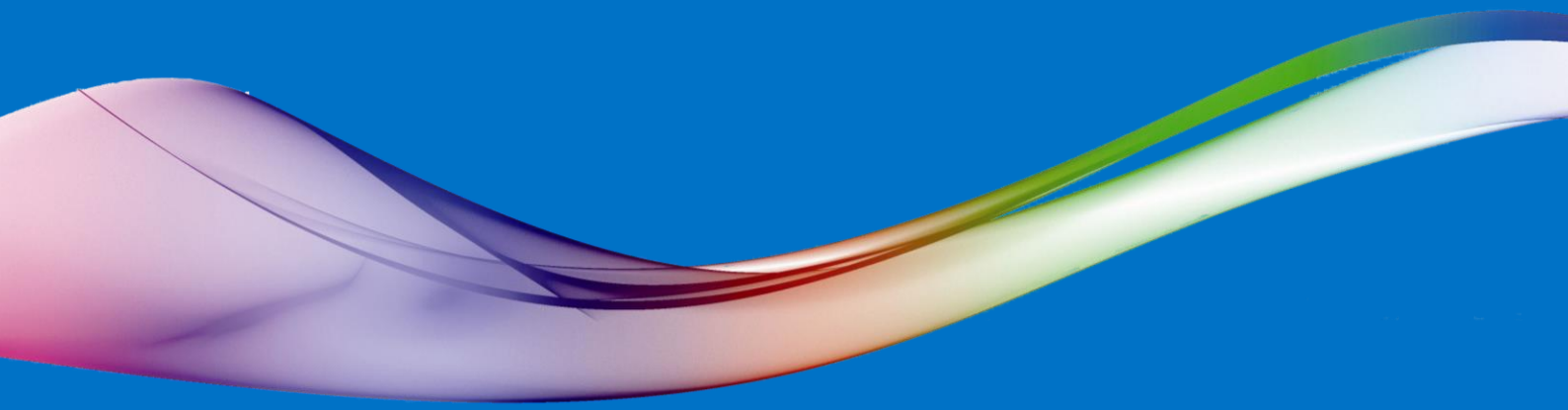
NHS
Wigan Borough
Clinical Commissioning Group

Safeguarding Children and Adults at Risk

Annual Report 2015/16



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Contents

Executive Summary

The purpose of this report is to provide an overview of WBCCG Safeguarding governance arrangements and the work completed by the WBCCG Safeguarding Team from 1st April 2015 to 31st March 2016 to ensure the CCG meets its statutory safeguarding responsibilities in respect of children and adults at risk.

The report focuses on the work of the WBCCG Safeguarding Team. The success of this team requires the full engagement of the commissioned Acute, Community and Mental Health Foundation Trusts, GP Practices across the CCG and Partner Agencies.

There are safeguarding systems in place across the Wigan Borough health economy. There are challenges in relation to training and response to Serious Case Reviews and Domestic Homicide Reviews within the Wigan Borough. It is essential that a high level of priority is given to safeguarding children and adults at risk.

The WBCCG Safeguarding Team is committed to meeting the challenges of safeguarding the population of Wigan Borough and will continue to work collaboratively with the Local Authority, WSAB, WSCB and key partners to develop robust systems to safeguard children and adults at risk.

1. Introduction

1.1 This is the third joint safeguarding children and adults at risk annual report for Wigan Borough Clinical Commissioning Group (WBCCG) and will inform the Wigan Safeguarding Adult Board Annual Report and Wigan Safeguarding Children Board Annual Report.

1.2 The report focuses on key drivers of work including the local and national safeguarding context, WBCCG governance arrangements and work with commissioned services and other key partners.

1.3 Safeguarding is 'everybody's business' and the WBCCG Safeguarding Team works to ensure that it remains a 'golden thread' running through all commissioned services. It remains the responsibility of every NHS funded organisation and healthcare professional to ensure that people in vulnerable circumstances are not only safe, but also receive the highest possible standard of care.

1.4 Safeguarding comprises a broad and complex agenda that in addition to the more commonly known work streams includes the following;

- Female Genital Mutilation
- Domestic Abuse
- Domestic Homicide Reviews
- Child Sexual Exploitation
- Mental Capacity Act & Deprivation of Liberty Safeguards
- Human Trafficking/Modern Day Slavery
- Serious Case Reviews
- Counter Terrorism (Prevent)
- Fabricated and Induced Illness
- Response to Saville
- Child Deaths
- Adult Deaths where abuse is suspected or the circumstances are unusual

1.5 The WBCCG Safeguarding Team works in partnership with key stakeholders to monitor the safeguarding arrangements of commissioned health services; to respond to adults and children who have been harmed or are at risk of harm, with the intention of delivering improved outcomes for the most vulnerable.

2. Purpose

2.1 The purpose of this report is to provide an overview of WBCCG Safeguarding governance arrangements and the work completed by the WBCCG Safeguarding Team from 1st April 2015 to 31st March 2016 to ensure the CCG meets its statutory safeguarding responsibilities in respect of adults and children.

3. National Context – Safeguarding

3.1. In July 2015 NHS England (NHSE) published the national non-statutory guidance 'Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework' which superseded 'Safeguarding Vulnerable People in the Reformed

NHS - Accountability and Assurance Framework' issued by NHS Commissioning Board in March 2013.

3.2. The purpose of the Accountability and Assurance Framework is to set out clearly the safeguarding roles, duties and responsibilities of all organisations commissioning NHS health and social care.

3.3. It was refreshed in partnership with colleagues from across the health and social care system, the Department of Health (DH) and the Department for Education (DfE), particularly recognising the new responsibilities set out in the Care Act 2014 which came into force on 1st April 2015.

3.4. The revised document also reflects NHS England organisational changes, the introduction of co-commissioning and the revised 'Working Together to Safeguard Children' statutory guidance (March 2015).

3.5. The document sets out how the health system operates, how it will be held to account both locally and nationally and makes clear the arrangements and processes to be undertaken to provide assurance to the NHS England Board with regard to the effectiveness of safeguarding arrangements across the system.

4. National Context – Safeguarding Adults

4.1. The Department of Health identified six safeguarding principles for adult safeguarding:

1	**Empowerment**	People are supported and encouraged to make their own decisions and give informed consent.
2	**Prevention**	It is better to take action before harm occurs.
3	**Proportionality**	Local solutions achieved through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
4	**Protection**	The least intrusive response appropriate to the risk presented.
5	**Partnership**	Support and representation for those in greatest need.
6	**Accountability**	Accountability and transparency in safeguarding practice.

4.2. The Care Act (2014) sets out a single, consistent route to establishing entitlement to public care and support for adults. It also provides a clear legal framework for how Local Authorities and other parts of the health care system should protect adults at risk of abuse or neglect.

4.3. Guidance was published specifying that the requirements of the Care Act must be implemented by April 2015.

4.4. The following have now been implemented by the Wigan Safeguarding Adult Board and the Local Authority:

- A change of the definition from that laid out within 'No Secrets, 2000';
- Development of a statutory Safeguarding Adults Board (See Section 12);
- The Local Authority makes enquiries, or ask others to, when they think an adult with care and/or support needs may be at risk of abuse or neglect; and to find out what, if any, action may be needed;
- Safeguarding Adult Reviews to be held where a failure in safeguarding is identified;
- Greater clarity and emphasis on the requirement to share information;
- Greater emphasis on Local Authorities to provide independent advocacy for the purposes of safeguarding adults.

5. National Context – Safeguarding Children

5.1. Section 11 of the Children Act (2004) places duties on a range of organisations and individuals to ensure their functions, and that of any service that they commission, are discharged having regard to the need to safeguard and promote the welfare of children. Section 11 places a duty on NHS organisations, including NHS England and Clinical Commissioning Groups (CCGs), NHS Trusts and NHS Foundation Trusts.

5.2. The statutory and supplementary guidance entitled 'Working Together to Safeguard Children, A guide to inter-agency working to safeguard and promote the welfare of children' (Department for Education, March 2015) supports the safeguarding children legislative framework.

5.3. Working Together states that CCGs are responsible for safeguarding quality assurance through contractual arrangements with all provider organisations. It also requires that CCGs employ, or have in place, a contractual agreement to secure the expertise of Designated Professionals.

