations from the CPP are being met and that the concerns are reducing. In this situation if the child/unborn child is made subject to a Child Protection Plan the CoCH staff member working with the family has to become a member of the Core Group **as per LSCB Child Protection Standards.** The child protection plan process has to be robust with multi-agency commitment as in this this situation the child remains in the care of the parents and the "risk" has to be managed and reduced via the CPP.

The CoCH Safeguarding Children Team is notified by Children's Social Care of all children in CWAC who are made subject to a Child Protection Plan. This follows the death of baby I&S in Haringey who died whilst subject to a CPP in 2006. I&S had been seen with injuries by health professionals who were not aware that he was subject to a CPP and was already known to be at risk of significant harm. **A Medi-tech alert is placed on the CoCH records of all children in CWAC who are made subject to a CPP.** This ensures that CoCH would know if a child they are in contact with e.g. in the AED is subject to CPP. The alert advises staff of what they must do. This is a live process overseen by the CoCH Safeguarding Children Team **Alerts are removed when the LA advises the CoCH safeguarding children team that CPP has ended**. This will either be because the concerns have decreased and the case is being managed as a section 17 of the 1989 CA "Child In Need" or because the child has been taken in to care and is now cared for by the Local Authority as a **Child in Care.**

## 9.8 Planning Meetings

**56** Planning meetings (Pre-birth and Discharge Planning meetings) have been undertaken attended by CoCH staff member involved in cases and a member of the CoCH Safeguarding Children Team as well as multi agency safeguarding colleagues e.g. Social Worker/support worker. This is an integral aspect of safe discharging process for the CoCH.

## 9.9 Clinical Incidents

There have been **14** clinical incidents relating to safeguarding children or domestic abuse issues in this reporting period. All have been actioned and responded to and notified as required to the CCG as part of the monthly Safeguarding Assurance Framework reporting to the CCG. This is a decrease on last year of 10; this may be as a result of under reporting by CoCH colleagues. This demonstrates the importance of continuous training and staff awareness to ensure staff recognise and escalate concerns.

The CoCH single agency safeguarding children annual audit plan, participation in LSCB multi agency Audit and the presentation of our single agency audits to the LSCB Audit and Case Review subgroup can help to provide evidence to the LSCB of our safeguarding arrangements. The detail in this report regarding our safeguarding activities can also help to evidence the effectiveness of our processes.

## 10.0 Audit: CoCH Safeguarding Children Audit Plan/Domestic Abuse Audit Plan 2015-2016

The CoCH annual audit of compliance with the Safeguarding & Promoting the Welfare of Children Policy in the 2 key areas, AED and in Maternity services 2015-2016 has been completed and has again evidenced very good compliance in all areas.

The CoCH annual audit of compliance with the Domestic Abuse Policy in the 3 key areas, AED and Maternity services 2015-2016 has been completed and has evidenced again very good compliance.

Both audits have also been presented to the CWAC LSCB Audit and Case Review subgroup.

## 10.1 Quarterly LSCB multi agency case audit process

The CoCH is represented at and takes part in this audit process. The need to complete the audits is a requirement of the **LSCB Performance Management and Quality Assurance (PM&QA) subgroup.** The aim is to ensure quality multi- agency practice around safeguarding children cases and to identify how practice should improve. Each audit will produce a multi -agency action plan. CoCH have submitted audit reports for some children and young people discussed in all of the quarterly audits in 2016-2017

**Update from Paula Lewis who represents the CoCH in this process:**
**Q1 audit**
Theme – Child In Need cases

CoCH submitted 2 audit tools

No formal feedback given following the audit

CoCH did not attend to facilitate due to A/L

**Q2 audit**

Theme – sexual abuse

CoCH submitted 4 audit tools for the audit and CoCH attended to facilitate.

Recommendations included:

Need for every strategy meeting where SA is an issue to consider the need for referral to SARC to complete CP medical.

Agencies ensuring that ALL staff groups have appropriate training to enable them to manage the risks re SA presented within their caseloads.

Continued promotion across agencies of the commissioned services involved in support/assessment of Sexual Abuse cases.

**Q3 audit**

Theme – Children missing from home

CoCH submitted 2 audit tools

CoCH unable to attend as facilitator due to A/L

Recommendations included:

Practitioners need to invest time to understand the underlying reasons that may lead a child deciding to go missing. This means trying always to capture the voice of the child.

Using the Pan Cheshire Escalation Policy in cases of dissatisfaction with partner agencies' decisions or outcomes.