6. National Context - Child Protection Information Sharing Project

6.1. The 'Child Protection - Information Sharing' (CP-IS) project, led by the Health and Social Care Information Centre (HSCIC), aims to improve the way that health and social care services work together across England to protect vulnerable children.

6.2. CP-IS focuses on improving the protection of children who have previously been identified as vulnerable by Social Services when they visit the following NHS unscheduled care settings:

- Emergency Departments
- Walk-in Centres
- GP Out of Hours
- Minor Injuries Units
- Paediatric Wards
- Maternity Units

- Ambulance Services

6.3. CP-IS provides health professionals with prompt and easy access to key social care information to help them to assess whether a child is at risk.

6.4. The process of identifying children who have been maltreated, or are at risk of significant harm from abuse or neglect, during a single attendance remains difficult for even the most experienced clinician.

6.5. The ability to correctly diagnose abuse or neglect depends on having the whole picture. Giving clinicians in unscheduled care settings access to relevant social care information is essential to successfully identify children who may be at risk.

6.6. The project links the IT systems of NHS unscheduled care to those used by social care child protection teams, so that information can be shared about three specific categories of child:

- Those with a child protection plan;
- Those classed as looked after (i.e. children with full and interim care orders or voluntary care agreements);
- Any pregnant woman whose unborn child has a pre-birth child protection plan.

6.7. Wigan was identified as a 'First Wave' early adopter of the CP-IS project and the CP-IS project went 'live' in the Wigan Borough on 02/02/15 in the Acute Trust in the Accident and Emergency Department and Maternity Department.

6.8. Implementation of CP-IS in the GP Out of Hours Service and Leigh Walk in Centre has been delayed due to issues with the ability of the clinical IT system to connect to Summary Care Record.

6.9. The Share to Care Programme Board will oversee the implementation of CP-IS within the Wigan Borough with the assistance of the Assistant Director Safeguarding Children and Looked After Children.

7. Local Context - NHS England Greater Manchester Area Team

7.1. The Director of Nursing for the NHSE GM Area Team is responsible for supporting and providing assurance in relation to safeguarding children and adults at risk of abuse or neglect.

7.2. The WBCCG Assistant Director Safeguarding Children/Designated Nurse for Safeguarding Children and Looked After Children (LAC) and the Assistant Director Safeguarding Adults attend the Safeguarding Collaborative hosted by the NHSE GM Area Team and support the NHSE GM Area Team in meeting its statutory safeguarding responsibilities.

7.3. The GM Safeguarding Children, Looked After Children and Safeguarding Adults Clinical Networks report to the Safeguarding Collaborative.

8. Local Context - WBCCG Safeguarding Team

8.1. The WBCCG Safeguarding Team works with partners to ensure that the Providers of the services we commission respond appropriately to children and adults at risk, with the intention of delivering improved outcomes and life chances for the most vulnerable.

8.2. WBCCG is required to have the following statutory safeguarding posts in place:

- Designated Nurse for Safeguarding Adults and identified Mental Capacity Act Lead
- Designated Nurse for Safeguarding Children and Looked After Children (LAC)
- Designated Doctor for Safeguarding Children
- Designated Paediatrician for Unexpected Deaths in Childhood
- Named General Practitioner (GP) Safeguarding

8.3. The CCG employs both an Assistant Director for Safeguarding Adults and Assistant Director Safeguarding Children and LAC/Designated Nurse who work across the health economy to build clinical awareness of safeguarding. This includes:

- Work with providers of WBCCG commissioned services to ensure children and adults at risk are safe, and a cohesive organisation wide strategy is in place which reflects national policy, local guidance and best practice;
- Work with Local Safeguarding Boards to ensure communication and governance processes are in place between WBCCG and Local Authority (LA) in order to ensure all services commissioned provide a comprehensive service to safeguard adults and children;
- Providing highly specialised clinical advice and expert knowledge to peers, other professionals; advanced level practitioners, nursing and residential homes and agencies within the geographical area on all safeguarding concerns.

8.4. A new Assistant Director for Safeguarding Adults commenced in post at the end of April 2015. This role also incorporates the lead for Mental Capacity Act.

8.5. The Assistant Director Safeguarding Children/Designated Nurse post holder was previously seconded to WBCCG from Bridgewater Community Healthcare NHS Trust in November 2014 for a period of 18 months. The post holder was interviewed and offered a permanent position with WBCCG in November 2015.

8.6. The Designated Doctor for Safeguarding Children post is commissioned from Wrightington, Wigan and Leigh NHS Foundation Trust (WWLFT). WBCCG has started to review the arrangements in relation to Designated Doctors to ensure robust service specifications are in place which set out clear accountability and performance management provision, and that the appropriate personnel meet the full requirements as set out in the competency framework for safeguarding professionals.

8.7. As part of this review a new Designated Doctor Safeguarding Children was interviewed and appointed in October 2015. The new post holder is a Consultant Paediatrician and fulfils all of the knowledge, skills and expertise required of the role in line with the safeguarding competency framework.

8.8. The Designated Paediatrician for Unexpected Deaths in Childhood resource is provided through the GM Rapid Response to Sudden Unexpected Death in Childhood (SUDC) Service. Within this service, Paediatricians work jointly with Greater Manchester Police (GMP) and Children's Social Care to investigate unexpected deaths and report to the Coroners and Child Death Overview Panels. The service aims to thoroughly investigate unexpected deaths and provide support and information to the families and professionals involved. A senior WWLFT Paediatrician is involved in delivering this service.

8.9. A Named GP for Safeguarding is employed by WBCCG and provides three programmed activities (PAs) per week. Although this post is not a statutory requirement it is considered good practice to secure their expertise to provide a primary care clinician's perspective to the safeguarding agenda. The role of the Named GP for Safeguarding is to work with the Designated Doctor and Nurse, and Practice Safeguarding Lead GPs to ensure that primary health care teams meet their safeguarding responsibilities.

8.10. A WBCCG Safeguarding Team Structure Chart can be seen in **Appendix 2.**

9 Local Context - WBCCG Safeguarding Governance Arrangements

9.1 The Chief Officer remains the Board Executive lead for safeguarding children, safeguarding adults at risk and LAC. The WBCCG Safeguarding Team is part of the Quality Directorate and reports directly to the Associate Director of Quality, Safety and Safeguarding.

9.2 The Safeguarding Team have established quarterly meetings with the Chief Officer to update her in relation to safeguarding matters. However, they continue to have direct access to the Chief Officer as required for example to discuss serious incidents and child deaths.

9.3 Key representatives of WBCCG are statutory members of Wigan Safeguarding Children Board, Wigan Safeguarding Adult Board and the Health and Wellbeing Board. The Assistant Directors Safeguarding/Designated Nurses act as expert advisors to their respective Safeguarding Board.

9.4 The 'Greater Manchester Commissioning Safeguarding Children, Young People and Adults at Risk Policy' February 2015 was revised in March 2016. The title of the document was amended to better reflect the content. The content of the document was refreshed to reflect legislative and structural changes within the health economy.

9.5 The document is now titled Safeguarding Children, Young People and Adults at Risk – Contractual Standards 2016-2017 and is a collaborative GM document. This document contains the safeguarding audit framework used to monitor all NHS and Non NHS providers of health care.

9.6 A Governance Framework can be seen in **Appendix 3.**

10 Local Context - WBCCG Quality, Safety and Safeguarding Group (QSSG)

10.1 The Safeguarding Team are integrated into the Quality Directorate which facilitates the commissioning of safe care with the requisite checks and balances to ensure that local healthcare provider services meet their responsibilities. Formal monitoring is undertaken through the Quality, Safety and Safeguarding Group (QSSG) meetings.

10.2 The QSSG meets with each of our three main providers of acute, community and mental health services, separately on a bi-monthly basis.

10.3 We assure compliance of provider organisations by:

- Monitoring against the NHS Provider Safeguarding Audit Tool to Monitor Standards based on CQC Essential Standards and Section 11 of the Children Act 2004, (See **Appendix 1**);
- Monitoring of the implementation of the Government's counter terrorism strategy (CONTEST) via the delivery of the PREVENT training. This is a statutory duty and is included as part of the NHS Provider Safeguarding Audit Tool;
- Monitoring provider responsibilities in relation to Mental Capacity Act and Deprivation of Liberty Safeguards;
- Monitoring in progress against Serious Case Review, Domestic Homicide Review and Local Case Review action plans;
- Monitoring of the management of allegations against staff working within healthcare providers.

10.4 The Safeguarding Team provides assurance to the Governing Body and NHSE on an annual basis in relation to NHS Provider Safeguarding Audit Tool review process. Each provider is required to demonstrate they are meeting the relevant safeguarding contractual standards by providing appropriate evidence to the WBCCG Safeguarding Team. Appropriate action is taken using the escalation process, where they do not.

10.5 In 2015/16 the Safeguarding Team have worked to improve the governance in relation to this process by developing a formal report. Each of our three main providers has received a 'Safeguarding Team Report: Validation of Evidence Submitted - NHS Provider Safeguarding Audit Toolkit 2015/16'.

10.6 This report lists all of the evidence submitted by the Provider and a detailed response from the Safeguarding Team regarding the level of assurance given against each safeguarding contractual standard. The final version of this report is agreed with each Provider at their QSSG meeting.

10.7 Quality, Safety and Safeguarding reports are also produced on a quarterly basis by the Safeguarding Team in partnership with the Quality Team. This report is

submitted to the WBCCG Clinical Governance Committee and in turn to the Governing Body.

11 Local Context – Wigan Borough Safeguarding Children Health Collaborative

11.1 The Wigan Borough Safeguarding Children Health Collaborative, hosted by WBCCG, is a group of local health safeguarding lead professionals who work together to provide a seamless safeguarding service to the children of the Wigan Borough. The group reviews and plans health responses to national and local health safeguarding priorities.

11.2 The Safeguarding Children Health Collaborative meets quarterly and is chaired by the Named GP Safeguarding Children. Membership includes safeguarding children leads from the following organisations:

- 5 Boroughs Partnership NHS Foundation Trust
- Bridgewater Community Healthcare NHS Foundation Trust
- Wigan Borough Clinical Commissioning Group
- Wrightington, Wigan & Leigh NHS Foundation Trust

11.3 The purpose of the collaborative is to systematically bring together safeguarding health professionals for children across the Wigan Borough to share safeguarding issues and information in order that as a health economy we work together to ensure that children are safe and achieve their full potential. The Collaborative will be focused on driving improvements in quality and safety by:

- The sharing and dissemination of information from the Greater Manchester Safeguarding Collaborative hosted by the NHS England Greater Manchester Area Team;
- Taking a strategic view on a whole systems approach to keeping children safe;
- Having insight and a thorough understanding of current roles and responsibilities in relation to safeguarding across the health economy;
- Shared learning and dissemination of feedback information with regard to lessons learned.

11.4 In order to achieve the purpose above, the Collaborative:

- Reviews progress in relation to implementing and embedding health related actions from Local and Serious Case Reviews;
- Shares and disseminates good practice and innovation across organisations;
- Disseminates national and local learning;
- Conducts themed safeguarding audits across the health economy as required;

- Works together to implement the strategic priorities of Wigan Safeguarding Children Board;

- Ensures the voice of the child is heard and responded to.

11.5 The Collaborative links with Wigan Safeguarding Children Board Executive Group and GM Designated and Named Professionals Forums.

11.6 The Collaborative also provides information as appropriate to the Safeguarding Collaborative hosted by the NHSE GM Area Team.

12 Wigan Safeguarding Adults Board (WSAB) and Sub Groups

12.1 The Care Act, 2014 states that Safeguarding Adult Board's must:

- Include the Local Authority, the NHS and the Police, who should meet regularly to discuss and act upon local safeguarding issues;

- Develop shared plans for safeguarding, working with local people to decide how best to protect adults in vulnerable situations;

- Publish a safeguarding strategic plan and report to the public annually on its progress, so that different organisations can make sure they are working together in the best way.

12.2 The WBCCG representative at WSAB is the Director of Quality.

12.3 The Assistant Director Safeguarding Adults supports the work of the WSAB and attends Board meetings and Sub Groups of the WSAB in the capacity of a professional adviser, in accordance with Care Act (2014). Professional advisors share their knowledge and expertise to support members in carrying out their functions and duties.

12.4 The Assistant Director Safeguarding Adults has significantly contributed to the work of the WSAB in the following ways:

- Co-Chair of the Learning and Improvement Sub Group;

- Supported Named Safeguarding Adult Nurses and Professionals by providing expert advice and support in relation to clinical practice;

- Contributing to multi-agency audits to review safeguarding practice across the Wigan Borough.

12.5 The following Sub Groups report to the WSAB:

WSAB SUB GROUP	PRIMARY PURPOSE
Learning and Improvement	To provide a systems leadership role regarding support and safeguarding processes and services that sit under the Building Stronger Communities Partnership and Adult Safeguarding jurisdiction. This will be done by sharing lessons learnt through case reviews, which identify a breakdown in systems, performance or communication and will through review facilitate change to improve service delivery and inform future commissioned services.
Mental Capacity Act (MCA)/Deprivation	To provide strategic leadership and support across the economy of Wigan in

of Liberty Safeguards (DoLS)	relation to The Mental Capacity Act (2005) and Deprivation of Liberty Safeguards(2009). To ensure health and social care provider agencies across Wigan fully implement the Mental Capacity Act 2005 (including DOLS). To provide assurance to Wigan Safeguarding Adult Board in relation to Mental Capacity Act implementation and the quality of practice or raise concerns as appropriate.
Training and Development	This is now a joint sub group for both Wigan Safeguarding Adult Board and Wigan Safeguarding Children Board. The Sub Group is responsible for the strategy, development, quality assurance and co-ordination of multi-agency safeguarding training provision. This will include making recommendations regarding the delivery, facilitation and commissioning of appropriate training resources and ensuring the regular review and evaluation of the training provision in line with the WSAB and WSCB Business Plans. The Sub Group works to ensure that learning from multiagency audits, and any lessons learned from Serious Case Reviews, Domestic Homicide Reviews and Local Case Reviews are embedded into practice in order to develop a culture of continuous learning and improvement for all partners of WSAB/WSCB.

13 WSAB Serious Case Reviews (SCRs) and Local Case Reviews (LCRs)

13.1 Safeguarding Adult Serious Case Reviews are undertaken by the Wigan Safeguarding Adult Board (WSAB) when:

- An adult has died, and the WSAB knows or suspects that the death resulted from abuse or neglect;
- The adult is still alive, and the WSAB knows or suspects that the adult has experienced serious abuse or neglect;
- There is any reasonable cause for concern regarding how organisations or professionals worked together to safeguard the adult.

13.2 The WSAB may also arrange for there to be a Local Case Review of any other case involving an adult in the Borough area where there is significant learning and the case falls short of the above threshold.

13.3 An overview of the WSAB Safeguarding Adult Serious Case Reviews and Local Case Reviews in 2015/16 are outlined in the table below:

REF ID	INCIDENT DATE	ORGANISATION	STATUS	StEIS Ref No
LCR Adult 6	March 2014	Health Economy	Investigation completed. A Local Multi-Agency Learning Event took place on 18/02/15 with adult and children's services. A Local Case Review Action Planning Meeting was held on 14/07/15 to agree the final action plan and accompanying timescales. A Final Report was received and signed off by WSAB. Report closed on StEIS. Action Plan being monitored by WSAB.	2014/8210
LCR Adult 7	July 2014	WWLFT	Single Agency Review completed. Report received by WBCCG Serious incident and Never Event (SINE) Panel from WWLFT. StEIS entry closed. WSAB Learning and Improvement Sub Group undertook a multi-agency audit to ensure actions from Root Case Analysis	2014/23316

			have been completed. Report completed and Action Plan being monitored by WSAB.	
LCR Adult 8	July 2014	Health Economy	WSAB have undertaken a LCR. Draft report was presented and discussed at Panel Meeting on 02/11/2015. WSAB have reviewed and agreed the Action Plan.	
LCR Adult 9	Nov 2014	Health Economy	WSAB have undertaken a LCR. First Panel Meeting held on 02/11/2015. Terms of Reference have been agreed and WBCCG Individual Management Review (IMR) Report completed February 2016, signed off by Chief Officer. 2nd and 3rd Panel Meetings held in April and May. Final draft report to be discussed and agreed at next Panel Meeting in July 2016.	
LCR Adult 10	May 2015	Health Economy	Independent Chair appointed and first Panel Meeting held on 16/11/2015. Terms of Reference agreed. IMR completed and signed off by Chief Officer. Systems Thinking Event held on 23/03/16 to review IMRs and subsequent Panel Meeting held on 03/05/16. Next Panel Meeting planned for 9th July 2016.	
SCR Adult 11	May 2015	Health Economy	WSAB to conduct a Serious Case Review. Independent Chair appointed and 1st Panel Meeting held on 28/01/16. IMR completed and signed off by Director of Quality. Systems Thinking Event held on 26/04/16. Next Panel Meeting planned for 12th July 2016.	