Understanding roles and responsibilities toward safeguarding a child who has gone missing by reference to Pan Cheshire Missing from Home Protocol 2016 - 2017

**Q4 audit**

Theme – Neglect

CoCH submitted 2 audit tools and CoCH attended as facilitator.

Recommendations (still in draft, awaiting agreement by LSCB board) include:

Agreed evidence based tools must be completed for all neglect cases (HCA/GCP)

A health organisation and service chart to be created and made available to all partners (assumptions made by other agencies that information shared with one health agency automatically ensured that the information was shared with all health agencies)

Where consent is granted at TAF and CIN, the lead worker must inform the GP of the case and, where child is school age, school health must be notified of the case.

All actions recommended in the above 4 audits are in place at the CoCH.

The process for the LSCB monitoring agency action plans re recommendations from these audits is under review to evidence individual agency implementation of any learning.

### 10.2 Single Agency Audit outcomes

The CoCH single agency audit outcomes are presented to the LSCB audit and case review subgroup when requested.

### 10.3 LSCB Practice Learning Review (PLR) Process

This is a process that will be initiated by the LSCB Board when potential concerns have arisen about the way in which a safeguarding children case has been managed (but the case does not reach the criterion for a Serious Case Review (SCR). The PLR is a multi- agency process. All agencies involved complete a chronology and management review. A multi -agency action plan will evolve from this process if there are recommendations to improve practice. **There are no open PLR's at present.**

### 11.0 Other Business

### 11.1 Liaison Health Visitor work with CoCH

The Liaison Health Visitor (LHV) (Community Care Western Cheshire) attends the CoCH AED, Children Unit and Neonatal Unit daily. In addition she meets daily with the CoCH safeguarding children team. The LHV is the CoCH close link to the Health Visiting and School Health Service in terms of information sharing and we work very closely from a safeguarding children perspective.

### 11.2 Child protection Information Sharing System (CPIS)

**Update from Paula Lewis CPIS Link:**

CoCH are currently progressing work to ensure that the Trust is in a position to comply with CP-IS requirements. CoCH CP-IS lead will be meeting with the Designated Nurse for Safeguarding and Safeguarding Children leads in neighbouring Trusts in the near future to share best practice regarding use of the Summary Care Record to access CP-IS. Following this, a plan for implementation across the Trust will be drawn up and agreed at Trust SGC Strategy Board.

### 11.3 LSCB Performance Management & Quality Assurance PM&QA) sub group meeting bi-monthly

These CoCH continues to be represented at this group nil significant to report at this time.

### 11.4 Children in Care (CIC)

The Designated Dr (CoCH Consultant Paediatrician, Community) for CIC works closely with the CIC nurses from Community Care Western Cheshire and with the CIC team from Children's Social Care. This ensures that when children are taken into

care by the Local Authority their Initial Health Assessments (IHA) are completed in a timely way. This is closely monitored as CIC are already at their most vulnerable and all must be done to ensure their health and development is not further impaired. All late IHA requests are escalated & there is a clear process in place to address delays in health assessments. There is regular monthly monitoring of performance on the SAF & all out of area placements are included to ensure they have the same timeliness & quality of care. There is a quality assurance process to ensure children's health plans are reflective of their complex needs. Feedback from the child/young person is sought (Rate My Health Assessment) so the voice of the child is central and a health data form completed to monitor service provision locally for this vulnerable group.

### 11.5 Child Death Overview panel (CDOP): Update from Rajiv Mittal CoCH

The Pan Cheshire CDOP is a subgroup of the Local Safeguarding Children Board (LSCB), and has a statutory responsibility to review all infant/child deaths 0-18 years who reside in Cheshire, regardless of where the death took place. It also includes perinatal and neonatal deaths which were registered as a live birth.

CDOP representatives are drawn from key multi-agency organisations. Others may be co-opted to contribute to the discussion if appropriate, i.e., neonatologists, microbiologists etc. There are 2 inter-related processes (either of which can trigger a criminal investigation, safeguarding or /and Serious Case Review)

- **Rapid Response :** a rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child also called as SUDIC (Sudden Unexpected Death In Infant or Child)
- **CDOP panel meeting** – A comprehensive review of all Child Deaths Expected & Unexpected (0-18 yrs.) and has the ultimate aim to prevent potentially avoidable deaths in the future.