14 Domestic Homicide Reviews (DHRs)

14.1 A DHR is conducted to review the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom he was related or with whom he was or had been in an intimate personal relationship, or a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.

REF ID	INCIDENT DATE	ORGANISATION	STATUS	StEIS Ref No
DHR 2	25/07/2014	Health Economy	Independent Chair appointed. IMR reports were requested and received from appropriate agencies. The Independent Chair has finalised the Overview Report and sent it to the Home Office Quality Assurance Group for approval. In Q4 the Home Office Quality Assurance Group reviewed the Overview Report who requested clarification regarding some of the content. Amendments have been made and are currently in the process of being quality assured before re-submission to the Home Office for final acceptance. WBCCG updated StEIS with key lessons learned and recommendations. A subsequent request by WBCCG to NHSE for closure was agreed.	2015/14834 StEIS entry closed by NHSE 11/11/15

DHR 3	13/11/2014	Health Economy	Independent Chair appointed. IMRs from appropriate agencies were requested and received. The Independent Chair produced a final draft Overview Report which was presented to the BSCP Board in November 2015. The Home Office Quality Assurance Group have reviewed the Overview Report and as a consequence requested further information which has been provided by the Chair. The Home Office Quality Assurance Group agreed the final report; however, the request not to publish the report in order to protect the children involved has been declined and is now subject to challenge by the Local Authority. WBCCG updated StEIS with key lessons learned and recommendations. A subsequent request by WBCCG to NHSE for closure was agreed.	2015/20709 StEIS entry closed by NHSE 11/11/15
DHR 4	01/02/2015	Health Economy	Independent Chair was appointed. IMRs were requested and received from appropriate agencies in Wigan, Liverpool and West Lancashire. Panel meetings held and the content of agency IMRs was discussed in full by way of a Systems Thinking Event. The Overview Report has been sent to the Home Office Quality Assurance Group for scrutiny and approval. It is scheduled to be reviewed on 27/04/16. WBCCG will update StEIS with key lessons learned and recommendations as soon as the Home Office approve the Overview Report.	2015/20763 Stop the clock request agreed by NHS England.

15 Wigan Safeguarding Children Board (WSCB) and Sub Groups

15.1 The Children Act 2004 and the Local Safeguarding Children Boards (LSCB) Regulations 2005 required all Local Authority areas to establish statutory LSCBs. LSCBs are required to coordinate and ensure the effectiveness of local arrangements and services to safeguard and promote the welfare of children in their area.

15.2 In terms of its legal status, WSCB is the key statutory body for agreeing how organisations in Wigan will co-operate to safeguard and promote the welfare of children in the area, and for ensuring the effectiveness of what they do.

15.3 To carry out its responsibilities effectively, WSCB requires representation from each of the identified statutory agencies in Working Together (2015). Member organisations are required to appoint representatives to the Board whose roles and seniority enable them to contribute to developing and maintaining strong and effective multi-agency safeguarding procedures and protocols, and ensure that local safeguarding services are adequately resourced.

15.4 The WBCCG representative at WSCB is the Chief Officer who is also the WBCCG Board Lead for safeguarding.

15.5 The Assistant Director Safeguarding Children/Designated Nurse supports the WSCB and attends Board meetings in the capacity of a professional adviser, in accordance with Working Together (2015).

15.6 Operational support is also provided by Assistant Director Safeguarding Children/Designated Nurse to the WSCB. This involves attendance at Sub Groups and leading on key areas of work as appropriate.

15.7 The Assistant Director Safeguarding Children/Designated Nurse has significantly contributed to the work of the WSCB in the following ways:

- Chair of the joint WSCB/WSAB Training and Development Sub Group;
- Chair of the WSCB Learning and Improvement Sub Group;
- Representative at the Bolton, Salford and Wigan Tripartite Child Death Overview Panel (CDOP);
- Facilitation of Local Case Reviews;
- Development of a WSCB Serious Case Review methodology and accompanying templates;
- Planning and delivery of multi-agency locality based briefings to front line staff;
- Supported Named Safeguarding Children Nurses and Professionals by providing expert advice, support and clinical supervision;
- Planning and delivery of WSCB Child Sexual Exploitation (CSE) Briefings to multi-agency audiences;
- Delivery of WSCB safeguarding training in relation to neglect, fabricated and induced illness and sexual abuse;
- Leading on, and contributing to, multi-agency audits to review safeguarding practice across the Wigan Borough.

15.8 The following Sub Groups report to the WSCB:

WSCB SUB GROUP	PRIMARY PURPOSE
Learning and Improvement	• To conduct individual case audits as identified by the Executive or constituent agencies; • To critically review actions and recommendations from Serious Case Reviews, Critical Incident Reviews, or individual agency reviews to ensure they have been implemented and embedded in practice; • To analyse areas of safeguarding work that have a specific common theme, such as teenage self-harm and multi-agency responses, CSE; • To collate audits by individual agencies so that there is a clear understanding of audit, analysis and learning activity that demonstrates impact of lessons learned.
Communication and Media	• To raise awareness of Wigan's Safeguarding Children Board, it's aims, priorities and responsibilities; • To inform and engage the whole community to support keeping children and young people safe in Wigan Borough;

	• To publicise the services available and the thresholds to ensure consistency; • To improve the accessibility and quality of information/advice available; • To ensure targeted communications by consulting with young people to find out the issues that matter to them; • To prepare responses to case reviews prior to hearings to minimise reputation risk; • To engage more effectively with communities and third sector groups to reach a wider audience; • To ensure safeguarding children is everybody's business.
Training and Professional Development	This is now a joint sub group for both Wigan Safeguarding Adult Board and Wigan Safeguarding Children Board. The Sub Group is responsible for the strategy, development, quality assurance and co-ordination of multi-agency safeguarding training provision. This will include making recommendations regarding the delivery, facilitation and commissioning of appropriate training resources and ensuring the regular review and evaluation of the training provision in line with the WSAB and WSCB Business Plans. The Sub Group works to ensure that learning from multiagency audits, and any lessons learned from Serious Case Reviews, Domestic Homicide Reviews and Local Case Reviews are embedded into practice in order to develop a culture of continuous learning and improvement for all partners of WSAB/WSCB.
Education	• Ensuring education settings compliance with statutory duties identified in Section 175 Education Act 2002, and other legal guidance any appropriate inspection reports; • Ensuring safe working practices within educational settings; • Enhancing the understanding of safeguarding in schools and education settings.
Child Sexual Exploitation	The role of the Child Sexual Exploitation (CSE) sub group is to oversee the effective delivery of the WSCB CSE Strategy through: • Developing proactive approach to addressing and preventing CSE; • Monitor and evaluate the quality and effectiveness of the CSE Strategy in identifying and tackling CSE; • Ensuring there are sufficient resources available to facilitate an effective response to CSE; • Ensuring that protocols relating to CSE are relevant, up to date and effective and that there is clarity in local practice and procedures in relation the approach to CSE; • Identify emerging patterns, threats, risks and opportunities relating to CSE and missing children so that agencies may target their service delivery activities appropriately; • Feeding into the review of lessons learned through the Learning and Improvement Group; • Supporting the delivery of multi-agency training through the WSCB Training Sub Group; • Supporting engagement with young people, carers, parents and professionals through the WSCB Communications and Engagement Sub Group; • Promote an understanding of CSE amongst the professionals in the Wigan Borough in collaboration with the Training Sub Group and the Communications and Engagement Sub Group.
Child Death Overview Panel	• Monitor and review all child deaths in the local area • Identifying themes or issues for future preventative action including support services for bereavement
Critical Incident Review Panel	Mandatory tasks: • Review cases that have been notified to Ofsted or NHS StEIS notifications to assess if the meet the criteria for a SCR or any other review • Review cases from Multi Agency Strategy meetings that have been referred in to the panel to see if they meet the criteria for a SCR or any other review • Decision making from these panels is shared with, and validated by WSCB Independent Chair

16 WSCB Serious Case Reviews (SCRs) and Local Case Reviews (LCRs)

16.1 SCRs are undertaken by Local Safeguarding Children Boards (LSCBs), for every case where abuse or neglect is known, or suspected, and either: a child dies, or is seriously harmed and there are concerns about how organisations or professionals worked together to protect the child.