**COCH Neonatal Unit Investigation**

There were a cluster of neonatal deaths identified between June 2015 and June 2016 at the Countess of Chester Hospital which are being investigated by the Cheshire Police. As a result of this inquiry, some changes have been made to the Pan Cheshire CDOP process called SUDIC protocol. The new protocol will be applicable to any baby who dies in neonatal unit or unexpected collapse in the neonatal unit or any neonatal death > 24 weeks gestation for the next 6 months (till 2017 end). It has also been identified the importance of understanding the CDOP process within North Wales and in maintaining effective communication with colleagues across the border.

The CoCH is represented on the Child Death Overview Panel by the Designated Dr for Safeguarding Children who is informed about all child deaths at the CoCH and all child deaths will be reviewed by the CDOP. Following the "Wood Review 2016", and as only 4% of child deaths relate to safeguarding, the Government has agreed to the transfer of national oversight of CDOPs from the Department for Education to the Department of Health, whilst maintaining the focus on learning in relation to safeguarding children issues if they arise in any child death. There are no open actions in relation to CDOP reviews at the CoCH at present.

### 11.6 Shared Safeguarding Responsibilities with other Providers

A meeting has taken place between the CoCH Safeguarding Children lead and the Head of Safeguarding Children for One to One Midwifery. Potential increased risks for service users where there are safeguarding issues were discussed. Process's for sharing information and individual provider safeguarding children responsibilities in relation to services users using both services have been clarified and agreed. Ongo9ng meetings will take place if and when required.

### 11.7 Betsi Cadwaladr University Health Board

Collaborative work continues with welsh colleagues to ensure effective communication takes place in respect of safeguarding issues as families move between services across North Wales and West Cheshire. Work on clinical pathways continues to be progressed to ensure consistency of policies, referral processes and access to services in order to keep children safe.

### .12.0 Children & Young People

The CoCH Lead Nurse for Children continues her work to champion the needs of children and young people across the Trust. Her work this year has included producing a quarterly report for the CWAC LSCB in relation to the numbers of children attending the CoCH with Self Harm issues and Mental Health issues. This data feeds into the work being undertaken by the LSCB in relation to this vulnerable group. The Lead nurse for children works to try to ensure that CoCH process's ensure the wishes and feelings of children are sort and that this can be evidenced in our health records and process's. the children and young people mental health services inclusion group led by CAMHS is a group pf young service users some of whom spoke at a recent training event organised by Cheshire Police. The CoCH lead Nurse is going to lead on inviting some of these young people to key meetings and staff events at the CoCH to deliver a short talk from their perspective regarding how they would like to be supported when in contact with the CoCH. The intention is that practice can be improved in this area as a result of feedback.

### 12.1 Gaining feedback from Children & Young People

The CoCH must be able to continue to evidence that it seeks the wishes and feelings of children and young people and that the impact of any changes at the Trust. The Lead Nurse for children champions the unique needs of children cross the Trust and there are a number of ways in which children's views are sought. The Lead Nurse also receives a daily report regarding numbers of young people aged 16 and 17 years cared for on our adult wards, this is to ensure any particular medical or nursing issues are addressed given they are children in the eyes of the law but are cared for on adult wards.

### 13.0 Challenges for the Safeguarding Team

Our work is high risk, every telephone call and every knock on the office door to discuss the smallest concern can lead to a serious safeguarding issue children or domestic abuse issue. Our aim is always to try to get our initial response from a CoCH perspective right in each case as research evidences that getting it wrong at the start can be a catalyst for getting it wrong in the longer term and case reviews have evidenced that those early mistakes were the catalyst for children (and adults in DA cases) being left at risk of serious or fatal harm.

The figures shown in this report indicate the numbers of cases dealt with but this is only one small part of the story in each case. The in-depth work involved in each case is difficult to quantify in a way that can truly demonstrate how much work is completed in each case. As such our capacity, given that we are a very small team continues to be the greatest challenge. But we remain committed each day to ensuring that we always respond with integrity in a timely way to all safeguarding children issues and domestic abuse issues this ensures that our statutory responsibilities and the values of the CoCH are upheld..

## 14.0 Recommendations

The Board of Directors is asked to note the contents of this detailed report and to acknowledge the significant amount achieved during 2016-2017.

Going forward we need to ensure we are ready for our next Safeguarding Children Inspection which is officially due in 2017 this will be undertaken within the new Ofsted, CQC, HMIC, and HM Inspectorate of Probation Joint Targeted Safeguarding Children Inspection Framework.

**Karen Milne, RM/ Dip HE / BA Hons**
**Named Midwife/Professional Safeguarding Children/ Lead Domestic Abuse**
**July 2017**