16.2 The WSCB may also arrange for there to be a Local Case Review of any other case involving an child in the Borough area where there is significant learning and the case falls short of the above SCR threshold

16.3 The LSCBs are responsible for overseeing the implementation of recommendations and action plans from SCRs. Wigan Safeguarding Children Board (WSCB) discharges this responsibility via SCR Scrutiny Panels where all agencies are required to present evidence to the panel for actions to be ratified as completed.

16.4 The Assistant Director Safeguarding Children/Designated Nurse is responsible for implementing and monitoring progress against actions required across the whole health economy, GPs and Clinical Commissioning Groups. Progress in relation to these actions is ultimately overseen by the WSCB SCR Scrutiny Panel as above.

16.5 The CCG is updated regarding progress in relation to these actions via the Quality, Safety and Safeguarding Quarterly Report and additional briefing papers submitted to the Clinical Governance Committee and Governing Body.

16.6 The CCG Safeguarding Team is required to have an overview of the actions tasked to the health economy and to support Named Safeguarding Leads in provider organisation with implementation of the action plans.

16.7 The CCG Safeguarding Team maintains oversight of provider progress via the QSSG meetings. Provider Named Safeguarding Leads give an update in relation to SCR action plans as part of the safeguarding assurance proforma.

16.8 The CCG Safeguarding Team also monitors progress against action plans via the Safeguarding Children Health Collaborative meeting and during safeguarding supervision provided by the Designated Nurse to Named Nurses.

16.9 An overview of the WSCB Serious Case Reviews and Local Case Reviews in 2015/16 are outlined in the table below:

REF ID	INCIDENT DATE	ORGANISATION	STATUS	StEIS Ref No
SCR Child C	21/02/2013	Health Economy	Delays in the SCR process due to criminal investigation. WSCB published Child C SCR Overview Report on 4th June 2015. The health element of these action plans has been monitored via WBCCG QSSG meetings. By Q3 2015/16 all health Providers had completed all actions and had their evidence validated at WSCB Scrutiny Panels. The Assistant Director Safeguarding Children was a Scrutiny Panel Member. The Safeguarding Team have completed all outstanding actions assigned to WBCCG regarding Child C and are scheduled to present evidence to a WSCB Scrutiny Panel on 26 April 2016.	
SCR	26/02/2013	Health Economy	Delays in the SCR process due to criminal investigation.	2015/22132

Child D			WSCB Scrutiny Panel held on 24/02/15, some concerns identified and escalated by WSCB to appropriate health provider regarding lack of progress against action plan. WSCB published the SCR Overview Report on 18 August 2015. By Q3 all health Providers have now completed all their actions and had their evidence validated at WSCB Scrutiny Panels. WBCCG Safeguarding Team have completed all outstanding actions regarding Child D and are scheduled to present evidence to a WSCB Scrutiny Panel on 26 April 2016**.** WBCCG updated StEIS with key lessons learned and recommendations. A subsequent request by WBCCG to NHSE for closure was agreed.	StEIS entry closed by NHSE on 11/11/15 following WBCCG request.
SCR Child E	23/10/2013	Health Economy	Investigation completed. The Child E SCR Overview Report was finalised in February 2015. A WSCB event was held in October 2015 and WSCB published the report on 27th October 2015. The action plan was reviewed at the November WSCB Meeting by Board members and the WSCB Learning and Improvement Sub Group has been tasked with overseeing progress. WBCCG updated StEIS with key lessons learned and recommendations. A subsequent request by WBCCG to NHSE for closure was agreed. WSCB plan to hold a Scrutiny Panel to review evidence in relation to the action plan in Quarter 2 of 2016/17.	2013/37007 2014/18544 StEIS entry closed by NHSE on 11/11/15 following WBCCG request.
SCR CHILD F & G	30/09/2015	Health Economy	A WSCB SCR Consideration Panel was held on 30 September 2015, the Panel recommended that the case met the criteria for a SCR. The WSCB appointed an Independent Author and the 1st SCR Panel meeting was held on 14 December 2015. A SCR Learning Event was held on the on 15th March, the Independent Author is now drafting her SCR Overview Report which will be discussed at the next SCR Panel meeting on 11th May 2016.	2016/1388
LCR Child DM	20/08/2014	Health Economy	Decision to hold a Local Case Review. Overview Author appointed and Learning Event held in December 2015. Recommendations agreed and action plan being formulated.	
LCR Child AT	27/09/2015	Health Economy	Decision to hold a Local Case Review. Overview Author appointed. Plan to hold 1st panel meeting in May 2016.	2015/31301 2015/31533

17 Child Deaths and Child Death Overview Panel (CDOP)

17.1 The statutory requirement for Local Safeguarding Children Boards (LSCBs) to undertake the functions relating to child deaths is set out in Working Together (2015). There are two interrelated processes for reviewing child deaths: a rapid response by key professionals to enquire into each unexpected child death, and an overview of all child deaths in the LSCB area(s) undertaken by a panel.

17.2 GM agreed to commission a Rapid Response Team that operates across the ten authorities. This allowed the creation of a team of consultant paediatricians who are available 24 hours a day seven days a week on a rota.

17.3 A Greater Manchester Protocol underpins the work of the team and provides a framework for a multi-agency response: in particular, between the acute hospitals, GMP, the four Coroners' offices, the rapid response paediatricians and Children's Social Care. The Team has been operational since 1st January 2009.

17.4 Government advice is that Child Death Overview Panels should cover populations of at least 500,000 and it was for this reason that the three authorities of Bolton, Salford and Wigan LSCBs agreed to form a tripartite panel to review the deaths of children resident in these three areas.

17.5 The Panel membership comprises representatives from the relevant disciplines across the three local authority areas. The aim is also to achieve a balance in representation between the three areas.

17.6 The CDOP carries out a multi-disciplinary review of child deaths (0-17 years inclusive) with the aim of understanding how and why children in Bolton, Salford and Wigan die. Panel members consider whether there are any factors which could have been modified to prevent or reduce the chances of a similar death in future.

17.7 The Child Death Overview Panel (CDOP) is responsible for reviewing information from a range of sources, including those who were involved in the care of the child, both before and immediately after the child's death, with a view to identifying:

- Any matters of concern affecting the safety and welfare of children in the area of the authority, including any case giving rise to the need for a serious case review or other internal single or multi-agency case review;
- Any general public health or safety concerns arising from the deaths of children.

17.8 The purpose of the Panel is to:

- Better understand the reasons for deaths in childhood;
- Use the findings to make recommendations to the LSCBs regarding preventative action to minimise the likelihood of further deaths in childhood;
- Initiate preventative action where appropriate to minimise the likelihood of further deaths in childhood;
- Seek to ensure an appropriate response to bereaved families;
- Increase public awareness about the issues that affect the health and safety of children; and
- Identify and advocate for identified changes in legislation, policy and practices to promote child health and safety and to prevent child deaths.

17.9 The Panel is responsible for producing a bi-annual work plan and an annual report, both of which should be reviewed by the LSCB Chairs on a regular basis.

17.10 The Assistant Director Safeguarding Children/Designated Nurse acts as a 'Single Point of Contact' for all child deaths, regardless of whether or not there are safeguarding concerns. As such all child deaths in Wigan Borough are notified to Assistant Director Safeguarding Children/Designated Nurse.

17.11 The Assistant Director Safeguarding Children/Designated Nurse is a member of the Child Death Overview Panel and attends the quarterly meeting.

17.12 There were a total of 63 childhood deaths notified to the CDOP in 2014/15. Since 2007/8 there have been a total of 519 child deaths across the 3 areas. As might be expected there are year on year variations.

17.13 When the numbers of deaths 2007-2015 across the CDOP are compared to the Rate per 10,000 Population 0-17years it can be seen that Wigan has the lowest rate at 2.51 with Bolton at 2.88 and Salford has the highest at 5.91. This compares to an average across Greater Manchester (GM) of 3.91.

17.14 It is important to recognise that not all notifications received in 2014/15 are dealt with in that 12 month period. Notifications received later in the year require information to be gathered which means they will be considered in the next 12 month period.

17.15 Equally some cases may result in coroner inquests, police investigations and in some cases Serious Case Reviews. The timescales of these investigations mean there will inevitably be significant periods between the notification to CDOP and the case being discussed and closed by CDOP. This explains why there were 63 notifications to CDOP but 66 cases were closed.

17.16 The In 2014/15 of the 66 cases closed 69.7% were children under 1 year old. In 2013/14 this figure was 68.9. In both cases this was above the average for GM which in 2014/15 stood at 64.5%

17.17 In 2014/15 the rate for 0-27 days was 44% in this CDOP. The average across GM was 41.6. In the main this can be explained by premature births where the infant is too under developed or because of severe life limiting conditions when the child is at its most vulnerable.

17.18 The CDOP Annual Report 2014/15 recommended that each LSCB ensure that Public Health take the lead in providing evidence of the work being carried out both locally and across GM that will have an impact on reducing the number of child deaths.

17.19 The report suggested the areas requiring specific focus were:

- Actions to prevent premature births which have a disproportionate effect on the child mortality rate;
- Actions to identify and then focus on groups where risk appears to be highest based on ethnicity and deprivation.

17.20 The 2015/16 data is not available until the publication of the CDOP 2015/16 Annual Report which is currently in development.

17.21 The Assistant Director Safeguarding Children/Designated Nurse works in partnership with key agencies to ensure the recommendations are disseminated and implemented.

18 Progress against Safeguarding Team Priorities Identified for 2015/16

18.1 The WBCCG Safeguarding Team priorities identified in the for 2015/16 Annual Report were:

'To ensure that WBCCG continues to meet all statutory responsibilities in relation to safeguarding adults and children, and review arrangements against the revised NHS England Accountability and Assurance Framework once published'

18.2 In February 2016 the Regional Lead Safeguarding NHSE North wrote to Chief Nurses/Directors Quality & Safeguarding to outline the assurance process NHSE North was planning to undertake with CCGs in relation to safeguarding statutory responsibilities.

18.3 The letter detailed the request from NHSE North for CCG Designated Nurses to complete the 'NHSE North Safeguarding Assurance Tool for use with CCGs'. This requires CCGs to self-assess against a number of safeguarding standards based on statutory responsibilities set out in 'Safeguarding Vulnerable People in the Reformed NHS Accountability and Assurance Framework' (2015).

18.4 The Safeguarding Assurance Tool was completed by the Safeguarding Team and presented for review at the Clinical Governance Committee and authorised for submission to NHSE by the Governing Body. The Assurance Tool was submitted to NHS England on 29th February 2016.

18.5 An assurance visit will be conducted by NHSE North Designated Nurses to WBCCG on 14th April 2016. The Safeguarding Team will be required to present all evidence in relation to each Key Line of Enquiry (KLOE).

18.6 NHSE North Designated Nurses will prepare a report detailing the ratings given to WBCCG against each of the KLOE. NHSE North will review all action plans to identify key themes and trends across the North Region with a view to identifying common areas requiring support.

18.7 The WBCCG Safeguarding Team will work on any KLOE which have been rated as 'amber' or 'red' in order to ensure WBCCG is fully compliant with its statutory responsibilities in relation to safeguarding.

18.8 The Safeguarding Team will include an overview of all 'amber' rated KLOE and associated action plans as part of the 'Quality, Safety and Safeguarding' quarterly report provided to both Clinical Governance Committee and Governing Body.

18.9 This work was also further supported by a Mersey Internal Audit Agency (MIAA) review of WBCCG arrangements for 'Safeguarding Children and the Protection of Vulnerable Adults' in Quarter 3 2015/2016.

18.10 The Safeguarding Team have prepared a comprehensive table of evidence which has been shared with the Auditor. A draft MIAA Report in relation this this review is planned to be presented by MIAA to the Safeguarding Team on 7 April 2016.

'To develop a GP Safeguarding Assurance framework as part of WBCCG joint commissioning arrangements with NHS England'

18.11 The Named GP Safeguarding Children, with the support of the Assistant Director/Designated Nurse Safeguarding Children and LAC has localised the Safeguarding Children and Young People: The Royal College of General Practitioners (RCGP)/National Society Prevention of Cruelty to Children (NSPCC) Safeguarding Children Toolkit for General Practice.

18.12 The Toolkit aims to provide Practices with a framework for integrating safeguarding children and young people into existing practice systems and processes for delivering primary care.

18.13 All 63 Practices were sent the 'GP Safeguarding Assurance Toolkit' at the beginning of Quarter 2. By the end of Quarter 4 the Safeguarding Team had received 61 completed Toolkits. Each GP Practice self-assessed themselves as 'Red', 'Amber' or 'Green' against 18 safeguarding standards.

18.14 The returns from each GP Practice were reviewed by the Named GP Safeguarding Children and comments/guidance provided where it was felt that the evidence did not support the self-assessed score.

18.15 To further support the launch of the WBCCG GP Safeguarding Assurance Toolkit the Safeguarding Team re-established the GP Safeguarding Lead Meetings.

18.16 Led by the Named GP Safeguarding Children, the Safeguarding Team held three GP Safeguarding Lead Meetings in Quarter 3 which were well evaluated by those attending.

18.17 The meetings focused on communicating key themes from Serious Case Reviews relating to children in Wigan and gave the GP Safeguarding Leads an opportunity to meet the Safeguarding Team.

18.18 The Team plan to hold further meetings in April 2016 where the focus will be on:

- Key themes and lessons learned from the three recent Domestic Homicide Reviews conducted in Wigan;
- Female Genital Mutilation (FGM) mandatory reporting legislation and statutory Department of Health dataset;
- Key themes and lessons learned from Child E Serious Case Review;
- Recently published intercollegiate document and impact on Safeguarding Adult Training.

18.19 In Quarter 4 the Assistant Director/Designated Nurse Safeguarding Children and LAC also supported the CCG Quality Team in conducting the 'Primary Care Quality Peer Reviews'.

18.20 The 'GP Safeguarding Assurance Toolkit' formed part of the 'Quality Peer Review' agenda and provided GP Practices with the opportunity to share good practice and identify areas for improvement in relation to safeguarding

18.21 As part of the Quality Peer review process each GP Practice was provided with their completed RAG rated GP Safeguarding Assurance Toolkit and a copy of the GP Safeguarding Assurance Dashboard developed by the WBCCG Safeguarding Team.

'To further develop and improve safeguarding assurance validation systems as part of the WBCCG Safeguarding Team's contribution to the Quality, Safety and Safeguarding Group.'

18.22 As part of the annual validation of provider evidence submitted against the safeguarding contractual standards the Safeguarding Team produced formal reports for each NHS Provider.

18.23 The reports were entitled 'Validation of Evidence Submitted - NHS Provider Safeguarding Audit Toolkit'. These reports gave an overview of:

- The evidence each Provider presented to WBCCG to demonstrate compliance against the agreed standards;
- The Safeguarding Teams comments following a review of the evidence and the rating which had been given;
- Any actions required by the Provider in order to address any 'AMBER' or 'RED' standards.

18.24 The reports were tabled for discussion at the QSSG meetings held with each Provider and have been agreed. These formal reports have helped the Safeguarding Team to further strengthen the existing governance arrangements in relation to this process.

'To ensure that all recommendations are fully implemented, and learning is embedded across the health economy in respect of SCRs, LCRs and DHRs.'

18.25 Sections 13, 14 and 16 of this report give an overview of the SCRs, LCRs and DHRs which have been conducted during 2015/16.

18.26 The Safeguarding Team has worked in partnership with the WSCB and WSAB to ensure all recommendations and learning is embedded across the health economy in respect of SCRs, LCRs and DHRs.

18.27 Oversight of providers is maintained via the QSSG meetings using the QSSG safeguarding proforma (see **Appendix 1**)

'To develop a WBCCG Safeguarding Adults at Risk Health Collaborative to mirror that of safeguarding children.'

18.28 This area of work has been initiated but not yet been fully completed. This work will continue to be developed and will form part of the Safeguarding Team key priorities for the coming year.

19 Safeguarding Team Priorities Identified for 2016/17

19.1 The WBCCG Safeguarding Team priorities for 2016/17 are to:

- Improve the oversight and governance in relation to performance against safeguarding contractual standards contracts with our smaller 'other' providers;

- Further develop the GP Safeguarding Lead Meetings and GP Safeguarding Assurance Tool;
- Develop a Safeguarding Adults at Risk Health Collaborative to mirror that of the Safeguarding Children Health Collaborative;
- Continue to work in partnership with colleagues to improve the quality of care homes;
- Improve the governance framework for the oversight of statutory responsibilities in relation to Looked After Children;
- Work to address all areas for improvement identified through completion of the NHS England Safeguarding Assurance Toolkit for CCGs;
- Work to address all areas for improvement identified by the Mersey Internal Audit Agency review of CCG Safeguarding Arrangements.

20 Conclusion

20.1 The Safeguarding Team continues to ensure that WBCCG meets its safeguarding responsibilities and monitors the arrangements of commissioned health services to provide assurance that adults and children at risk of abuse or neglect are safe.

20.2 The Safeguarding Team continues to work with Named Safeguarding Nurses/Leads across provider services to ensure that safeguarding arrangements across the Wigan Borough health economy are robust and fit for purpose.

20.3 There are safeguarding systems in place across the Wigan Borough health economy. There are challenges in relation to training and response to Serious Case Reviews within the Wigan Borough. It is essential that a high level of priority is given to safeguarding adults and children.

20.4 The WBCCG Safeguarding Team is committed to meeting the challenges of safeguarding the population of Wigan Borough and will continue to work collaboratively with the Local Authority, WSAB, WSCB and key partners to develop robust systems to safeguard adults and children.

21 Recommendations

21.1 The NHS Wigan Borough Clinical Commissioning Group Governing Body is asked to:

- Note the contents of the report and accept assurance that Wigan Borough CCG is meeting its statutory responsibilities in relation to safeguarding children and adults at risk.
- Continue to support the WBCCG Safeguarding Team in meeting statutory responsibilities and facilitating relationships with key partners to ensure children and adults at risk are effectively safeguarded.

Glossary

CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panel
CSE	Child Sexual Exploitation
CQC	Care Quality Commission
DHR	Domestic Homicide Review
DoLS	Deprivation of Liberty Safeguards
FGM	Female Genital Mutilation
GM	Greater Manchester
GMP	Greater Manchester Police
GP	General Practitioner
LAC	Looked After Children
LCR	Local Case Review
LSCB	Local Safeguarding Children Board
MCA	Mental Capacity Act
SCR	Serious Case Review
SUDC	Sudden Unexpected Death in Childhood
StEIS	Strategic Executive Information System
WSAB	Wigan Safeguarding Adult Board
WSCB	Wigan Safeguarding Child Board

Appendix 1 WBCCG QSSG MEETING SAFEGUARDING PROFORMA 2015/16

The Quality, Safety and Safeguarding Group (*the Group*) is a sub group of the NHS Wigan Borough Clinical Commissioning Group (WBCCG) Clinical Governance Committee. The Group will review and monitor compliance with SAFEGUARDING standards as specified in the contract.
The provider must fill in the pro-forma and return as part of QSSG submission to WBCCG: laura.hickinson@wiganboroughccg.nhs.uk or julie.screen@wiganboroughccg.nhs.uk **by:**

FOR SUBMISSION TO QSSG MEETING ON:		
ENDORSED BY:		
NAME:	**DESIGNATION:**	**DATE:**
NAME:	**DESIGNATION:**	**DATE:**

SECTION 1 – SAFEGUARDING TRAINING ACTIVITY & COMPLIANCE

Non-Compliant | **Non-Compliant with Action Plan** | **Full Compliance**

SAFEGUARDING CHILDREN	Data from Month(s)/ Quarter	No. of Staff Eligible	No. Staff Compliant	% of Staff Compliant & RAG Rating	SAFEGUARDING ADULTS	Data from Month(s)/ Quarter	No. Staff Eligible	No. Staff Compliant	% of Staff Compliant & RAG Rating
Safeguarding Children Training Level 1 (TARGET: 95%)					Safeguarding Adult Training (TARGET: 85%)				
Safeguarding Children Training Level 2 (TARGET: 85%)					Mental Capacity Act Training (TARGET: 85%)				
Safeguarding Children Training Level 3 (TARGET: 85%)					Prevent Wrap 3 Training (TARGET: 100%)				

In the event a training compliance target is not met an action plan MUST be submitted so that the level of risk can be assessed

SECTION 2 – SAFEGUARDING OPERATIONAL ACTIVITY					
Non-Compliant			Non-Compliant with Action Plan		Full Compliance
SAFEGUARDING CHILDREN	**Comments/ Narrative**	**Date/ Timescale**	**SAFEGUARDING ADULTS**	**Comments/ Narrative**	**Date/ Timescale**
Progress against Action Plans in relation to Child Serious Case Reviews:			Progress against Action Plans in relation to Adult Serious Case Reviews:		
Progress against Action Plans in relation to Child Local Case Reviews			Progress against Action Plans in relation to Adult Local Case Reviews:		
Progress against Action Plans in relation to Single Agency Reviews:			Progress against Action Plans in relation to Single Agency Reviews:		
Progress against Action Plans in relation to Domestic Homicide Reviews:			Progress against Action Plans in relation to Domestic Homicide Reviews:		
Please send updated action plans as a separate attachment and submit with this proforma for review by WBCCG Safeguarding Team					
SAFEGUARDING CHILDREN	**Comments/ Narrative**	**Date/ Timescale**	**SAFEGUARDING ADULTS**	**Comments/ Narrative**	**Date/ Timescale**
Number of LADO referrals currently open:			Number of IMCA referrals made relating to Serious Medical Treatment (e.g. DNACPR, Surgery, etc):		
Number of safeguarding children incidents raised via incident reporting system (Datix/Ulysses):			Number of DoLS Applications/Authorisations:		
Current vacancies within Safeguarding Children Team (all bandings):			Number of safeguarding adult incidents raised via incident reporting system (Datix/Ulysses):		
Current vacancies within Children in Care Nursing Team (all bandings):			Number of safeguarding adult concerns raised via internal safeguarding team systems:		
Date of last supervision with Named Nurse & Designated Nurse Safeguarding Children:			Current vacancies within Safeguarding Adult Team (all bandings):		

SECTION 3 – NHS PROVIDER SAFEGUARDING AUDIT TOOL				
Not Applicable	Non-Compliant	Partial Compliance	Full Compliance	
SAFEGUARDING STANDARD		COMMENTS	BRAG RATING	
1	There is a Board lead for safeguarding children and adults at risk.			
2	The organisation is linked into the Local Safeguarding Children Board (LSCB) and Local Safeguarding Adult Board (LSAB).			
3	Identification of a named doctor and named nurse (and named midwife if the organisation provides maternity services) for safeguarding children. In the case of out of hours services, ambulance trusts and independent providers, this could be a named professional from any relevant health or social care background.			
4	There is a named lead for safeguarding children, a named lead for adults at risk and a named lead for MCA. This must include the statutory role for managing adult safeguarding allegations against staff.			
5	The Provider Board regularly reviews safeguarding across the organisation.			
6	An adverse incident reporting system is in place which identifies circumstances/instances which have compromised the safety and welfare of children and/or adults at risk.			
7	A programme of internal audit and review is in place that enables the organisation to evidence the learning from review, incidents and inspections.			
8	Staff at all levels, have easy access to safeguarding policies and procedures. These policies and procedures must be consistent with statutory, national and local guidance.			
9	There is clear guidance on managing allegations against staff and volunteers working with children and/or adults at risk in line with those of the LSCB and LSAB.			
10	There is a process for ensuring that patients are routinely asked about dependents such as children, or about any			

	caring responsibilities.		
11	There are agreed systems, standards and protocols for sharing information within the service and between agencies in accordance with national and local guidance.		
12	The organisation works with partners to protect children and adults at risk and participates in reviews as set out in statutory, national and local guidance.		
13	Safeguarding responsibilities are reflected in all job descriptions relevant to role and responsibilities.		
14	Staff working directly with children and adults at risk have access to advice, support and supervision. This includes clinical and safeguarding supervision as per the organisation's safeguarding supervision policy. Named professionals seek advice and **access regular formal supervision from designated professionals for complex issues or where concerns may have to be escalated.**		
15	There is a training strategy for safeguarding.		
16	Staff are trained to the appropriate levels in accordance with the current safeguarding children intercollegiate document and the anticipated adults intercollegiate document.		
17	There is a process for following up children who do not attend appointments.		
18	There is a system for flagging children for whom there are safeguarding concerns.		
19	When it is known that a child is not accessing education a referral will be made to the Local Authority in which the child lives.		
20	There is clear guidance as to the discharge of children for whom there are child protection concerns.		
21	The child's GP and health visitor/school nurse is notified of admissions/discharges.		
22	All attendances for children under 18 years to A&E, ambulatory care units, walk-in centres and minor injury units should be notified to the child's GP. Attendances at A&E will also be copied to the health visitor and/or school nurse depending on the age of the child.		
Applies only to Community Providers offering services to children, families and adults			
23	Community health practitioners should have a clear means		

	of identifying in records those children (together with their parents and siblings) who are subject to a child protection plan or Looked After Children.		
24	There is good communication between GPs, community nursing services (i.e. health visiting, school nursing and community midwifery services) in respect of children for whom there are concerns.		
Mental Capacity Act and Deprivation of Liberty Safeguards (MCA & DoLS)			
25	All staff have access to a clear policy and documentation to support implementation of the Mental Capacity Act (2005).		
26	Paid staff and volunteers are trained to support implementation of the Mental Capacity Act (2005) and where applicable Deprivation of Liberty Safeguards (2009). There is a clear training strategy to identify the level of awareness required by staff.		
27	Decision Makers under the MCA have a clear referral process to Independent Mental Capacity Advocacy (IMCA). Appropriate referrals are made in relation to Serious Medical Treatment (SMT).		
28	There are clear procedures on the implementation and management of Deprivation of Liberty Safeguards (2009) in line with the Code of Practice.		
29	There is a system for flagging adults in inpatient care who have learning disabilities or dementia.		
30	Inpatient organisations adhere to DoLS statute and can evidence appropriate urgent authorisations and standard applications.		
31	The use of restraint (as per the Mental Capacity Act) is always appropriate, reasonable, proportionate and justifiable to that individual. Where appropriate, staff required to use restrictive physical interventions have received specialist training.		
Prevent			
32	The Provider is meeting the contracted Prevent agenda requirements.		
Lampard			
33	The Provider is meeting the contracted Lampard Review recommendations (Saville):		

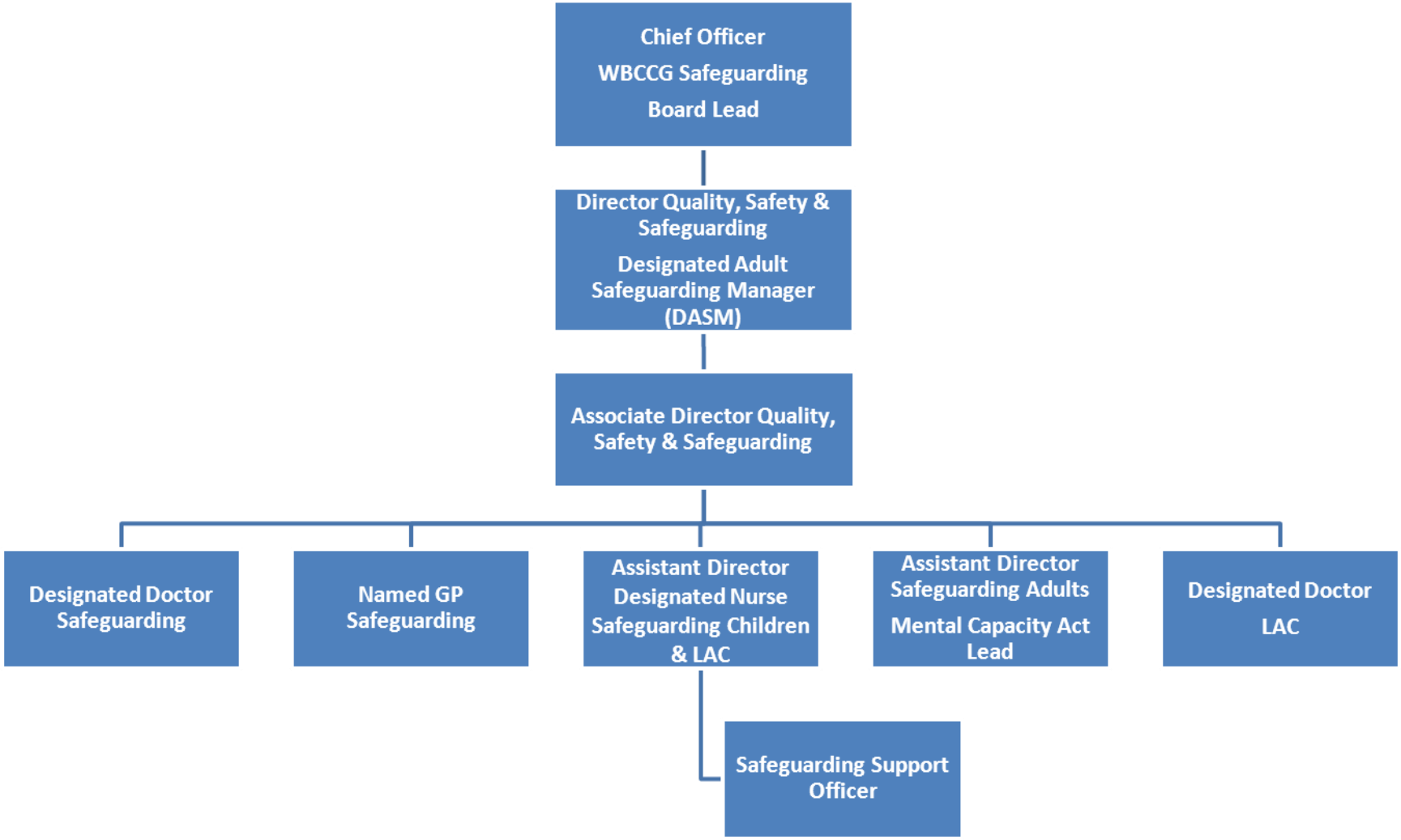
33.1	Recommendation 1 – All NHS hospital providers should have a policy for agreeing to and managing visits by celebrities, VIPs and other official visitors. The policy should apply to all such visits without exception.		
33.2	Recommendation 2 – All NHS providers should: review their voluntary services arrangements and ensure that they are fit for purpose; volunteers are properly recruited; selected and trained and are subject to appropriate management and supervision; all voluntary services managers have development opportunities and are properly supported.		
33.3	Recommendation 4 – All NHS provider staff and volunteers should be required to undergo formal refresher training in safeguarding in safeguarding at the appropriate level at least every 3 years.		
33.4	Recommendation 5 – All NHS provider staff should undertake regular reviews of: their safeguarding resources, structures and processes (including training programmes); the behaviours and responsiveness of management and staff in relation to safeguarding issues to ensure that their arrangements are robust and operate as effectively as possible.		
33.5	Recommendation 7 – All NHS providers should undertake DBS checks (including where applicable enhanced DBS and barding list checks) on their staff and volunteers every 3 years. The implementation of this recommendation should be supported by NHS employers.		
33.6	Recommendation 9 – All NHS providers should devise a robust trust-wide policy setting out how access to patients and visitors to the internet, social networks and other social media activities such as blogs and Twitter is managed and where necessary, restricted. Such policy should be widely publicised to staff, patients and visitors and should be regularly reviewed and updated as necessary.		
33.7	Recommendation 10 – All NHS providers should ensure that arrangements and processes for the recruitment, checking and general employment and training of contract and agency staff are consistent with their own internal HR processes and		

	standards and are subject to monitoring and oversight by their own HR managers.		
33.8	Recommendation 11 – NHS providers should review their recruitment, check training and general employment processes to ensure they operate in a consistent and robust manner across all departments and functions and that overall responsibility for these matters rests with a single executive director.		
33.9	Recommendation 12 – NHS providers and their associated charities should consider the adequacy of their policies and procedures in relation to the assessment and management of the risks to their brand and reputation, including as a result of their associations with celebrities and major donors, and whether their risk registers adequately reflect this.		

SECTION 4 – PROVIDER ACTION PLANS						
No:	**Issue Identified**	**Actions to be Taken**	**Evidence**	**Lead Officer**	**Timescale**	**RAG Rating/ Comments**

Appendix 2

WBCCG SAFEGUARDING TEAM STRUCTURE



GOVERNANCE FRAMEWORK